Q&A

Querying for clinical validation

Clinical Documentation Improvement Week

As part of the third annual Clinical Documentation Improvement Week, ACDIS has conducted a series of interviews with CDI professionals on a variety of emerging industry topics. ***Donna D. Wilson, RHIA, CCS, CCDS,*** *a senior director in the consulting division of Compliance Concepts, Inc., answered the following questions regarding querying for clinical validation. Contact Wilson at* dwilson@ccius.com.

Q **Can you explain the concept of querying for clinical validation of a diagnosis?**

Querying for clinical validation of a diagnosis is when a physician documents a diagnosis (principal or secondary) that is not supported by clinical indicators within the health record. When there is lack of clinical support for a diagnosis, querying is necessary to validate the diagnosis. Coders and CDI professionals are not questioning the medical judgment of the physician, but they query mainly to support the coded diagnosis.

The recent AHIMA/ACDIS Practice Brief entitled "Guidelines for Achieving a Compliant Query Practice" addresses clinical validation and shares a good example of a non-leading query for cases where the physician documents a diagnosis without clinical support:

> *The focus of external audits has expanded in recent years to include clinical validation review. The Centers for Medicare & Medicaid Services (CMS) has instructed coders to "refer to the Coding Clinic guidelines and query the physician when clinical validation is required." The practitioner does not have to use the criteria specifically outlined by Coding Clinic, but reasonable support within the health record for the diagnosis must be present. When a practitioner documents a diagnosis that does not appear to be supported by the clinical indicators in the health record, it is currently advised that a query be generated to address the conflict or that the conflict be addressed through the facility's escalation policy. CMS recommends that each facility develop an escalation policy for unanswered queries and to address any staff concerns regarding queries. In the event that a query does not receive a professional response, the case should be referred for further review in accordance with the facility's escalation policy. The escalation process may include, but is not limited to, referral to a physician advisor, the chief medical officer, or other administrative personnel."*

Q **Why is it important to ensure clinical validity?**

Clinical validation is important for two reasons: to ensure that the codes assigned are truly reflective of the patient's condition and to decrease coding/DRG denials. Note the following statement in the latest Recovery Auditor Scope of Work (2013):

> *Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented*

in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.

What are some of the vulnerabilities that Recovery Auditors and other auditing agencies are finding?

The main vulnerability (which is an easy data dive for payers) is locating claims with one CC or one MCC. Government and private insurers are hiring coding/DRG auditors to review claims with one CC or one MCC in order to clinically validate the assigned diagnosis. The return on investment from these reviews has proven to be far too great for Congress and other agencies to pass up.

What are some diagnoses that you typically see in the health record that lack clinical support, and why?

The main diagnoses that we see in the health record that lack clinical support include pneumonia (486 = MCC), sepsis (038.9 = MCC), postoperative respiratory failure (518.81 = MCC), and congenital esophageal stricture (750.3 = MCC).

How does this work in practice? How would you educate and/or actually query a physician about a diagnosis without clinical support?

In the workplace, the best practice is to communicate on-on-one with the physician to explain your reasoning behind the query for clinical validation. If this personal interaction is not feasible, then CDI/coding professionals should rereview the latest ACDIS/AHIMA Practice Brief (February 2013), which outlines an excellent example of a query to develop for clinical validation: *http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050018.hcsp?dDocName=bok1_050018*

How can CDI professionals and physician advisors (PA) play a role in decreasing coding/DRG denials?

CDI professionals/PAs are the missing link in the denial management process. Government and nongovernment payers are moving their focus to clinical validation of a diagnosis prior to coding. A physician may write a diagnosis in one progress note, but it must be supported clinically. The CDI/PA can concurrently query the physicians, which allows coders to have a completely documented health record at discharge.