# Q&A

## CDI WEEK

### Clinical Validation

*As part of the seventh annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics.* **Terry Ann Simmons, MSN, RN, CCRN-K, CCDS**, *a clinical documentation specialist at Hartford Healthcare, Hospital of Central Connecticut in New Britain, and a member of the 2017 CDI Week Committee, answered these questions on CDI and clinical validation. Contact her at* terry.simmons@hhchealth.org.

**Q** **How does clinical validation differ from DRG validation?**

**A** Clinical and DRG validation involve two different skill sets. Coding professionals use their expertise with coding conventions and guidelines to select the correct codes for sequencing of the principal diagnosis and any secondary diagnoses. Coders know how to apply rules and exclusion criteria to documentation that may be viewed differently through the clinician's lens. The level of care and utilization of resources brings the views together.

The DRG and clinical processes are different, and communication with coders is vital for successful reviews. Clinical validation requires expertise with pathophysiology and treatment. Experience caring for patients facilitates the process by providing the clinical documentation specialist a wealth of references for the human response to illness and treatment.

When a question arises during a chart review, the CDI specialist asks for documentation of what the provider saw in that response to illness and treatment. The diagnosis belongs to the provider.

**Q** **What does your clinical validation process look like? Can you describe it? (e.g., is it part of the CDI staff's ongoing concurrent review process? Do you have a pre-bill/post-discharge second look process?)**

**A** Clinical validation built into concurrent review provides as near to real-time clarification as possible. The physician has a clear recollection, and the documentation can support why a particular course of treatment was prescribed at that time. Changes in condition are more easily compared, especially for off-shift covering providers. Clinical validation supports the accuracy and integrity of the record as a communication tool.

**Q** **What is the most difficult part of clinical validation reviews? (e.g., crafting a compliant non-leading query, establishing a comprehensive process for reviews, working with physicians to develop facility or system wide clinical criteria for frequently targeted diagnoses)**

**A** Clinicians often see things the same way: "Oh, I know what the note is saying." It helps to look at a note from different angles so that interpretation by

any possible reader isn't necessary. The note must be clear because the diagnosis is what the doctor says it is, as they're the one caring for the patient.

Asking for clarification of criteria can be difficult. Some clinical indicators must seem obvious or redundant to the provider writing the notes, but they do add up to a clearer picture of what is going on with the patient.

Recommending evidence-based criteria from sources such as the National Kidney Foundation or ASPEN can assist, but the choice is ultimately up to the provider to include the criteria that informed their decision.

**Q** **Why are clinical validation reviews more important now than they may have been previously? (e.g., the 2017 Official Guidelines 1.a.19 and the Fourth Quarter 2016 Coding Clinic, or the prevalence of claims denials based on lack of supportive clinical indicators)**

**A** Clinical validation is not simply to see if the patient has the disease documented. It is to clarify with the provider if the condition is resolved, excluded, ruled out, or improving. Patients are complex, and therapies for one illness may not be indicated for another condition; congestive heart failure and renal failure are classic examples.

Presenting symptoms can be vague and reflect many different illnesses. A chief complaint of weakness can turn out to be a serious problem. Clarifying promotes a clear, consistent record that keeps ruled-out or excluded conditions from getting into the coding while the providers and specialist consultants are able to communicate in the chart.

The ACDIS white paper "Clinical validation and the role of the CDI professional" is a good resource to use as it pulls sourced information together and includes query design options for best practice.

**Q** **What portions of the medical record are the most helpful when conducting clinical validation reviews?**
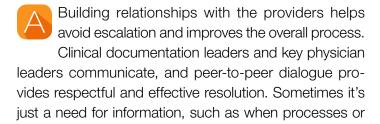
**A** The physical exams in the emergency department and history and physical set the stage for the principal diagnosis and present on admission conditions. Baseline lab values give definitions for comparing the patient's usual state of health to the current diagnoses. Nursing, nutrition, physical, or respiratory therapy documentation adds description, and many providers will reference reports from these clinicians as they collaborate in caring for the patient.

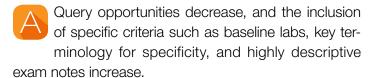**Q** **Can you describe your escalation process, if you have one?**

**A** Building relationships with the providers helps avoid escalation and improves the overall process. Clinical documentation leaders and key physician leaders communicate, and peer-to-peer dialogue provides respectful and effective resolution. Sometimes it's just a need for information, such as when processes or formats change. Why escalate when you can relate and communicate?

**Q** **How do you assess the success of your clinical validation efforts?**

**A** Query opportunities decrease, and the inclusion of specific criteria such as baseline labs, key terminology for specificity, and highly descriptive exam notes increase.

**Q** **How do you provide general education regarding clinical validation to the medical staff?**

**A** We do formal presentations with slides, mini presentations on selected topics at meetings, and one-on-one conversations in the clinical areas or over the telephone. A strong relationship with the medical staff where CDI specialists are seen as a resource is key. The CDI specialists must be up to date and able to answer questions. The doctors can look things up and have tools and applications at the ready.

The clinical documentation team has to offer more. We must be trusted to provide information and recommendations that are in line with regulatory guidelines and evidence-based practice. Having someone with a unique skill set, ethics, and expertise to explain why and how things work or are needed in the chart provides value.