

Denials Management: Case Studies and Best Practice

Today's Presenter



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Agenda

- Review payor denials
- Determine trends with denials
- Common DRGs being denied
- Diagnosis issues with denials
- Review rebuttal examples
- Review outcome examples
- Review denials management review processes

Sections

Section One – What , Who and Why Denials Management?

Section Two – Setting up your team for best practice.

Section Three – The denial and rebuttal process.

Section Four – Denial and rebuttal examples.

Section Five – Wrapping up with Q&A.



What, Who, and Why Denials Management

What is Denials Management?

Denial Management is the Evaluation and Maintenance of:

- understanding why a medical claim is being denied,
- determining best practices for reducing denials, and
- creating processes, procedures, and strategies that prevent future denials that increase the accuracy of reimbursement on initial claim submissions.

Who Makes up a Denials Management Team?

- **A Denials Management Steering Committee**

- Admission/registration staff
- Case Management/Utilization Review members
- Financial services/Account Receivable
- Clinical Documentation Improvement staff
- Health Information Management staff
- Information Technology department
- Chief Financial Officer
- Compliance
- Contracting Department
- Hospitalist, Physician Advisors for peer-reviews

Who Makes up a Denials Management Team?

- **A Denials Management Steering Committee Should Consist of Leadership from:**
 - Admission/registration staff
 - Case Management/Utilization Review members
 - Financial services
 - Clinical Documentation Improvement staff
 - Health Information Management staff
 - Information Technology department
 - Chief Financial Officer
 - Compliance
 - Contracting Department
 - Hospitalist, Physician Advisors for peer-reviews

Who Makes up a Denials Management Team?

- **Admission/Registration staff**
 - Incorrect Plan/ID numbers
 - Verification of benefits and eligibility issues
 - Pre-authorization issues
- **Case Management/Utilization Review Members**
 - Length of stay/continued stay
 - Level of care
 - Appropriate service(s)
- **Financial Services**
 - Billing edits
 - Submission issues
 - Timely-filing issues

Who Makes up a Denials Management Team?

- **Clinical Documentation Improvement Staff**

- Review clinical picture.
- Respond to denials for medical necessity and relevance
- Educate providers and staff on appropriate documentation.

- **Health Information Management Staff**

- DRG evaluations based on coding errors (principal diagnosis, procedural coding).
- Respond to denials based on coding issues.

- **Information Technology Department**

- Help with tracking for trend analysis.
- Set up alerts for providers to aid in documentation needs to avoid future denials.
- Routing concerns for prompt access to denials.

Who Makes up a Denials Management Team?

- **Chief Financial Officer**
 - Invested interest in overall financial impact of denials from baseline.
 - Executive leadership role to help support the growth of the Denial Management Department.
- **Compliance**
 - Ensures compliance within all aspects of the denial process; request for information, documentation, corporate compliance, education of staff, and auditing.
- **Hospitalist, Physician Advisors for Peer-reviews**
 - Responds to denials based on clinical picture and medical necessity issues.
 - Works with insurance appeals for peer-to-peer reviews in order to overturn denials.
 - Educates clinical staff about previous outcomes of denials in order to prevent future issues.

Who Makes up a Denials Management Team?

- **Contracting Department**

- Investigates contract for possible revision request or updates to new contract requirements in order to avoid future denials.
- Helps to negotiate future contracts in favor of the patient and the facility with coverage needs.

Each department needs to understand their routing processes are consistent and manageable

- Electronic/Mail/Email/Fax
- Ensures that all payer responses are received appropriately, dispersed properly, and in a timely way.

Who Makes up a Denials Management Team?

- **Denials Management Core Frontline Team is Comprised of:**
 - Admission/registration staff – may work only those claims that have been deemed a registration issue.
 - Case Management/Utilization Review members
 - Financial services
 - Clinical Documentation Improvement staff
 - Health Information Management staff
 - Hospitalist, Physician Advisors for peer-reviews

Each area may be divided up by denial type and possibly payor.

Why Denials Management?

The goal of a denials management team - is to maintain appropriate reimbursement and/or recover unpaid or reduced payments from insurance carriers as a result of claims denials through claims analysis.

A denials management department investigates each denied claim for trending by payor and/or cause.

Ultimately, denials management works with insurance companies through an appeals process to recover appropriate payment.

Why Denials Management?

“According to recent estimates, “the gross charges denied by payers has grown 15 to 20% of all claims submitted. The average cost to rework a claim is about \$25.00 per claim according to” (Healthcare Financial Management Association). As many as 65% of claims never get worked resulting in an estimated 3% loss of net revenue”.

Source: <https://www.assurancemd.com/denial-management-requires-expertise-and-dedicated-focus/>

Setting Up Your Process & Structure – Best Practice

Setting Up Your Process and Teams

- First, analyze your current denials process. What works and what doesn't.
- Understand where all denials come from (electronic, manual/mail, fax). Expedite and streamline this process.
- Use analysis to determine process and structure needs with improvement suggestions.
- Utilize the entire Steering Committee, Leadership, and frontline staff to help with process and structure determinations.
- Create procedure and policies that fit the entire workflow of denial management with a drill-down to individual roles and functions.

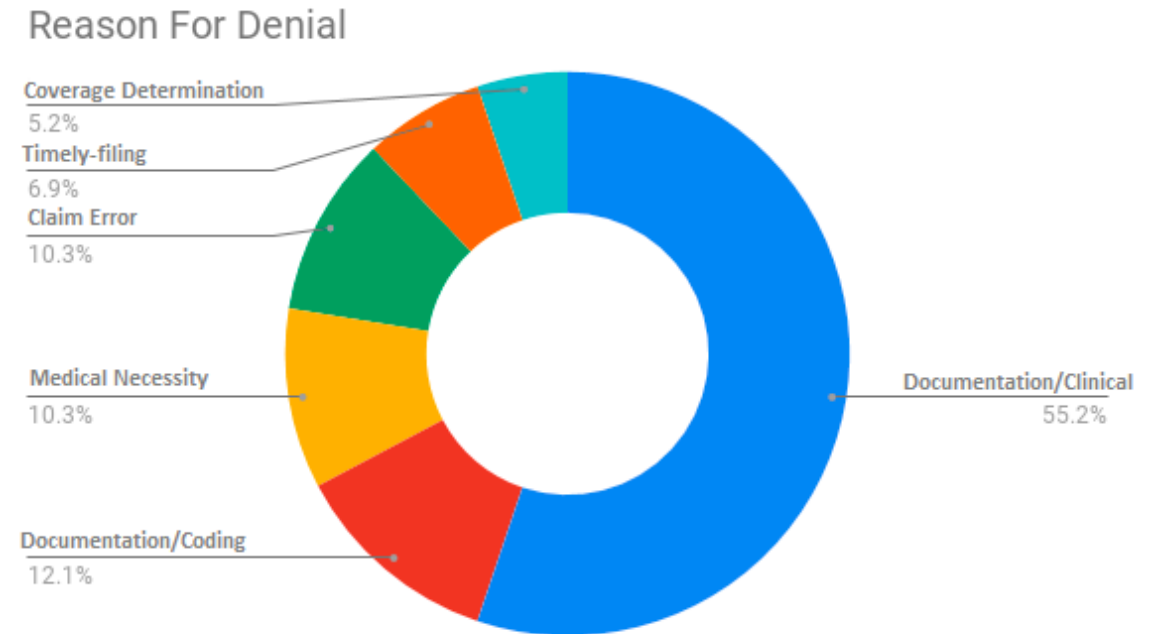
Setting Up Teams

- Divide teams by department and role.
- Incorporate communication styles that don't hinder timeliness of appeals.
- Determine formal processes for categorizing denials and routing needs.
- Determine follow-up protocol for denial, rebuttals, appeal levels, and peer-to-peer reviews.
- Implement tracking methods for trend analysis and continued process improvement.
- Look at specializing denial team members into specific payor groups.

Setting Up Teams

Categorizing your denials by their root cause, is one of the most important aspects of denial management. This aids with proper assignment of resources to the right denial and expedites review time.

- Claim Error
- Medical Necessity
- Documentation & Clinical Significance
- Coding/DRG Variance



Setting Up Teams

Failure to categorize and route denied claims creates:

- Wasted time with rerouting denials
- Lost or misplaced claims
- Frustration with staff
- Unsuccessful or irrelevant appeals
- Delays and missed response deadlines
- Inconsistent handling and processing of denial reviews

Setting Up Teams

Creating teams and sorting denials aids:

- Ensures timely TAT for denials appeals.
- Helps shorten timeline for achieving final payment.
- Ensures specialized and consistent staffing needs based on payor trends and denial reasons.
- Increases overturn rates.
- Reduces denials on future claims.
- Helps individual team areas to create consistent education for staff.

The Denial & Rebuttal Process

Levels of Denial

APPEALING MEDICARE DECISIONS



Source: Centers for Medicare and Medicaid Services. (2020, January). *Medicare Parts A & B Appeals Process*. Retrieved from <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf>

Denial Rights

- Requesting a redetermination/reconsideration
- Request for an internal and external review
- Request for a peer-to-peer review
- Request for a determination to be appealed



Denial Process

Responding to a denial letter what to include in a rebuttal:

- Include date of original denial
- Reiterate the denial reason or denial rationale.
- List the codes and reimbursement affects.
- State your stance for redetermination and the resolution you seek (disagree).
- Back your determination with clinical facts and solid references/sources to overturn the denial rationale. (re-write reference guidance and list source).
- Note areas that are inconsistent in their argument.
- Enlist provider help when needed for validity.
- Ensure appropriate contact information is included to avoid delay and additional confusion.

Denial Process

Example to Avoid

We are in receipt of your fax which included an unsigned copy of our initial audit findings letter. The correspondence did not include information indicating agreement or disagreement with the initial audit findings. Upon review, we uphold our decision which identified an overpayment as a result of a code change which caused an adjustment of the DRG.

Denial Process

Move From Denials Management to Denials Prevention

- Who is denying (payer)
- What is being denied (DRG, Procedure, Diagnosis)
- Who is affected (Physician, CDI, Coder)
- Number of denials (by payor, by provider, by coder, by CDI)
- Who and what has been overturned (payor, DRG, Procedure, Diagnosis, Medical Necessity)
- Who and what has been upheld in a denial (payor, DRG, Procedure, Diagnosis, Medical Necessity)
- Overall cost of denials (amount denied, amount pending, amount recouped)

Denial Process

Additional areas of concern for denials prevention:

- Review trends such as payer denials and share with facility stakeholders
- Assess regulations such as the IPPS Rule
- Be aware of OIG Annual Work Plan
- Know RAC Target Areas

Focus on PREVENTION not *AVOIDANCE*

Denial Process

Items to track for trending and future prevention processes/benchmark:

- Appeal type and patient type
- Number of denials/denied claims
- Number of appeals/appeals per claim
- Number of paid claims (no denial)
- Payor denial rate
- Variance with expected payment
- Payment post appeal
- Appeal adjustment amounts
- TAT for payment
- Number of pending appeals

Denial, Rebuttal Examples, & Outcomes

2019 Inpatient Trends – Most Common MS-DRGs Denied Due to CC/MCC

- 166 – Other Respiratory System O.R. Procedures w MCC
- 177 – Respiratory Infections and Inflammations w CC
- 243 – Permanent Cardiac Pacemaker Implant w CC
- 286 – Circulatory Disorders Except AMI, w Cardiac Catheterization w MCC
- 309 – Cardiac Arrhythmia & Conduction Disorders w CC
- 326 – Stomach, Esophageal & Duodenal Procedure w MCC
- 329 – Major Small & Large Bowel Procedures w MCC
- 374 – Digestive Malignancy w MCC
- 380 – Complicated Peptic Ulcer w MCC
- 442 – Disorders of Liver Except Malignancy, Cirrhosis, Alcoholic Hepatitis w CC
- 480 – Hip & Femur Procedures Except Major Joint w MCC
- 823 – Lymphoma & Non-Acute Leukemia w Other Procedure w MCC

2019 Inpatient Trends – Common MS-DRGs Denied

Additional MS-DRGs:

813 – Coagulation Disorders

871 – Septicemia or Severe Sepsis w/o Mechanical Ventilation & 96 hours w MCC

981 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w MCC

982 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w CC

983 – Extensive O.R. Procedure Unrelated to Principal Diagnosis w/o CC/MCC

987 – Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis w MCC

988 – Non-Extensive O.R. Procedure Unrelated to Principal Diagnosis w CC

2019 Inpatient Trends – Common Coding/CDI Reasons for Claim Review

- One CC reported on claim.
 - Pleural effusion with CHF.
- One MCC with and without CCs.
 - Clinical significance acute respiratory failure.
 - Clinical significance of pneumonia.
- Diagnostic versus therapeutic procedure codes.
 - Bronchoscopies.

2019 Inpatient Trends – Common Coding/CDI Reasons for Claim Review – Bronchoscopy

Payers pull claims with bronchoscopies procedure codes with the hope of finding an error. Bronchoscopies can be complicated to code. If not coded correctly, can make a major impact on payment.

Typically targeted is MS-DRG 163 – 168

Payer denials with decrease are common with a focus on bronchoscopies that have been assigned to the wrong DRG due to inappropriate usage of the seventh character "Z" for therapeutic which carries more weight as a major procedure instead of the more appropriate seventh character of "X" for diagnostic.

Scenario – Patient with previous visit right upper lobe brushing and BAL suspicious for malignancy. Admitted for diagnostic biopsy by bronchoscopy.

Operative report documentation: "Right VATS with diagnostic biopsies of the right upper lobe, right middle lobe, and left lower lobe by bronchoscopy". Recommend changing procedure codes seventh character from "Z" for therapeutic to "X" for diagnostic. By updating the procedure codes the MS-DRG would move to 168 other respiratory system O.R. procedures without CC/MCC for a decrease in reimbursement of around \$4,000.

By adding changing the procedure codes from therapeutic to diagnostic the MS-DRG shifts from 165 for major chest procedure without CC/MCC to 168 for other respiratory O.R. procedures without CC/MCC for an overall decrease of around \$4,000.

Continued 2019 Inpatient Trends – Common Coding/CDI Reasons for Claim Review

- Sequencing of principal/secondary diagnoses code.
 - Pulmonary embolism.
 - Hemorrhagic disorder versus bleed versus blood loss anemia.
- POA discrepancy. (principal dx with a POA of “N”).
- Sepsis.
 - As secondary diagnosis with POA of “Y”.
 - Clinical significance sepsis.

Continued 2019 Inpatient Trends – Common Coding/CDI Reasons for Claim Review

- MS-DRG.
 - 673 OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC
 - 981 EXTENSIVE O.R. PROCEDURE UNRELATED TO PRINCIPAL DIAGNOSIS W MCC
 - 940 O.R. PROC W DIAGNOSES OF OTHER CONTACT W HEALTH SERVICES W CC



Denial Rationale with Rebuttal Example – One CC

Denial:

Dear Valued Provider,

Denial of submitted MS-DRG 191 Chronic obstructive pulmonary disease w CC due to lack of supporting documentation of I24.8 Other forms of acute ischemic heart disease as secondary diagnosis on claim. MS-DRG revised to 192 Chronic obstructive pulmonary disease w/o CC/MCC.

Rebuttal:

Disagree with payer's suggestion to remove secondary diagnosis I24.8 Other forms of acute ischemic heart disease.

Rebuttal Rationale: Documentation in chart support coding of I24.8:

Troponin lab values: 04/29 @0043 = 58 and @0641 = 46

04/30 Hospitalist progress note: "Elevated troponin, trending down, no chest pain, probably secondary to demand ischemia, continue monitoring."

Discharge Summary: "elevated troponin, trending down, no chest pain, probably secondary to demand ischemia, continue his outpatient medications. Schedule visit with Cardiology."

Continued Rebuttal Example with Guidelines– One CC

Guidelines Supporting Coding of I24.8:

ICD-10-CM Official Guidelines for Coding and Reporting FY 2019

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

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

clinical evaluation; or

therapeutic treatment; or

diagnostic procedures; or

extended length of hospital stay; or

increased nursing care and/or monitoring.

And

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance.

Overtaken

Denial Rationale Example – One CC

Dear Valued Provider,

Insurance XXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 418

Corrected DRG: 419

- Remove secondary diagnosis code J98.11 (Atelectasis). Pulmonary Consult on 04/29 stated, "this is atelectasis and represents a normal finding... This finding does not require follow-up nor intervention" Diagnosis code J98.11 is not supported according to ICD-10-CM Official Guidelines Section III. Reporting Additional Diagnoses.

Should you disagree with the audit findings, please provide XXXXX additional information that supports the original coding on the claim. To facilitate response, please include a copy of this letter with the correspondence regarding this matter.

This patient account is scheduled for adjustment on XX-XX-XXXX. Should you have any questions concerning this account, please contact client representative at XXX-XXX-XXXX ext. XXXXX or e-mail at XXXXXXXXX@XXXXX.com prior to the scheduled adjustment date.

Denial Rationale Example – One CC

Denial
Maintained

Per denial: Facility reported secondary diagnosis J98.11 Atelectasis.

Payer suggestion to remove J98.11, which shifts the MS-DRG from 418 Laparoscopic cholecystectomy w/o C.D.E. w CC to 419 Laparoscopic cholecystectomy w/o C.D.E. w/o CC/MCC for a decrease of \$2,286.96.

Agree with payer's suggestion to remove J98.11 Atelectasis.

Payer Denial Rationale: Pulmonary Consult on 4/29 stated, "this is atelectasis and represents a normal finding... This finding does not require follow-up nor intervention" Diagnosis code J98.11 is not supported according to ICD-10-CM Official Guidelines Section III. Reporting Additional Diagnoses.

No Rebuttal Rationale: Under reference, included additional material regarding ICD-10-CM Official Guidelines Section III. Reporting Additional Diagnoses. On the physician order for Pulmonary Consult, the reason for consult is "LLL consolidation on cxr." Although, the attending physician ordered a Pulmonary Consult, the Pulmonologist indicated simple atelectasis and this finding does not require follow-up nor intervention.

Reference: ICD-10-CM Official Guidelines for Coding and Reporting FY 2019.

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

B. Abnormal findings

Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the provider indicates their clinical significance. If the findings are outside the normal range and the attending provider has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the provider whether the abnormal finding should be added.

Denial Example – CHF with Pleural Effusion

Insurance XXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 292

Corrected DRG: 293

- Remove secondary diagnosis code J91.8 (Pleural effusion in other conditions classified elsewhere). It is noted that the Cardio H&P, Palliative Care Consult, and Discharge Summary indicated that the CXR revealed small bilateral pleural effusion. However, there was no further diagnostic work-up nor therapeutic intervention found within the provided record .
- Per Coding Clinic, 2nd Quarter 2015: Page 15; Heart Failure with Pleural Effusion states to only assign pleural effusion as a secondary code only if the condition was evaluated or treated. Therefore, diagnosis code J91.8 is not supported.

Rebuttal Rationale Example – CHF with Pleural Effusion

Denial Summation:

Facility reported secondary diagnosis J91.8 pleural effusion in other conditions classified elsewhere. Payer is removing J91.8, which shifts the MS-DRG from 292 heart failure & shock w CC to 293 heart failure & shock w/o CC/MCC for a decrease of \$1,807.01.

Rebuttal:

Agree with removing second secondary diagnosis J91.8 pleural effusion in other conditions classified elsewhere.

Payer Denial Rationale: "It is noted that the Cardio H&P, Palliative Care Consult, and Discharge Summary indicated that the CXR revealed small bilateral pleural effusion. However, there was no further diagnostic work-up nor therapeutic intervention found within the provided record. Per Coding Clinic, 2nd Quarter 2015: Page 15; Heart Failure with Pleural Effusion states to only assign pleural effusion as a secondary code only if the condition was evaluated or treated. Therefore, diagnosis code J91.8 is not supported."

Denial Maintained

Reconsideration Denial Example – One MCC

Acute Respiratory Failure

Rebuttal Response:

A review of your appeal has been completed. XXXX upholds the audit determination to remove J96.01, Acute respiratory failure with hypoxia. Although the patient required low flow oxygen after being extubated, they were comfortable with no indication of any respiratory distress. The patient was maintained on 2 liters oxygen throughout the entire stay with normal vitals, respiratory rate of 20 to 22 and sats at 94 to 96. They were deemed stable for discharge on low flow oxygen as well. While XXXX acknowledges guideline Section I.A.19 that addresses provider documentation of a condition, this guideline does not replace that code assignment is based on consistent and complete documentation. Query the physician when clinical validation is required. Please be advised that you have the right to dispute this determination by submitting an appeal to XXXX.

The original claim was submitted as DRG 823.

After reviewing the medical records and reconsideration submitted, we have determined that DRG 825 is appropriate.

Reconsideration Rebuttal Example – One MCC

Acute Respiratory Failure

Reconsideration Rebuttal:

Disagree with the recommendation to remove secondary diagnosis code J96.01, Acute Respiratory failure with hypoxia as a secondary diagnosis.

The diagnosis of Acute Respiratory failure with hypoxia has substantial documentation. The diagnosis was consistently documented throughout the chart. Acute hypoxic Respiratory Failure was supported by clinical indicators and justified due to documentation of the left main bronchus obstruction/carcinoma with patient requiring full mechanical ventilation support.

ABG parameters for respiratory failure:

pH = 7.59 (7.35 – 7.45)

pCO₂ = 27 (35 – 45)

pO₂ = 64 (80 – 100)

FIO₂ = 30%

P/F ratio (pO₂/FIO₂) = 213 (>400)

I am recommending the above suggested change not be applied to this account.

Denial Rationale Example – One MCC Pneumonia

Insurance XXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 329

Corrected DRG: 330

- Replace secondary diagnosis code *J69.0* (Pneumonitis due to inhalation of food and vomit) with diagnosis code *J95.4* (Chemical pneumonitis due to anesthesia). This patient underwent an exploratory laparotomy, right hemicolectomy on 5/11. Progress Note on 5/19 stated, "Postoperatively, he seemed to suffer from persistent nausea with vomiting and subsequently suspected to have developed a mild aspiration pneumonia and placed on antibiotic therapy." Discharge Summary documented, "On 5/22 POD 11, the patient was followed by ID and placed on IV abx (ancef/flagyl/vanc per ID), to tx asp pna." Coding Index direct as follow: Pneumonia · aspiration postprocedural - *J95.4* , Chemical pneumonitis due to anesthesia (Postprocedural aspiration pneumonia).

Should you disagree with the audit findings, please provide XXXXX additional information that supports the original coding on the claim . To facilitate response, please include a copy of this letter with the correspondence regarding this matter and direct to:

This patient account is scheduled for adjustment on XX-XX-XXXX. Should you have any questions concerning this account , please contact client representative at XXX-XXX-XXXX ext. XXXXX or e-mail at XXXXXX@XXXXX.com prior to the scheduled adjustment date.

Rebuttal Example – One MCC Pneumonia

Overtaken

Denial Summation:

Payor request to replace secondary diagnosis code J69.0 (Pneumonitis due to inhalation of food and vomit) with diagnosis code J95.4 (J95.4, Chemical pneumonitis due to anesthesia).

Rebuttal:

Disagree with proposed DRG 330.

Agree with original DRG 329. Documentation does not note a clear correlation between the procedure and the aspiration pneumonia.

Anesthesia notation "No anesthesia complications".

Discharge note states, "aspiration pneumonia" under the discharge diagnosis section.

Pulmonary Consult notes, "Left-sided aspiration pneumonia: The patient has a combination of right greater than left pleural effusion, bilateral lower lobe atelectasis, some diaphragmatic fluid, and possible left lower lobe aspiration pneumonia."

Continued Rebuttal Example – One MCC Pneumonia

Overturned

Rebuttal Continued....

See the Official Coding Guidelines for 2019 Section B of the General Guidelines, 16. Documentation of Complications of Care which notes:

"Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-affect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented."

Providers often use the verbiage of post procedural and post operative to describe a timeframe and not a causal relationship. Care should be used in assuming a linkage between a condition that happens during the post operative period to a complication without specific notation as a complication or a clarification linking the two.

The 2019 ICD-10-CM Code book Index notes, Pneumonia, aspiration (same level as main term) = J69.0 in order to use J95.4 the coder would have to go to the indented subterm "due to" and then see "postoperative". In order to use the subterm "due to" a linkage would have to be made by the provider as to a complication. J95.4 also has an additional notation in the tabular for use of an additional code to report the drug (T41.-).

Denial Sequencing of principal/secondary diagnoses code Pulmonary embolism

Please accept this letter as a follow up to your request for a consideration of the overpayment identified in our correspondence. After reviewing the documentation provided, our initial overpayment determination has been upheld.

Initial DRG 177

Corrected DRG 175

Denial Rationale: J69.0 (pneumonitis due to inhalation of food and vomit) is assigned as principal diagnosis with I26.99 as a secondary diagnosis. Per the ICD-10-CM coding guidelines on co-equal diagnoses, *“In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, **any one of the diagnoses may be sequenced first.**”*

Continue Denial Sequencing of principal/secondary diagnoses code Pulmonary embolism

Continued.....

However, the diagnoses of I26.99 and J69.0 are not co-equal. Based on the diagnostic workup and level of care provided, I26.99 (Other pulmonary embolism without acute cor pulmonale) is the condition that most closely meets the principal diagnosis definition. In accordance with this reference and physician, I26.99 has been sequenced as the principal diagnosis and code J69.0 was assigned as a secondary diagnosis.

This results in a change in DRG from 177 to DRG 175.

Denial Sequencing of principal/secondary diagnoses code Hemorrhagic Disorders v/s GI Bleed

Insurance XXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 813

Corrected DRG: 378

- Use diagnosis code K92.2 (Gastrointestinal hemorrhage, unspecified) as the principal diagnosis. This patient presented to the ED with cc of anemia. I-I&P documented, "in ED noted to have hgb of 5.7 and grossly positive on Hemoccult." Coding Clinic, 1st Quarter 2016: Page 14 states that for bleeding such as hemoptysis, hematuria, hematemesis, hematochezia, etc. , and drug induced hemorrhagic disorder may be assigned , however this depends on the circumstances of admission. In this case, the patient presented with anemia and GI bleed. Therefore, diagnosis code K92.2 is supported as the principal diagnosis.
- Use diagnosis code D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) as a secondary diagnosis.

Rebuttal Rationale Example – Hemorrhagic Disorders v/s GI Bleed

Overtaken

Per denial – Use diagnosis code K92.2 (Gastrointestinal hemorrhage, unspecified) as the principal diagnosis. Use diagnosis code D68.32 (Hemorrhagic disorder due to extrinsic circulating anticoagulants) as a secondary diagnosis.

Disagree with proposed DRG of 378. Patient was admitted with anemia found to be due to "GI bleed on Xarelto" as noted in the cardiology progress note on discharge. No GI bleed was found on colonoscopy or EGD. Xarelto was discontinued at discharge with patient being placed on Amiodarone. Treatment included hematology consult, 3 units of PRBC with improvement of HH and stabilization of HH with discontinuation of Xarelto.

Denial Example Sepsis

Listed as secondary dx with POA=Yes

Per denial: Facility reported K31.1 Adult hypertrophic pyloric stenosis as principal diagnosis with secondary diagnosis A41.9 Sepsis, unspecified organism. Payer is suggesting to resequencing A41.9 as principal diagnosis with K31.1 as a secondary diagnosis for a shift in MS-DRG from 380 Complicated peptic ulcer w MCC to 871 Septicemia or severe sepsis w/o MV >96 hours w MC.

Payer Denial Rationale: Use diagnosis code A41.9 (Sepsis, unspecified organism) as the principal diagnosis. This patient was noted to have a high pulse rate of 110, pulse ox 89, and WBC 13.5. Progress Note 12/31 stated, "Sepsis Present on admission, evident by bacteremia and tachycardia, much improved. Source likely UTI, although concern for aspiration on admission." Progress Note 01/02 indicated, "Sepsis, PNA Likely related to aspiration PNA (vs pneumonitis) on admission. Discharge Summary also listed under Discharge Diagnosis, "Sepsis." Based on the provided record, diagnosis code A41.9 is supported as the principal diagnosis. This is consistent with ICD-10-CM Official Guidelines Section I.C.1.d. Coding of Sepsis and Severe Sepsis.

Use diagnosis code K31.1 (Adult hypertrophic pyloric stenosis) as a secondary diagnosis.

Agree with Payer to sequence A41.9 Sepsis, unspecified as principal diagnosis with K31.1 Adult hypertrophic pyloric stenosis secondary diagnosis.

Denial Example Sepsis

Clinical Significance

Denial Rationale:

A principal diagnosis code assignment of A41.9 (Sepsis, unspecified organism) was reported by the hospital. This condition does not qualify for reporting as the principal diagnosis based on the documentation in the medical record and coding guidelines.

While the provider documents the condition of sepsis in the discharge summary, the medical record support was incomplete regarding the diagnosis of sepsis-3. The diagnostic information indicates a creatinine of 0.36-0.49, a total bilirubin of 0.7, and the patient was not hypotensive. Although sepsis is documented by the provider all diagnoses should be supported by clear physician documentation as well as have reasonable support through clinical data.

In the future - Utilize a team approach with a clinical indicator committee that houses peers from your clinical documentation improvement and coding team, hospitalist and intensivist, as well as managed care for creating a list of clinical criteria for diagnoses found from trending reports by the denials management team to be commonly denied. Use this team to negotiate contracts with payers, and have your facility's clinical indicators defined in the contract for diagnoses such as sepsis.

Denial Example – Acute Renal Failure

Insurance XXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 673

Corrected DRG: 286

- Use diagnosis code I13.2 (Hypertensive chronic kidney disease with heart failure and with stage 5 chronic kidney/ESRD) as the principal diagnosis. This patient with a history of HTN, CHF, and chronic renal failure presented with cc of dyspnea and a high BP of 179/116. In addition, labs displayed a high BNP of 510. ED documented, "today symptoms seem to be related to his worsening kidney function and possible congestive heart failure." H&P stated, "This is a 57-year-old male... presenting with worsening shortness of breath and found with AKI on CKD Stage V ... hypertensive emergency, congestive heart failure exacerbation." In this case, patient presented with multifactorial conditions. Therefore, diagnosis code I13.2 is supported according to the UHDDS Official Guidelines.
- Use diagnosis code N17.9 (Acute kidney failure, unspecified) as a secondary diagnosis.

Rebuttal Rationale Example – Acute Renal Failure

Overturned

Per denial – Use diagnosis code I13.2 (Hypertensive heart disease & chronic kidney disease with heart failure and with stage 5 chronic kidney/ESRD) as the principal diagnosis. This patient with a history of HTN, CHF, and chronic renal failure presented with cc of dyspnea and a high BP. Use N17.9 (acute kidney failure, unspecified) as an additional diagnosis.

Disagree with proposed DRG 286 from denial.

Agree with initial MS-DRG of 673 as patient clinical picture warrants N17.9 acute renal failure as the principal diagnosis.

Documentation: Patient admitted with creatinine of 13.9 with a baseline at 4.4. Patient was previously diagnosed with stage 4 CKD not on dialysis. On day of admission interventional radiology was brought in to place a tunneled dialysis catheter for emergency dialysis. At admission patient's Bun was 87 with a low of 57 during the stay. GFR was 7 on admission with a low of 5 (extremely low requiring dialysis). BNP was the highest at 510 and is not excessively high for an exacerbation of CHF and can be affected by the kidney injury status. Although patient was admitted with both CHF exacerbation and acute renal failure in the presence of chronic stage 4 CKD, treatment focus was on stabilization of the kidney injury.

Maintain principal diagnosis of N17.9 acute renal failure, unspecified.

Denial Rationale Example – 981 (Unrelated to Principal)

Insurance XXXXXX has completed an audit of the medical record on the above mentioned claim to verify that the documentation in the medical record supports the ICD-10 codes billed and DRG assignment.

Original DRG: 981

Corrected DRG: 193

- Replace procedure code 009Y3ZX (Drainage of Lumbar Spinal Cord, Percutaneous Approach, Diagnostic) with 009U3ZX (Drainage of Spinal Canal, Percutaneous Approach, Diagnostic). This patient received a lumbar spinal puncture on 5/24. IR Report documented, "a 22 gauge spinal needle was advanced into the lumbar spinal canal at the L3-4 level under fluoroscopic guidance..." Coding index directs lumbar spinal canal puncture to procedure code 009U3ZX.

Should you disagree with the audit findings, please provide XXXXX additional information that supports the original coding on the claim. To facilitate response, please include a copy of this letter with the correspondence regarding this matter and direct to:

This patient account is scheduled for adjustment on XX-XX-XXXX. Should you have any questions concerning this account, please contact client representative at XXX-XXX-XXXX ext. XXXXX or e-mail a XXXXXX@XXXXX.com prior to the scheduled adjustment date.

Rebuttal Example – 981 (Unrelated to Principal)

Denial Maintained

Per denial: Facility reported procedure code 009Y3ZX drainage of lumbar spinal cord, percutaneous approach. Suggestion by payer to replace procedure code 009Y3ZX with 009U3ZX drainage of spinal canal, percutaneous approach, diagnostic for a shift in MS-DRG from 981 Extensive O.R. procedure unrelated to principal diagnosis w MCC to 193 Simple pneumonia & pleurisy w MCC for a decrease of \$17,702.66.

Disagree with Payer's Original DRG of 981 to Corrected DRG: 193. However, agree with Payer's suggestion of replacing procedure code 009Y3ZX drainage of lumbar spinal cord, percutaneous approach with procedure code 009Y3ZX

Payer Denial Rationale: This patient received a lumbar spinal puncture on 5/24. IR Report documented, "a 22 gauge spinal needle was advanced into the lumbar spinal canal at the L3-4 level under fluoroscopic guidance..." Coding index directs lumbar spinal canal puncture to procedure code 009U3ZX.

Rebuttal Rationale: MS-DRG Grouper version 35, populates MS-DRG 193, for both procedure codes 009Y3ZX Drainage of Lumbar Spinal Cord, Percutaneous and Approach and procedure code 009U3ZX Drainage of Spinal Canal, Percutaneous Approach when coded mutually exclusive of each other.

In this scenario the coding department reviewed the claim with some confusion as to why changing the procedure from therapeutic to diagnostic on the claim did not shift the MS-DRG from 981. The contracting department was contacted and they found that the payor was using V33 of the grouper and at that time the grouper pulled to the MS-DRG of 193 previously. Review was necessary to understand the variance in groupers and procedural weight in this scenario. No rebuttal needed and denial was upheld.

Wrapping Up



Resources

AHIMA <http://www.ahima.org/>

AssuranceMD <https://www.assurancemd.com/denial-management-requires-expertise-and-dedicated-focus/>

Centers for Medicare and Medicaid Services. (2020, January). Medicare Parts A & B Appeals Process. Retrieved from <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf>

HBMA https://www.hbma.org/meeting_calendar/details.php?event=1894

HFMA https://www.hfma.org/home-b.html?adobe_mc_sdid=SDOD%3D33943C3EE7F859E6-3F8A67E2EE5D678%7CMCORGID%3DC6CD364C5AF2F3CF0A495C66%40AdobeOrg%7CTS%D1589910634&adobe_mc_ref=https%3A%2F%2Fwww.google.com%2F

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