Clinical Denials Assessment

Scope: Managed Resources assessed the denial and appeal process for The assessment entailed an information gathering session and a sample review of DRG and Medical Necessity denials.

Reported Obstacles:

- DRG challenges with Sepsis, Acute Respiratory Failure, Malnutrition, AKI, and Pneumonia
- Influx of DRG denials
- Challenges with United Healthcare

Medical Necessity Appeals

Findings

- Appeal letters included a case summary (with pertinent lab findings, diagnoses, and intensity of services) and rebuttal citing either Medicare Benefit Policy Manual or MCG Guidelines

Recommendations

- Include all relevant points to appeal
  - Physician Judgement + Criteria + Statutory Language
  - Physician Judgement + Medical Literature + Statutory Language

  Remember, ***the physician*** is responsible for deciding whether a patient should be admitted as inpatient. Both IQ and MCG state:

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  Include all physician documentation that supports medical necessity. For example,

  "Given concern for cardiorenal syndrome, patient requires inpatient admission with aggressive diuresis and close monitoring of renal status. I anticipate >2MN stay"

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- Spell out the individual circumstances the payer should consider, especially if patient does not meet criteria.

- Include statutory language to support appeal. Example: (Denial for no authorization for Labor and Delivery):
  - **Newborns' and Mothers' Health Protection Act (NMHPA):** "The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) is a federal law that affects the length of time a mother and newborn child are covered for a hospital stay in connection with childbirth. In general, **group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay** in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section."[1]

- Include medical literature, especially if the patient does not meet criteria. Example:

  Genitourinary Infections and Preterm Labor
  - "Approximately 40 percent of spontaneous births are thought to be caused by infection. Systemic maternal infections such as pyelonephritis have been associated with preterm delivery." [2] *Due to Ms. G's history of preterm delivery, her attending Obstetrician determined that she was not medically stable for Outpatient care. She required inpatient admission with IV antibiotics to treat her pyelonephritis.*

- Cite NCD and LCD specifics, if applicable

DRG Appeals

Findings

- Use of Coding Clinics, Coding Guidelines, and [redacted] specific criteria (Sepsis)
- Appeal letter refutes specific points in denial letter

Recommendations

- Add statutory language to appeals, as applicable. Example:

  CMS and Statutory Noncompliance:

Blue Shield provides no clinical or coding explanation for under-reimbursement of this claim. The unexplained under-reimbursement is a mere refusal of contractually obligated payment and violates CMS regulations and California state law. *As such, dismissal is required, and full reimbursement must be remitted.*

  - **CMS Conditions of Participation** specifies**, "**Clinical validation involves a clinical review of the case performed by a clinician (RN, CMD or therapist) *and* the skills of a certified

[1] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html
[2] https://www.aafp.org/afp/2002/0115/p241.html

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coder."[3] **Reimbursement cannot be denied to a provider without providing such reasoned, qualified review.**

- The **CMS Medicare Program Integrity Manual** requires that, "contractors *shall* use individuals who are trained and experienced ICD-10 coders to perform DRG validation functions. . . . The contractor shall base DRG validation upon accepted principles of coding practice consistent with Guidelines established for ICD Coding, the UHDS and coding clarifications issued by CMS." [4] **According to all these authorities, reimbursement cannot be denied to a provider without providing *qualified* review to the provider.**

- **Health & Safety Code §1367.01 (h) (4)** states, "Responses regarding decisions to deny, delay, or modify health care services . . . shall include a clear and concise explanation of the clinical reasons for the plan's decision and a description of the criteria or guidelines used, and the." **Denial of reimbursement requires such explanation be submitted to the provider.**

- Cite system policies and/or contract language if applicable to appeal (Sepsis 2 criteria).

- Include medical literature to support clinical validation appeals. Refute the medical literature cited in the denial letter, if possible. Example:

  The denial letter stated "the patient presented with zero percent documented weight loss in six months. This does not meet the ASPEN guidelines for distinguishing non-severe malnutrition in acute illness."

  - *As noted above, there was clear documentation of weight loss (with contextual timeframe) in the medical record.*
  - *The prevailing standard for diagnosing Malnutrition is GLIM criteria, NOT ASPEN. In September of 2019, the World Health Organization and American ASPEN adopted the GLIM criteria as a valid way of confirming a Malnutrition diagnosis. The GLIM criteria defined Adult Malnutrition as Stage 1 (Moderate) or Stage 2 (Severe) based on the presence of 2 categories of characteristics: Phenotypic and Etiologic. GLIM criteria for Malnutrition are present when one Phenotypic criteria and one Etiologic criteria within a severity level are present.* [5]

[3] CMS, as reported and quoted in Clinical Validation, the Next Level of CDI JAHIMA August 2016.

[4] Medicare Program Integrity Manual Chapter 6.5.2 (2019***) reported at*** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf

[5] In September 2018 the Global Leadership Initiative on Malnutrition (GLIM) agreed by Consensus to use the GLIM Criteria to diagnose Malnutrition consistently world-wide. This included ASPEN (USA), ESPN (Europe) FELANPE (Latin America), PENSA (Asia) doi.org/10.1002/jpen 1440 *and also reported at* Cederholm, T. et al *GLIM criteria for the Diagnosis of Malnutrition* Clinical Nutrition February 2019 Volume 38 Issue 1, p. 1-9 reported at https://www.clinicalnutritionjournal.com/article/S0261-5614(18)31344-X/fulltext

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Overall Recommendations:

- Evaluate follow up process. Consider administrative support to help with payer follow up.
- Pursue arbitration/ involve legal once appeals exhausted with the payer.
- Raise issues in contract negotiations, using specific data you have obtained.

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