# Fight until the very end: Sepsis and malnutrition denials

***By Carolyn Riel***

Payers deny claims on a wide variety of grounds, but it's no secret that certain diagnoses seem to be frequent denial targets. Each year, respondents to the *CDI Week Industry Survey* say that both sepsis and malnutrition remain top denied diagnoses, and there is little sign of those denial rates slowing.

"The criteria for diagnosing sepsis wasn't always an issue," says **Krysten Brooks, RN, BSN, MBA,** senior healthcare performance advisor with 3M Health Information Systems, headquartered in Salt Lake City, Utah. "For years, there was general consensus on the definition of sepsis and everyone followed the standard CMS guidelines using systemic inflammatory response syndrome [SIRS] criteria."

That accepted definition of sepsis remained largely unchanged for over two decades until the year 2014. "The European Society of Intensive Care Medicine and the Society of Critical Care Medicine convened a task force to review the sepsis definition with members representing critical care, infectious disease, surgical, and pulmonary specialists. The task force then published the Third International Consensus Definitions for Sepsis and Septic Shock, which created the sepsis-3 criteria," Brooks says.

At this point, CMS recognizes the Sepsis-3 guidelines, but has yet to endorse that criteria set. "CMS is taking time to evaluate real-world issues with using Sepsis-3 criteria, so as yet, they haven't formally adopted it," Brooks says. "Although some organizations are starting to use Sepsis-3 criteria, many people are in the dark as to which criteria to follow—CMS Sirs criteria or Sepsis-3. And now fiscal year (FY) 2021 official coding guidelines have changed, including criteria for assessing neurologic mentation using the Glasgow comma scale score. This is now limited to traumatic brain injuries, which means that this scoring system can no longer be used as criteria with Sepsis-3."

Along with sepsis, CDI professionals continually see denials for severe protein-calorie malnutrition, especially given that it remains a *frequent audit target for the Office of Inspector General* (OIG).

"It used to be that denial rates for malnutrition from the Recovery Audit Contractor [RAC] weren't very high, and we didn't have a major issue with clinical validation denials until more recently," says **Vaughn**

**Matacale, MD, CCDS,** director of the CDI advisor program at Vidant Health in Greenville, North Carolina. "But then there was an issue where an OIG subcontractor had an extremely high error rate, which was out of sync with our experience with other external auditors. […] Do we get denials out of that? Sure. We still get some malnutrition denials, and sometimes we agree with their point, but most of the time we appeal."

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> *Vaughn Matacale, MD, CCDS*

## Malnutrition criteria challenges

When it comes to malnutrition audits and denials, many stem from the use of severe protein-calorie malnutrition diagnoses, according to Matacale, specifically in relation to kwashiorkor.

"A few years ago, the OIG began doing a series of audits for kwashiorkor diagnoses, and malnutrition was on their radar after that," he says. "Even after the implementation of ICD-10, which resolved many issues from ICD-9 and kwashiorkor, the increase of denials for malnutrition persisted."

In ICD-9-CM, there was a *coding classification discrepancy* between the Tabular List and the Alphabetic Index on the use of diagnosis code 260. In the Index, four other malnutrition diagnoses corresponded to code 260, but in the Tabular List, the code was only for kwashiorkor. Cases of kwashiorkor are highly rare in the United States and are often only seen in children during periods of famine.

Because kwashiorkor is so rarely seen in the United States, its coding raised level of awareness within the external auditor community and within the broader industry. "It's been on the radar," says Matacale.

In addition to kwashiorkor, "protein-calorie malnutrition is a major complication or comorbidity (MCC), so it's a high target like some other MCC diagnoses," Matacale adds.

The treatment and diagnosis criteria for malnutrition, according to Brooks, are also quite specific and stringent. Her education with facilities that contract with 3M focuses on both *American Society for Parenteral and Enteral Nutrition* (ASPEN) criteria as well as *Global Leadership Initiative on Malnutrition (GLIM) scores,* with GLIM being the newer and more intense of the two criteria sets, yet still not the universally recognized guidelines.

"For ASPEN guidelines, you need at least two criteria to even query about malnutrition," says Matacale. "You have to heavily rely on the dietitian to give that criteria within consultations in order to form queries for malnutrition."

## Sepsis criteria challenges

Because of the industry's confusion over sepsis criteria sets, organizations find it difficult to decide which guidelines to follow for their sepsis documentation.

"Many third-party payers have adopted Sepsis-3 criteria, which is not in line with what CMS is doing," says Brooks. "It's important to remember that the first level of sepsis as defined in the SIRs criteria is not reflected in Sepsis-3. In SIRS, we evaluate for sepsis, severe sepsis, and septic shock, while in Sepsis-3 we're looking for only the two severe types of sepsis."

In her role as a 3M performance advisor, Brooks says she tries to provide detailed education on this topic and what it means to use CMS criteria versus Sepsis-3.

"We remind [organizations] that CMS introduced their core measures back in 2016, and although it's a voluntary program, sepsis-related elements can affect quality reporting and value-based purchasing," she says. CMS wants organizations to recognize and treat sepsis early while documenting it appropriately. "Brooks explains that if a facility is following Sepsis-3 criteria but not following CMS SIRS criteria, they may be under-reporting regular sepsis. This will impact their quality metrics and their success under value-based purchasing. A hospital's severity scores and likely its

observed-versus-expected mortality scores may suffer in comparison with peer hospitals, suggesting the hospital is providing poor care to not-very-sick patients.

In contrast, Brooks says that, crucially, organizations often forget that with Sepsis-3, they're not being graded on regular sepsis, but are being scored on the bundle of severe sepsis and septic shock.

"While you still want to be reporting sepsis, remember that you're being scored from a quality perspective on severe sepsis and septic shock," says Brooks. "That takes the sting out of which criteria to follow."

While CMS has not fully adopted Sepsis-3 criteria, William Haik, MD, FCCP, CDIP, director of DRG Review Inc. in Fort Walton Beach, Florida, recommends hospitals start using Sepsis-3 criteria and introducing it into their regular record reviews.

"RACs have started to really move towards Sepsis-3, where many hospitals are still using Sepsis-2 or unsure of which criteria to use, but the move is headed towards Sepsis-3," he says. "I think it's more reflective of what sepsis actually is: organ dysfunction due to infection."

Haik says he often sees hospitals that are using different criteria within their own walls and from physician to physician, so even if they do choose to stick with Sepsis-2 criteria, organizations need to make a concerted and formalized effort to get everyone on the same page.

"The problem with this is a lack of consistency, and physicians will agree to what they believe sepsis is, but unfortunately it's not consistent with the literature," he says.

## Organizational criteria for malnutrition

An important step toward preventing denials on the front end is *developing organizational policies and diagnostic criteria*. This process should involve multiple departments, and the end product should represent the organization's consensus statement on the condition's diagnostic criteria, which can be used to appeal denials and anchor clinical validation queries.

For tackling malnutrition, Matacale suggests a facility adopt ASPEN and Academy of Nutrition and Dietetics (AND) guidelines for their diagnostic criteria. "The guidelines set forth by those entities are really the authorities in the industry as far as malnutrition documentation goes," he says.

While it may be tempting to write your own guidelines, Matacale strongly suggests against it. Because there is already an industry standard available that's been peer-reviewed and accepted by the broader medical community, this should be the standard facilities use. "These tools are already available to you," he says. "The majority of hospitals that have been surveyed by AND and ASPEN have said these are the predominant criteria being used, so that shows you what the industry standard is."

The criteria for malnutrition, however, is somewhat in a state of flux because of the newly created GLIM guidelines, Haik adds.

"I'd adhere to the ASPEN criteria for now, but at least peer over the counter at GLIM too as it's very possible that will become the more relevant criteria at some point," he says. Additionally, at least one of the RACs is using GLIM even though the AND has not fully field tested those criteria. "GLIM uses international standards for criteria, and the problem with that is we're very different in the United States than other countries. We are more likely to have people who are obese but also malnourished, something not as common in other countries."

## Organizational criteria for sepsis

As with malnutrition, Brooks says it's important to have a formal organizationwide clinical criteria set for sepsis.

"I've seen many organizations rely on an unspoken policy but not set criteria that they're going to follow," she says. "When they're faced with multiple denials, for example, because they used SIRS criteria instead ofSepsis-3 criteria, they need to ensure their contract with payers specifies that they're using SIRS criteria." That way, when they do receive a denial based on Sepsis-3, they can refer back to the contract in their appeal letter and reiterate that they use SIRS criteria and shouldn't be held to Sepsis-3.

When writing the sepsis criteria for the organization, make sure to

include a multidisciplinary group of medical professionals in the discussion. This helps to ensure they're all on the same page and feel they've had their voices heard.

"Physicians aren't bound to one set of criteria for sepsis; their diagnosis is based on medical judgment and their clinical experience," says Brooks. "According to *Coding Clinic*, physicians can determine a finding of sepsis based on their preferred definition or guidelines, but the diagnosis has to be supported in their documentation. Additionally, CDI specialists should also look at labs, nursing notes, vital signs, and overall clinical presentation to support the diagnosis."

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## Malnutrition clinical validation, denial prevention

While much of CDI's work traditionally focuses on physicians, don't forget the dietitians when discussing malnutrition as they can help ensure that the relevant information to malnutrition is in the patient's chart, visible and sufficiently detailed, for the physician to review.

"Make sure all the applicable criteria are present to start, but also that it's easy to locate as well as consistently documented," Matacale says. "Make sure it's all uniform. That's very important when dealing with malnutrition."

While the dietitian's documentation is crucial for capturing malnutrition, the dietitian isn't the only one who needs education, because the treating physician still has to make the diagnosis in order for it to be coded. "When I say document, I don't mean they just sign the nutritionist's paper," says Haik. "If they just sign it and say that they agree, that can be challenged."

Even though it's easier for the physician to simply sign and agree with an assessment, Haik says that asking the physician to document the diagnosis and treatment plan, and then sign it, will ensure the documentation is bullet (or audit) proof.

Don't be shy about clinically validating malnutrition either, Matacale says. At Vidant, anyone examining the record or working in it is entitled to ask for clinical validation. "We believe everyone working on this has a valid perspective," he says. When a malnutrition case goes into the clinical validation pathway, Matacale says it is reviewed by the coding auditor or CDI manager who may try to resolve the issue, then it might go to the physician advisor, who will have a dialogue with the attending physician to clarify or query.

Like any clinical validation question, make sure to look for the relevant treatments for malnutrition in the record as well, Matacale says, which may be outlined in the dietitian's assessment and can be brought forward during the query process.

"For malnutrition, it starts with the least invasive [treatments] and moves to the most," he says. "When you're looking at reportability, don't dismiss your assessments and treatments because they're 'not enough.' When you're appealing, report all things that can be reported and that have been met and how they've been met."

## Sepsis clinical validation, denial prevention

As sepsis denials continue to grow, Brooks says it's becoming apparent that many of the issues revolve around clinical validation.

"may determine a patient has met criteria for sepsis because the patient had one heart rate above 90, or an infection with a white blood cell count that meets criteria. But auditors are looking for more," she says. "Third party payers and CMS want to see trends. If a patient comes into the emergency department with a high white blood count, is it sepsis or something else? After the patient receives a fluid bolus and labs, and vital signs return to normal, it's likely the patient did not have sepsis, but rather another condition such as dehydration causing abnormal

values." Brooks also says that in addition to trends, CDI specialists should also look for contradictory notes from the emergency department and attending physician.

According to Brooks, CDI professionals should query the physician to determine whether that one SIRS element was linked to a sepsis diagnosis or caused by some other condition. Additionally, pay attention to the treatment provided to the patient: Does it support the diagnosis of sepsis?

"If sepsis is documented based only on the criteria of heart rate and white blood cell count, it's going to be denied. If a patient is diagnosed with sepsis but isn't being treated with antibiotics or for an infection, ask 'is it really sepsis?'" she says. "It's important to establish multiple criteria when it comes to sepsis."

When posing a sepsis clinical validation query, Brooks notes that the physician doesn't want to read a drawn-out story. "They already know the patient; they just want to know what the question is," she says. Instead of writing out the patient's entire chart in the query, just include the relevant clinical indicators and ask the physician whether the diagnosis of sepsis is appropriate.

If a CDI specialist sends a clinical validation query and the physician still says that the patient has sepsis, then there isn't much more that can be done on the CDI side of things. "Have a plan for what to do when that happens," Brooks says. "It's up to the CDI team to ask the questions and escalate the issue if necessary. The best approach is to engage your physician champion to work with the physician. Ultimately, physicians want their patient's story to be accurate."

Even going off Sepsis-2 criteria, CMS can be strict about denying sepsis, so cases have to be strong and consistent throughout. "Organizations are frequently in the position of having to fight denials and go through the lengthy process of appealing," she says. "You can't just stop at the first denial letter and say 'Okay, we lost.' You have to follow all the way through to the end." Brooks says that auditors will often cite just one or two element in the record to justify a denial. Take the time to go back and review the medical record as they may have missed something significant. Be prepared to defend the claim to get the reimbursement to which you're entitled, she adds.

If your front-end tactics fail you and you're left with only the appeal process as recourse, make sure you provide and cite the resources you're using to fight the denial, such as official coding guidelines or medical journals, and include where you found that information. Physician involvement is also essential. Your physician champion or the attending physician can talk directly to auditors and explain the rationale for sepsis, which may lead the auditor to recommend the claim be resubmitted.

"Rely on official coding guidelines, the medical literature, and support your physicians when fighting a tricky denial," Brooks says. "Fight the fight, and fight until the very end."