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Report on Medicare Compliance Volume 29, Number 24. June 29, 2020

Denials Are More Complex, Overturn Rate Has Dropped, Experts Say

By Nina Youngstrom

When an auditor removed a secondary diagnosis of acute and chronic respiratory failure (code J96.21) from a claim for a patient with a history of chronic obstructive pulmonary disease (COPD), the hospital had grounds to appeal. In its denial, the auditor said diagnosing respiratory failure in COPD patients requires a degree of change in their state, not just chronically lower oxygen pressure and increased carbon dioxide. But the auditor was wrong, and the documentation proved it. As the hospital explained in its appeal, when the patient presented to the emergency room in moderate respiratory distress, he had been using three liters of oxygen at night but then required six liters to maintain oxygen saturation of 93%. "The doubling of the patient's oxygen requirements to maintain an oxygen saturation greater than 90% clearly demonstrates a change from the usual state," according to the appeal letter, which also noted that a drop in partial pressure of oxygen equal to or greater than 10 to 15 millimeters of Mercury "generally indicates acute respiratory failure."

The hospital won the appeal, said physician Adriane Martin, vice president of physician services at Enjoin, a clinical documentation improvement company.

With that kind of clinical evidence, hospitals can beat back denials. But they're getting more complex, Martin said during a recent webinar sponsored by RACmonitor.com. "The denials we're seeing are more difficult to overturn," she explained. That's the case whether they're coding or clinical denials. One in 10 claims are denied at a typical 350-bed hospital, and Medicare Advantage (MA) plans and commercial payers are denying an increasing number of claims.

The reason that denials are more complex is that payers change the criteria, Martin said. "It's always a moving target," she contended. For example, providers use validated, universal criteria for diagnosing malnutrition from the American Society for Parenteral and Enteral Nutrition (ASPEN), but she said a lot of MA plans "create Frankenstein criteria. They take a little from here and there. They have not necessarily been clinically validated or widely adopted. They're counting on the fact it is an onerous process to appeal one of these denials and just denying everything and hoping some of them will stick."

Hospitals and other providers are winning fewer appeals, added Andrea Taylor, director of denials management at Enjoin, during the webinar. "The commercial overturn rate is down 11%, and Medicare is down 10%," she noted.

The next wave of denials may be claims for COVID-19, although for now auditors seem to be leaving these claims alone. "I have not seen denials at this time," Martin said. Her concern, however, is that because Medicare and commercial payers are cutting everyone slack during the public health emergency, "people will take it as a free for all" and skimp on documentation.

Auditors perform two types of audits: DRG validations, which focus on whether correct coding or sequencing was applied, and clinical validations, which examine whether the patient truly has the conditions that were documented, Martin said. In addition to reducing reimbursement, denials could affect pay for performance, Martin said. "Often you are getting deletion of secondary codes such as malnutrition. If you delete malnutrition, you weaken the risk adjustment," she noted. "If they kick out the risk adjusters, it doesn't accurately represent your population. That shows how denials have an impact that's not as readily visible."

Auditor May Have Overlooked Physician Query

When considering an appeal, read the denial letter carefully. Is it about coding or clinical validity? If the reviewer refers to *Coding Clinic*, a newsletter published by the American Hospital Association, it's a DRG validation. A denial letter that refers to the *Harrison's Principles of Internal Medicine*, for example, is a clinical validation. The type of review tells you what kind of expertise is necessary to craft the appeal letter. Appeals of denials from DRG validations require a coder, while appeals of denials from clinical validations call for a clinician. Hospitals may be able to reverse denials if auditors applied coding guidelines incorrectly or retroactively, or the *Coding Clinic* wasn't pertinent to your case. Maybe auditors overlooked a physician query that supported the diagnosis, Martin said.

In another case, an auditor recommended changing the principal diagnosis of a patient admitted with syncope (R55), who was also diagnosed at admission with dehydration and acute kidney injury. The hospital reported the principal diagnosis as hypovolemia (E86.1), but the reviewer changed it to acute renal failure (ARF), unspecified (N17.9), saying it was the condition that occasioned the admission. The auditor cited *Coding Clinic* to support this position, including an article from the third quarter of 2002 on ARF due to dehydration and treated with IV hydration only.

"The problem is, that's not the heart of the matter," Martin said. As the hospital explained in the appeal, the physician was queried about the underlying cause of the syncope and responded that it was "truly multifactorial. Hypovolemia probably was the most prominent cause." Consistent with chapter 18 of the *Official Guidelines for Coding and Reporting*,[1] the etiology of syncope was established by query as the principal diagnosis. There also was no clinical support for an ARF diagnosis.

Martin said the hospital won this appeal too.

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1 CMS, *ICD-10-CM Official Guidelines for Coding and Reporting, FY 2020: (October 1, 2019 - September 30, 2020)*, ch. 18, 73-75, https://bit.ly/2Kad977.