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Errors in References Could Undo Claim Denials; DRG Validations Hit on Multiple Fronts

By Nina Youngstrom

In a vivid example of why hospitals should pore over the references that auditors use to deny claims, the secondary diagnosis of blood loss anemia was removed from a Midwest hospital's claim for a male patient's admission based partly on several resources that weren't relevant or binding, an attorney said. They included an American College of Obstetricians and Gynecologists' practice bulletin on postpartum hemorrhage, Common Terminology Criteria for Adverse Events (CTCAE), and a well-known blog.

"CTCAE is a set of criteria for reporting adverse events of cancer therapy. This patient did not have cancer," said Richelle Marting, an attorney and certified coder in Olathe, Kansas. The postpartum article obviously isn't relevant to a man, and blogs aren't binding.

The use of references that don't support the reasons for removing a secondary diagnosis from a claim or denying the claim, sometimes in the form of outdated coding guidance, is not uncommon, she noted. It's a compelling avenue of appeal as hospitals straddle three parallel worlds: DRG validation, clinical validation (or both simultaneously for the same claim), and "holding payers accountable" to policies and contract terms that may be independent of the merits of a claim denial. The reason for the Medicare Advantage plan or commercial payer's denial—coding or clinical—may not always be clear. DRG and clinical validations may be conflated by payers and the audit contractors they hire to review claims, she said, and "sometimes I write up an appeal that addresses both just in case."

Against this backdrop, Marting suggested hospitals highlight information in their response to documentation requests that supports the substance of the claims and ties it back to contract provisions, policy language or manual language. When the volume of the payer's denials of claims and appeals crosses a certain threshold, particularly where a trend is identified, they may be elevated to managed care contracting and senior hospital leaders, who can reach out to the payer's senior leaders. "The hospital can say, 'This is becoming a big issue,'" Marting said. She said this strategy has started to improve one major health plan's behavior vis-à-vis the Missouri hospital that she appeals claim denials for.