You Asked For It!
Winning Appeal Language

Kendall Smith, MD
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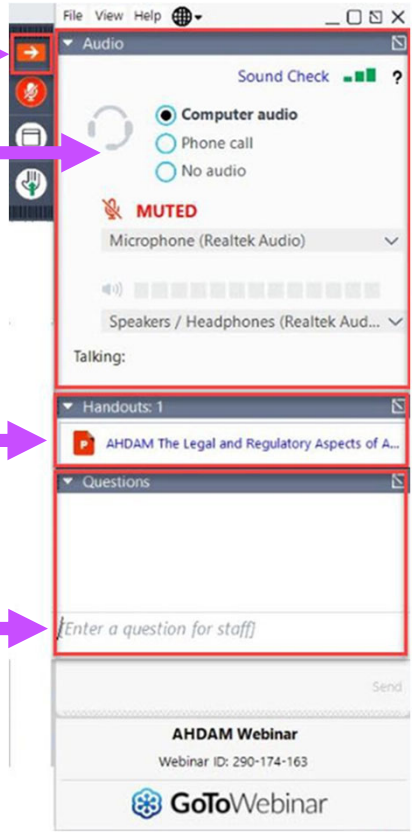

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The Association for Healthcare Denial and Appeal Management

- The nation's only association dedicated to Healthcare Denial and Appeal Management.
- Our mission is to support and promote professionals working in the field of healthcare insurance denial and appeal management through education and collaboration.
- Our vision is to create an even playing field where patients and healthcare providers are successful in persuading medical insurers to make proper payment decisions.

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****Free CEUs are offered to AHDAM members only.****

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- Disclosure: No individuals in a position to control content for this activity have any relevant financial relationships to declare.

* *Physicians must attend the entire presentation.*

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- AMEDCO: CME for physicians: Association of Clinical Documentation Improvement Specialists (ACDIS):
- Certified Clinical Documentation Specialist (CCDS, CCDS-O)
- National Association of Healthcare Revenue Integrity (NAHRI): Certification in Healthcare Revenue Integrity (CHRI)
- Commission for Case Manager Certification (CCMC): CCM board certified case managers
- American Nurse Credentialing Center (ANCC): Continuing nursing education – **awaiting approval**

  This nursing continuing professional development activity was approved by the Northeast Multistate Division Education Unit, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

CE Language (for physicians)

Association for Healthcare Denial & Appeal Management

You Asked for It! Winning Appeal Language.

September 25, 2024

Online

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September 25, 2024 Online

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Objectives - After Attending This Program You Should Be Able To Self Report You Can Identify:

- one successful strategy to consider when writing healthcare related appeals
- one common mistake to avoid when writing healthcare related appeals
- one strategy that is frequently overlooked when writing healthcare related appeals

AMEDCO: Learner Notification, continued (for physicians)

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All individuals in a position to control the content of CE are listed below.

Name	Commercial Interest: Relationship
Karla Hiravi	NA
Alice Pompton	NA
Jo Shultz	NA

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Learning Outcomes

At the conclusion of the webinar, the learner will be able to self report they can identify:

- one successful strategy to consider when writing healthcare related appeals
- one common mistake to avoid when writing healthcare related appeals
- one strategy that is frequently overlooked when writing healthcare related appeals

Presenter

Kendall Smith, MD, SFHM
Chief Physician Advisor | PayerWatch - AppealMasters

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

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Host and Presenter

Karla Hiravi, RN, BSN
President, AHDAM
Senior Vice President | PayerWatch - AppealMasters

Karla is a registered nurse and holds a BSN from the University of Pittsburgh, Johnstown. She has over forty years of varied experiences in healthcare, including Clinical Documentation Improvement (CDI), management of a CDI department, development of a hospital-based denial and appeal program, development of an oncology research program, nurse and physician education, appeal writing, presentations at the Administrative Law Judge (ALJ) level, and direct management of appeals at every level, up to post ALJ appeals. Karla presently serves as President of AHDAM and Senior Vice President of Clinical Resources at PayerWatch, where she continues to participate in and educate clinicians and coders about the medical appeal process.

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Overview

Often confused:

Technical Denials

vs.

Medical Necessity Denials

Coding Denials

vs.

Clinical Validation Denials

Must understand exactly what is denied prior to writing an appeal

Appeal Strategies

First and foremost:

Never, EVER believe that the payer's rationale is correct.

- ***Scrutinize EVERY reason given to deny.***
- ***Push back at EVERY reason given that is not correct.***

Technical Denial Case Studies

Technical Denials

What they are not:

- Not clinical: not patient status, not clinical validation, not medical necessity
- Not coding: not based on coding guidelines

Examples of what they are:

- Clerical errors
- Missing documentation
- No authorization
- Failure to send in clinical information to the payer
- Failure to meet submission deadlines

Appeal Strategies Technical Denials

Address the reason for the denial

- What **extenuating circumstance(s) <u>out of your control</u>** led to the denial?

  Examples:

  - patient confused (unable to provide information)
  - did not bring insurance card
  - correct insurance discovered after admission or after discharge

- Scrutinize patient account notes (PANs) and the medical record for information pertaining to the reason for denial

- Follow with an appeal that outlines the medical necessity and requests retro-authorization.

Case Study 1
Technical Denial

Overturned

Denial letter:

- The request for authorization submitted by (hospital) for (patient) has been denied.

- Timely notification to the health plan for inpatient care is required. The notification was not timely, so the plan did not have an opportunity to evaluate treatment options. This is an administrative decision. The member may not be billed for these services.

Case Study 1
Technical Denial

This is a request for Claim Payment Dispute on (patient's) denied claim for inpatient services at (hospital). The following is a summary of the denial from (payer A), as well as substantiation of the medical necessity that supports the need for services as provided and billed.

Statements of Fact

Extenuating circumstances existed that prevented (hospital)from requesting authorization from (payer) in a timely manner. Please consider the following:

Hospital staff went into their portal and found an insurance card for (patient) for (payer A).

The expiration date on the (payer A) was 12/31/9999.

(Payer A) gave the staff an authorization number.

It wasn't until 8/10/22 that hospital staff realized that the patient was not covered under (payer A).

On 8/12/22, hospital staff contacted (payer B) and talked to Mary, who was unable to process retro NOA over the phone.

As requested by (Payer B), the inpatient authorization form for admission 3/3/2022 was faxed to (Payer B).

(Payer B) denied retro-authorization for untimely notification.

Case Study 1
Technical Denial

A typical medical necessity appeal was then written, followed by:

Summary:

(Patient) required inpatient status for symptomatic atrial fibrillation. As stated by his cardiologist, he was at risk for a host of complications and required drug therapy, anticoagulation, close monitoring, and ablation.

Hospital staff did their best to ascertain his insurance coverage, as noted earlier. They had no way to know at the time of admission that (payer 2) was the primary insurer, nor could they have known that (payer 1) was not active.

We are requesting that these facts are all taken into consideration, as well as the prompt and excellent care given to Mr. X, and ask that retro-authorization is granted.

Case Study 2
Technical Denial

- Denial letter: The admission was administratively denied due to failure to obtain prior authorization for a **planned** inpatient admission.

- PANs: noted the attending's (a cardiologist) office staff stated they **had never done prior authorizations on direct admissions.** It was advised to provide medical necessity or acceptable rationale for late precertification.

- H&P: (Patient) is a 73 y.o. female who presents for **planned** admission for Milrinone initiation.

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Case Study 2
Technical Denial

Admission Information*

- Arrival Date/Time: (blank)
- Admit Date/Time: 08/06/2024 1028
- IP Adm. Date/Time: 08/06/2024 1054
- Admission Type: Urgent
- Point of Origin: Physician Or Clinic Referral
- Primary Service: Cardiology
- Service Area: (Hospital)
- Unit: (Hospital) 3 North
- Admit Provider: R.L., MD
- Attending Provider: R. L., MD
- Referring Provider: A. K.,MD

* Look for this information where the demographic and insurance information is found – typically at the beginning of the medical record.

Case Study 2
Technical Denial

(Patient) was **directly and urgently admitted to the hospital from her cardiologist's office.** Specifically, she was **directly admitted for milrinone initiation**, **as was documented numerous times** throughout the medical record.

The following information was incorporated into a typical medical necessity appeal.

Referring physician: **Directly admitted to (hospital) for milrinone initiation** (p. 30)

Presents for decompensated heart failure requiring milrinone initiation.(p. 16)

Reason for admission: acute decompensated heart failure (p. 29)

Directly admitted for milrinone initiation. (pp. 30, 75, 88, 100, 116, 127, 134)

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Patient Status Case Studies

Case Study 3 Patient Status

Medicare Advantage after 1/1/24

Overturned

Scenario: 82-year-old lady presented to ED with SOB with minimal exertion. In ED: RR 38, tachypnea, rales, rhonchi, SpO2 89%, bilateral pleural effusions, bibasilar consolidations, BNP 2,090, WBC 11,300.

Administered IV Lasix, IV antibiotics, O2 via nasal cannula. After multiple reassessments, she remained SOB and tachypneic with RR 38-52.

Documented to have failed ED observation, so **admitted to telemetry with inpatient status with an expectation for at least a 2 midnight stay**.

Diagnoses made of decompensated CHF, acute hypoxemic respiratory failure, and concern for superimposed pneumonia. Plan included aggressive IV diuresis, IV antibiotics, oxygen therapy.

Case Study 3
Patient Status

Medicare Advantage after 1/1/24

Authorization for inpatient admission was requested timely but denied – no rationale available.

Level of care appeal written.

Included were specific **peer reviewed medical references**, pertinent to the case.

Case Study 3
Patient Status

Published medical literature as references to support your appeal are often overlooked

"Published medical literature" refers generally to scientific data or research studies that have been published in **peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession**, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association."

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Case Study 3 Patient Status

Published medical literature as references to support an appeal are often overlooked

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Ponikowski, P., et al. (2016). 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC). *European Heart Journal, 37*(27), 2129–2200. doi:10.1093/eurheartj/ehw128. As found on: *https://academic.oup.com/eurheartj/article-lookup/doi/10.1093/eurheartj/ehw128*

Signs & Symptoms typical of Heart Failure [p. 2140]:

- **Breathlessness, orthopnea, paroxysmal nocturnal dyspnea, bendopnea, tachypnea**
- **Reduced exercise tolerance, fatigue, tiredness, increased time to recover after exercise**
- **Nocturnal cough, wheezing**
- **Pulmonary crepitations, reduced air entry and dullness to percussion at lung bases (pleural effusion)**

Signs and symptoms of heart failure may be difficult to identify and interpret in obese individuals, the elderly and in patients with chronic lung disease. [p. 2138]

"**AF (atrial fibrillation) is the most common arrhythmia in HF (heart failure) irrespective of concomitant LVEF (left ventricular ejection fraction); it increases the risk of thromboembolic complications (particularly stroke) and may impair cardiac function, leading to worsening symptoms of HF**." [p. 2159]

"**Anemia (defined as a hemoglobin concentration <13.0 g/dL in men and <12.0 g/dL in women) is common in HF, particularly in hospitalized patients**. [p. 2168]

"Anemia is associated with advanced symptoms, worse functional status, greater risk of HF hospitalization and reduced survival." [p. 2168]

"Patients with HF and concomitant valvular heart disease constitute a **high-risk population**." [p. 2170]

"AHF (acute heart failure) refers to rapid onset or worsening of symptoms and/or signs of HF. **It is a life-threatening medical condition requiring urgent evaluation and treatment, typically leading to urgent hospital admission**." [p. 2171]

Criteria for hospitalization or ICU/CCU admission [p. 2177]:

- **Patients with persistent, significant dyspnea or hemodynamic instability.**
- **High-risk patients (i.e. with persistent, significant dyspnea, hemodynamic instability, recurrent arrhythmias, AHF and associated ACS)**
- **Oxygen saturation (SpO2) <90%**

Patients admitted with AHF are not medically fit for discharge until they are hemodynamically stable, euvolemic, established on evidence-based oral medication and with stable renal function for at least 24 hours before discharge [p. 2183]

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Case Study 3 Patient Status

Published medical literature as references to support an appeal are often overlooked

Link applicable reference bullet points to arguments in your appeal.

"Ms. X suffered from persistent and significant dyspnea due to acute heart failure despite aggressive emergency treatment. Her SpO2 was < 90% and she required oxygen therapy. As such, she was considered high risk and met criteria for hospitalization per Ponikowski, et al.(2016)."

Criteria for hospitalization or ICU/CCU admission [p. 2177]:

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Case Study 3
Patient Status

Medicare Advantage after 1/1/24

The physicians were clear in their documentation that their expectation was that Ms. X's **medically necessary** hospital care would cross at least 2 midnights. Ms. X required multiple days of aggressive treatment that included IV antibiotics, IV diuresis, telemetry monitoring and multiple consultations (cardiology and infectious disease in addition to the attending hospitalist).

Coverage criteria is specified in the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) and the statutory requirements at section 1852(a) of the Social Security Act and 42 C.F.R 422.100. **These standards for coverage criteria are meant to ensure that basic benefits coverage for MA enrollees is no more restrictive than Traditional Medicare.**

Had authorization been approved and then denied later, consider:

42 CFR 422.138 states, "**If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity** and may not reopen such a decision for any reason except for good cause (as provided at § 405.986 of this chapter) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616." *(emphasis added)*

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DRG (Coding)Validation vs. Clinical Validation

Per CMS:

- **DRG Validation** is the process of reviewing physician documentation and determining whether the correct codes, and sequencing were applied to the billing of the claim. This type of review shall be performed by a certified coder. For DRG Validations, certified coders shall ensure they are not looking beyond what is documented by the physician and are not making determinations that are not consistent with the guidance in Coding Clinic.
- **Clinical validation** is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

Appeal Strategies: Coding and Clinical Validation Denials

First and foremost:

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- ***Scrutinize EVERY reason given to deny.***
- ***Push back at EVERY reason given that is not correct.***

Coding Case Studies

Case Study 4
Coding Denial

Overturned

Payer:

Per provider documentation, the wedge resection was only a diagnostic procedure with no therapeutic benefit and therefore would be coded with X qualifier not the Z qualifier.

Appeal:
The reviewer alleges that per provider documentation, the wedge resection was only a diagnostic procedure with no therapeutic benefit and therefore would be coded with X qualifier not the Z qualifier.

The provided rationale is incorrect because the procedure included a therapeutic component to remove the lesion. **Per CC 4th Q 2007 page 189 as shown below "a wedge resection is typically performed for the treatment of small lung nodules."**

The wedge resection was done to remove the lesion and surrounding lung tissue. The patient had a growing right upper lobe lesion that was PET avid with no signs of any disease anywhere else. A resection versus observation was proposed. The resection was preferred by the patient. The operative report states "We began by visualizing the lesion in the right upper lobe. Using a robotic thick tissue stapler, we were able to wedge out the lesion." **That documentation definitely supports a therapeutic component and Z is the correct qualifier. The qualifier "X" is exclusively used for diagnostic procedures only**.

Case Study 4
Coding Denial

Document Source & Date	Pertinent Information	Page(s)
Operative note, 6/01/21	Flexible bronchoscopy, right robot-assisted **wedge resection** with mediastinal lymph node dissection. POSTOPERATIVE DIAGNOSIS: Right upper lobe nodule. PROCEDURE: We began by visualizing the lesion in the right upper lobe. Using a robotic thick tissue stapler, we were able to **wedge out the lesion.**	87

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Case Study 4
Coding Denial

ICD-10-PCS Code Assignment Support-0BBC4ZZ

ICD-10-PCS Character		ICD-10-PCS Character Assigned	Rationale and Support for Character Assignment
1	**Section**	0	Medical and Surgical
2	**Body System**	B	Respiratory System
3	**Root Operation**	B	Excision
4	**Body Part**	C	Upper Lung Lobe, left
5	**Approach**	4	Percutaneous Endoscopic
6	**Device**	Z	No device
7	**Qualifier**	Z	No qualifier **-lesion was removed-therapeutic**

Case Study 4
Coding Denial

Source/Reference	**Thoracoscopic Procedures of the Chest** ***Coding Clinic*, Fourth Quarter 2007 Page: 109** **Effective with Discharges: October 1, 2007** **Other coding advice or code assignments contained in this issue Effective with Discharges: October 19, 2007**
Practice Guideline Recommendation	Effective October 1, 2007, several new codes and new subcategories were created to separately identify thoracoscopic surgeries of the chest. Thoracoscopic wedge resection (32.20) **is the surgical removal of a wedge-shaped portion of tissue from one, or both, lungs via a thoracoscope and is typically performed for the treatment of small lung nodules.**
Source/Reference	**Therapeutic and Diagnostic Paracentesis** ***Coding Clinic* for ICD-10-CM/PCS, Third Quarter 2017: Page 12** **Effective with discharges July 27, 2017.**
Practice Guideline Recommendation	Question: A 64-year-old patient with new onset ascites presents for abdominal paracentesis. An ultrasound guided diagnostic and therapeutic paracentesis are both performed via a catheter. Is it appropriate to report two procedure codes for the diagnostic and therapeutic paracentesis? Answer: Assign only the following code: 0W9G3ZZ Drainage of peritoneal cavity, percutaneous approach, for the diagnostic and therapeutic paracentesis **If there is a therapeutic component to the procedure, only the qualifier "Z" is used, rather than the qualifier "X." The qualifier "X" is exclusively used for diagnostic procedures only**. If there are two separate procedures, one diagnostic and the other therapeutic, then both procedures are code separately. For example, a diagnostic drainage procedure that uses a different approach or samples a different site from the therapeutic drainage procedure requires two separate codes to capture both the diagnostic procedure (biopsy) and the therapeutic procedure.

Case Study 5
Coding Denial

Overturned

Payer:
The reviewer alleges that C64.2, malignant neoplasm of left kidney except renal pelvis, was discovered incidentally on a radiological exam done for a different issue and did not require any workup or management for the condition while inpatient.

The payer's rationale is incorrect because in accordance with the official coding guidelines section III.C if the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", compatible with", "consistent with", or other similar terms indicating uncertainty, **code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.**

The medical record indicates the patient's suspected renal cell carcinoma **met the definition of a secondary diagnosis** in that the diagnosis **required a urology consult for the suspected renal cell carcinoma, a follow up appointment with the on-call provider, evaluation by the patient's providers, and a renal ultrasound.**

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Case Study 5
Coding Denial

Document Source & Date	Pertinent Information
Hospitalist Progress Note 2/18/2022	**We will obtain a renal ultrasound** to understand the left kidney mass.
Consultation Note 2/18/2022	Left renal mass. Incidental finding on CT scan. **Worrisome for renal cell carcinoma. Recommend nonurgent, outpatient urology evaluation**.
Discharge Summary Note 2/20/2022	**2.9 x 3x1 cm lesion in the left renal cortex concern for RCC** Suspicious heterogeneous 2.9 x 3.1 cm lesion in the left renal cortex worrisome for renal cell carcinoma. **Consider nonemergent urological consultation**. He did have a 2.9 x 3.1 cm lesion in the left renal cortex. This is worrisome for a developing renal cell cancer. **Urology referral to on-call urologist Dr. Dxxxx has been made.**

Case Study 5
Coding Denial

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Reporting Additional Diagnoses
ICD-10-CM Official Guidelines for Coding and Reporting
Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

The UHDDS item #11-b defines Other Diagnoses as "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

For reporting purposes the definition for "other diagnoses" is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; **MET: Hospitalist evaluated condition**

or therapeutic treatment;

or diagnostic procedures; **MET: Renal ultrasound**

or extended length of hospital stay;

or increased nursing care and/or monitoring.

C. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", "still to be ruled out", "compatible with", "consistent with", or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the **diagnostic workup, arrangements for further workup or observation,** and initial therapeutic approach that correspond most closely with the established diagnosis.

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Clinical Validation Case Studies

Case Study 6 Clinical Validation Denial

Overturned

Payer: Although the diagnosis of sepsis is documented throughout the medical record, sufficient supporting documentation was not found within the medical record to validate this diagnosis based on Sepsis 3 clinical criteria.

Appeal:

Document Source & Date	Pertinent Information	Page(s)
ED Provider Note, 4/2/23	Significant acute erythema of the right lower leg with swelling of the calf and foot, tenderness to foot and calf, significant pain to light palpation of the foot and dorsum, tenderness to ankle as well however less so. Able to range the ankle but severe pain to foot. **Cellulitis** Medications given in ED: Vancomycin 1250 mg Lactated Ringers bolus 1000 ml **Indication for IV hydration is: treatment of sepsis.**	17, 19
H&P Notes, 4/2/23	**Sepsis 2/2 RLE cellulitis** **Presented w(ith) tachycardia and leukocytosis.** **Adtl** (additional) **1L LR bolus (received 1L already in the ED**	44
H&P Notes, 4/2/23	**Clinical Quality Reminders**: Sepsis suspected (suspected infection with 2 of the following: RR > 20, HR > 90, T > 38°C or < 36°C, WBC > 12,000 or < 4,000): Yes - will initiate sepsis order set.	45
Discharge Summary, 4/5/23	**Sepsis 2/2 rle cellulitis** h/o mrsa Received vanc/zosyn 4/3-5, then doxycycline/Keflex for total 7-day course Heptocellular transaminitis: mild, due to sepsis vs hepatitis New Medications: Cephalexin, doxycycline hyclate	50-52

Case Study 6 Clinical Validation Denial

Vital Signs/Measurements

Test	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
WBC – Leukocytes	4/2/23	**12.2**	≥ 12 000 cells/μL or ≤ 4000 cells/μL	86

Laboratory

Vital Signs/Measurements	Date(s)	Results	Reference Range of values that are representative of Sepsis	Page(s)
Heart Rate	4/2/23	**119** **104** **105**	≥ 90 beats/min	27 36 38

Case Study 6 Clinical Validation Denial

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Justification for Appeal

The arguments presented below justify the inclusion of sepsis as a valid diagnosis for the following reasons:

There is not consensus in the medical community as to what constitutes "Sepsis". The payer references material that appears to originate from The Third International Consensus Definitions for Sepsis and Septic Shock. As clearly shown in the Evidence Based Guideline section below, this information has not been endorsed by many members of the medical community. Thus, it remains only one possible piece of information that physicians may consider, or may decide not to consider, when evaluating and treating their patients. **Physicians are not bound by one group's opinions as to what constitutes a certain diagnosis.**

Several states (IL, NY, OH, WI) have instituted laws, regulations, or policies to improve sepsis prevention and early recognition (***https://www.cdc.gov/hai/pdfs/sepsis/VS-Sepsis-Policy-FINAL.pdf***). Because the state of New York implemented regulations in 2013 regarding early diagnosis and treatment of sepsis using the SIRS + Infection (Sepsis 2) criteria, the Greater New York Health Association confirmed in January 2019 that United Healthcare had written to both the New York State Department of Health and the New York State Department of Financial Services, stating that it would not implement Sepsis-3 criteria in its medical record audits in the state of New York. **This underscores the continued need to recognize SIRS + Infection as appropriate diagnostic criteria for the early detection of sepsis.**

There are multiple definitions of sepsis used by physicians and hospitals. In this case, it is obvious that both the hospital and physicians use sepsis 2 criteria to diagnose sepsis. Providers were clear that because of leukocytosis and tachycardia with an underlying infection of cellulitis, that sepsis was present. Documentation explicitly supports treatment for sepsis. It is also clear that the hospital endorses the use of sepsis 2 criteria as evidenced by the "Quality Reminder" found in the H&P to remind physicians of the criteria and use of a sepsis order set. Reviewers of a medical record, of unknown qualifications, should never be permitted to negate diagnoses made by the examining and treating physicians.

The CDC recognizes and endorses the early detection and treatment of sepsis in order to reduce sepsis mortality (https://www.cdc.gov/sepsis/prevention-activities/index.html).

The use of SOFA criteria as defined in The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) is not helpful for early detection of patients with sepsis.

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Case Study 6 Clinical Validation Denial

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Cortes-Puch, I. & Hartog, C. (July 2016). Opening the Debate on the New Sepsis Definition. Change Is Not Necessarily Progress: Revision of the Sepsis Definition Should Be Based on New Scientific Insights. *American Journal of Respiratory and Critical Care Medicine.* As found on: *http://www.atsjournals.org/doi/full/10.1164/rccm.201604-0734ED*
"Despite…limitations, the SIRS criteria have been practical and widely used for quality improvement initiatives (8/9) and awareness campaigns (10) to educate clinicians and the public about the early signs and symptoms of sepsis and that delaying treatment can be lethal." [p.2] **"There is currently no test or gold standard to identify patients with sepsis…Determining the diagnostic accuracy of a new or revised definition is not feasible without a gold standard to identify patients with the clinical syndrome**." [p.2] **"The decision to revise the definition should reflect unambiguous new developments in the field, rather than expert opinion. Changes in the definition should be occasioned by true breakthroughs in scientific understand or clinical evidence, and not by changes in task force members, their inclinations, or new consensus procedures**." [p.1] **"The new definition, requiring the presence of organ failure, may hinder general awareness of the importance of early recognition and treatment**. Ideally, patients at risk for sepsis should be identified before organ dysfunction is established to prevent organ injury from occurring…The revised definition will likely identify a sicker population and could potentially delay treatment of patients who might benefit from an early approach." [p.2] **"Early recognition and treatment of sepsis is currently accepted as a general principal**, and has been deemed especially important in low and middle-income regions (11). However, the 2016 task force failed to include representatives from any of these regions where the underlying infections and the priorities for improving quality of care may differ from those in high-income regions. **Some professional societies** of emergency medicine and low and middle-income regions have already voiced this concern and **have not endorsed this new definition** (12, 13)." [p.2]

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Case Study 7 Clinical Validation Denial

Overturned

After review of the claim and the hospital chart, we are reclassifying the diagnosis related group (DRG).

According to the case review information from the hospital during the hospital stay, and the clinical record reviewed after discharge, billing with a Medical DRG 790, Extreme Immaturity or Respiratory Distress Syndrome, Neonate, is not supported by the clinical information in the chart.

Review of the record for this 34w 2d twin newborn documents repeatedly that transient tachypnea of the newborn (TTN) is one of the potential diagnoses explaining the need for breathing support (CPAP) for the first two days.

Evidence in the chart more strongly supports that the diagnosis of TTN, ICD P 22.1, is the correct diagnosis. In addition to early neonatologist notes documenting that, the hospital course summary by the attending neonatologist on 11/24 documents TTN as the diagnosis and not RDS.

The only X-ray supplied in the chart provided for review did not show hypoinflation, but hyperinflation of the newborn based on diagnostic testing and clinical course.

The chart documents that the infant did have respiratory distress necessitating CPAP support, but, as with TTN, the breathing problems resolved by the third day.

The clinical information does not support the diagnosis of respiratory distress syndrome, ICD code P22.0.

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Justification for Appeal

(Interdisciplinary documentation, pertinent VS, and pertinent studies preceded this section of the appeal and clinical references followed this section)

The clinical information contained in the medical record is consistent with evidence based guidelines for establishing the diagnosis.

1. Shortly after birth, the neonatal assessment and plan of care included clinical evaluation, monitoring, and management of the infant's Respiratory Distress Syndrome. This is evidenced by documentation in the medical record of **grunting, retractions, abnormal ABGS, late preterm, placed on NIMV and then CPAP, surfactant considered**.

- **Surfactant would never be considered for TTN because there is not a surfactant deficiency in TTN as there is in RDS.**

2. The auditor claimed that the chest Xray showed hyperinflation, rather than hypoinflation.

- What the auditor did not relay was that **the baby was on a CPAP at the time the chest Xray was taken.**
- A CPAP can absolutely cause hyperinflation of the lungs. The radiologist even alluded to that with the statement of, " **Lungs appear mildly hyperinflated which may be secondary to CPAP administration**."

3. The auditor claimed that TTN was documented repeatedly for the first 2 days as a potential diagnosis.

- **Of concern is that the above statement does not state that RDS was also repeatedly documented as a potential diagnosis**.
- For the first 2 days, documentation was "TTN vs RDS."

4. The auditor claims the neonatologist documented TTN in the 11/24 progress note.

- Of concern is that the **auditor did not state that the neonatologist also documented S/P RDS in the same note.**

5. After study, the treating and examining physicians responsible for the care of this premature infant made a diagnosis of RDS, not TTN. Three days of respiratory distress is not inconsistent with RDS.

6. Please note the discharge summary that is eminently clear this baby had overcome RDS. There is not mention of TTN whatsoever in the discharge summary.

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References

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Questions and Answers

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Thank you for attending today's event!

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