

The "art"

Clinical Validation

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Objectives

- ▶ Discuss the impact of Recovery Auditors/Private Pay Audits as related to clinical validation
- ▶ Define clinical validation vs DRG validation
- ▶ Define the term clinical indicators
- ▶ Discuss the use of clinical indicators in query practice
- ▶ Construct queries to obtain missing/vague diagnoses
- ▶ Construct queries when there is no clinical support for a documented diagnoses

Back in the day....

The Provider documented a diagnosis

- ▶ We did not question validity of diagnosis
 - ▶ We coded the diagnosis
 - ▶ We got paid
-
- ▶ A new dimension has been added....We are now experiencing a new world order....

New Kid in Town....

- ▶ Recovery Auditors Arrived
- ▶ Introduction of the concept of clinical validation
- ▶ The game changed

- ▶ Recovery Auditors & Private Payer Auditors review records for:
 - ▶ Medical Necessity
 - ▶ **Clinical Validation**
 - ▶ DRG Validation

What is DRG Validation?

- ▶ The process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim.
- ▶ Review focuses on physician documentation and code assignment in comparison to the *Official Guidelines of Coding and Reporting*
- ▶ Performed by a certified coder

- ▶ Answers the question **“Did we code it correctly?”**

What is Clinical Validation?

- ▶ The process of clinical review of a claim to see whether or not the patient really has the conditions that were documented.
- ▶ Performed by a clinician, retrospectively after claims submission
 - ▶ The Recovery Audit Statement of Work states this is NOT the coder's responsibility
- ▶ May result in claims denial when the clinical indicators in the record do not support the reported diagnoses and procedures.

What are Clinical Indicators?

- ▶ **Clinical indicators offer support within the record for the diagnoses applied to the patient. They can consist of:**
 - ▶ **Laboratory or diagnostic test results**
 - ▶ **Imaging studies**
 - ▶ **Treatments- medications, interventions, infusions, services**
 - ▶ **Patient's response to treatment**
 - ▶ **Patient assessments and plans of care (by all caregivers)**
 - ▶ **Symptoms**
 - ▶ **Observations**
 - ▶ **Objective data- vital signs, height/weight etc.**

Traditional use of Clinical Indicators

- ▶ Coders and CDIS have traditionally used clinical indicators to support a query for vague, incomplete or missing diagnoses.
- ▶ The AHIMA/ACDIS Query Practice Brief of 2013 states:
 - ▶ *“To support why a query was initiated, all queries must be accompanied by the relevant clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested. ”*
 - ▶ *“Clinical indicators should be derived from the specific medical record under review and the unique episode of care. Clinical indicators supporting the query may include elements from the entire medical record, such as diagnostic findings and provider impressions.”*

Traditional Use of Clinical Indicators

- ▶ ***Guidelines for Achieving a Compliant Query Practice*** continues to state:
 - ▶ ***“A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure. The justification (i.e., inclusion of relevant clinical indicators) for the query is more important than the query format.”***

Coding and CDI staff are quite comfortable in identifying clinical indicators that are used to support a query to obtain missing, vague or incomplete diagnoses. This has been and continues to be an important part of our daily practice both on the concurrent and retrospective side.

Sources to Establish Clinical Indicators

- ▶ **AHA Coding Clinics**
- ▶ **AHRQ- Agency of Healthcare Research and Quality**
 - ▶ <http://www.guideline.gov/content.aspx?id=39352>
- ▶ **Professional Organizations specific to the appropriate diagnosis**
 - ▶ **ASPEN- Nutritional Diagnoses**
 - ▶ **American Society of Parenteral and Enteral Nutrition**
 - ▶ **KDIGO- Renal Function**
 - ▶ <http://kdigo.org/home/guidelines/>
 - ▶ **American College of Cardiologist Foundation/ American Heart Association**
 - ▶ **Surviving Sepsis Campaign**
 - ▶ <http://www.survivingsepsis.org/Guidelines/Pages/default.aspx>

Best Practice- Establish Organizational Defined Criteria

- ▶ **Targets those diagnoses that are vulnerable to challenge**
- ▶ **Establishes consistency in query practice by coders and CDIS**
- ▶ **Use as teaching tools for medical staff/ ancillary staff**
- ▶ **Promotes consistent documentation by all who document within the record**

- ▶ **Common diagnoses: Acute renal failure, respiratory failure- acute and chronic, levels of malnutrition, encephalopathy, sepsis, severe sepsis....**

Example of Clinical Indicators Sepsis

- ▶ Fever ($\geq 101^{\circ}$ F/ $>38.3^{\circ}$ C) or hypothermia ($<96.8^{\circ}$ F/ $< 36.0^{\circ}$ C)
- ▶ WBC $> 12,000$ or $<4,000$ or $>10\%$ Bands
- ▶ Tachycardia
- ▶ Tachypnea
- ▶ Elevated procalcitonin
- ▶ Elevated C-reactive protein
- ▶ Altered mental status
- ▶ Non-diabetic hyperglycemia (blood sugar $> 120\text{mg/dl}$)
- ▶ Evidence of acute organ failure

Example of Clinical Indicators

Sepsis

Treatment Includes:

- ▶ IV antibiotics
- ▶ IV Fluids- aggressive hydration
- ▶ Monitoring of organ function
- ▶ Supportive measures to maintain organ perfusion/function
 - ▶ Oxygen
 - ▶ Vasopressors
 - ▶ Monitoring of vital signs, urine output, etc.

Query for Sepsis

- ▶ ED record demonstrates respiratory rate of 32 per minute, HR of 96, febrile with admission temp of 38.5°. Blood cultures positive for e coli. Metabolic encephalopathy and UTI identified as admission diagnoses. Diagnostics demonstrated an elevated pro-calcitonin (2.5 ng/ml). Treatment includes antibiotics, oxygen and fluids. Please clarify the condition you are monitoring and treating.
- ▶ A. UTI with sepsis
- ▶ B. UTI only
- ▶ C. Other _____
- ▶ D. Unknown

Example of Clinical Indicators

Chronic Respiratory Failure

- ▶ Hypoxemia (baseline $pO_2 \leq 60$)
- ▶ Chronic Home Oxygen
- ▶ Baseline elevated pCO_2 , elevated bicarb level, with normal pH (7.35-7.45)
- ▶ Polycythemia
- ▶ Cor-pulmonale

Query for Chronic Respiratory Failure

Mrs. Smith has been admitted for acute on chronic systolic heart failure. Respiratory assessment indicates patient is dependent on home oxygen and is maintained on 2-3 liters NP. Documentation also states a compensated respiratory acidosis, with elevated bicarb levels. Your documentation indicates aggressive pulmonary toilet and monitoring to prevent exacerbation of chronic lung disease.

Please clarify the status of patient's chronic lung disease.

- A. Chronic respiratory failure
- B. Other _____
- C. Unknown

Example of Clinical Indicators Acute Respiratory Failure

- ▶ **Symptoms:**
 - ▶ Shortness of breath, dyspnea
 - ▶ Tachypnea
 - ▶ Labored breathing, wheezing, stridor
 - ▶ Accessory muscle use, nasal flaring, grunting
- ▶ **Diagnostics:**
 - ▶ Hypoxemia ($pO_2 < 60$ mmHg/ $SpO_2 < 91\%$ on room air)
 - ▶ Hypercapnea ($pCo_2 > 50$ mmHg with $pH < 7.35$)
- ▶ **Treatment:**
 - ▶ Supplemental oxygen
 - ▶ BiPap, CPAP
 - ▶ Treatment of underlying condition

Example of Clinical Indicators- Malnutrition

- ▶ **Physical Findings**
 - ▶ emaciation, cachexia, muscle wasting, temporal wasting
- ▶ **Risk Factors**
 - ▶ cancer, chemotherapy, HIV disease, malabsorption, end stage organ disease, digestive disorders
- ▶ **Biochemical Factors**
 - ▶ low albumin, prealbumin, cholesterol, transferrin, anemia
- ▶ **Body mass Composition**
 - ▶ Low BMI, recent or progressive unintended weight loss

Diagnostic Resources- Malnutrition

- ▶ **ASPEN- American Society for Parenteral and Enteral Nutrition**
 - ▶ http://malnutrition.andjrnl.org/Content/articles/1-Consensus_Statement.pdf
- ▶ **WHO- Pediatric Standards**
 - ▶ http://www.who.int/nutrition/publications/severemalnutrition/9789241598163_eng.pdf
- ▶ **Merck Manual**
 - ▶ <http://www.merckmanuals.com/professional/nutritional-disorders/undernutrition/protein-energy-undernutrition>

Example of Clinical Indicators Encephalopathy

- ▶ Acute or sub-acute mental status alteration associated with metabolic or toxic factors
- ▶ Will demonstrate improvement with removal of underlying metabolic or toxic factors
- ▶ Does not wax and wane
- ▶ Treatment addresses the underlying “insult” and maintaining patient safety in the setting of altered mental status.

Everybody Has Sepsis? Really?

- ▶ What do we do when we have an over exuberant provider?
- ▶ The provider who “gives” everyone the diagnosis of sepsis? Or acute respiratory failure?

- ▶ How do we address the situation where we have a documented diagnosis but no clinical indicators within the record to support its presence?

Who starts the conversation?

- ▶ **The Coder?**
- ▶ **The CDI specialist?**
- ▶ **The HIM Director?**
- ▶ **The CDI Director?**
- ▶ **The Physician Advisor?**

Examples: Escalation Policy

- ▶ A multi-disciplinary committee (consisting of physicians, quality, compliance, and HIM staff) to review cases submitted by CDI and coding staff when diagnoses are inconsistent with the patient's clinical picture, or the clinical picture is inconsistent with the diagnoses. The committee can provide guidance on the best course of action on a case-by-case basis.
- ▶ When the question of clinical validity is identified in practitioner documentation, the facility may wish to follow their internal escalation policy rather than requiring the CDI specialist/coder to query the practitioner.

How do you Query?

- ▶ Apply the same process you would to capture a missing or vague diagnosis. Identify the indicators that support your question and the answers relevant to these indicators.
- ▶ Begin by listing your clinical indicators to support your query
 - ▶ Know that your indicators may actually be a LACK of indicators
 - ▶ Normal labs/diagnostics
 - ▶ Lack of supporting symptoms or patient presentation
 - ▶ Lack of appropriate treatments/medications

Query Example- Lack of Indicators

Dr. McDreamy, you have indicated within your H&P and progress notes dated 6/12 and 6/13 that Mrs. McGinty was admitted for treatment of sepsis in the presence of an aspiration pneumonia. Respiratory rate upon admission was 32/minute which quickly decreased to 18-20 after oxygen respiratory treatment applied. Patient has remained afebrile throughout admission. Lab results indicate an elevated white count of 11,000 with 3% bands. Blood cultures pending. All other labs are found to be within normal limits. Please further clarify the diagnosis of sepsis.

- ▶ A. Sepsis is ruled out as a diagnosis
- ▶ B. Sepsis determined to be present
- ▶ C. Other: _____
- ▶ D. Unable to determine

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Query Example- Lack of Indicators

Dr. Welby your documentation in the progress note dated 6/15 indicates the diagnosis of acute respiratory failure, in the presence of a COPD exacerbation. The patient is being treated with 3 liters of oxygen NP and maintaining an oxygen saturation of 93%. Respiratory therapy assessment indicates patient uses home oxygen at 2-3 liters. ED physician describes a compensated acidosis as demonstrated by ABG drawn upon arrival. Respiratory rate 28 with no accessory muscle use or signs of distress noted. Please further clarify the status of patient's respiratory function.

- a. Patient admitted with COPD exacerbation, chronic respiratory failure.
- b. Acute respiratory failure has been ruled out.
- c. COPD exacerbation with acute respiratory failure
- d. Other
- e. Unable to determine

Query Example- Lack of Indicators

Dr. Quinn you have indicated within your H&P the diagnosis of metabolic encephalopathy as being present on admission. Mr. BeFuddle has been admitted with altered mental status with a history of Alzheimer's dementia related to a UTI. Nursing admission assessment describes baseline mental status as intermittent disorientation to place and time, easily reoriented with verbal cuing. Nursing progress notes describe confusion worsening during night hours but cleared with morning light. Patient cooperative and oriented throughout the day, no intervention needed. Please clarify the patient's mental status for this admission.

- A. Encephalopathy ruled out with further consideration.
- B. Patient exhibiting an acute confusion
- C. Sun-downing in the presence of Alzheimer's Disease
- D. Other
- E. Unable to determine

Do Understand....

- ▶ **The provider can use ANY clinical indicators s/he determines to be relevant to support a diagnosis.**
- ▶ **The 2013 AHIMA practice brief: Guidelines for a Achieving a Compliant Query Practice in association with ACDIS stresses the importance of clinical indicators. It is advised that queries be generated when a diagnosis does not appear to be supported by clinical indicator(s) within the health record**
- ▶ **But the attending physician is the ultimately responsible to determine which diagnoses are applied to the patient based on any clinical indicators they determine to be relevant.**

Coding Clinic for ICD-10 1st Qtr. 2014

- ▶ Question: We understand there are no plans to translate all previous issues of Coding Clinic for ICD-9-CM into ICD-10-CM/PCS . . . Can we use the clinical information published in Coding Clinic for ICD-9-CM when coding with ICD-10?
- ▶ Answer: Clinical information published in *Coding Clinic* whether for ICD-9 or ICD-10 **doesn't constitute clinical criteria for establishing a diagnosis**, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition

Do we have any say in the matter?

Questions to ask?

Is the diagnosis considered reportable? Does it require:

- ▶ **Clinical Evaluation? Diagnostic procedures?**
- ▶ **Therapeutic treatment?**
- ▶ **Extended length of stay or increased nursing care/monitoring?**

Does the physician state the diagnosis is present within the patient encounter?

Do we have the right to determine whether diagnosis is valid or no?

Are we able to add an undocumented diagnosis because we think it is present?

Are we physicians caring for the patient?

UHDDS: Key Elements in Code Assignment

Conditions should be coded that affect patient care in terms of requiring:

1. Clinical evaluation, or
2. Therapeutic treatment, or
3. Diagnostic procedures, or
4. Extended length of hospital stay, or
5. Increased nursing care and/or monitoring

It is important to note that a diagnosis is not required to meet all of these criteria

Do we have any say in the matter?

Questions to ask?

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- ▶ **Clinical Evaluation? Diagnostic procedures?**
- ▶ **Therapeutic treatment?**
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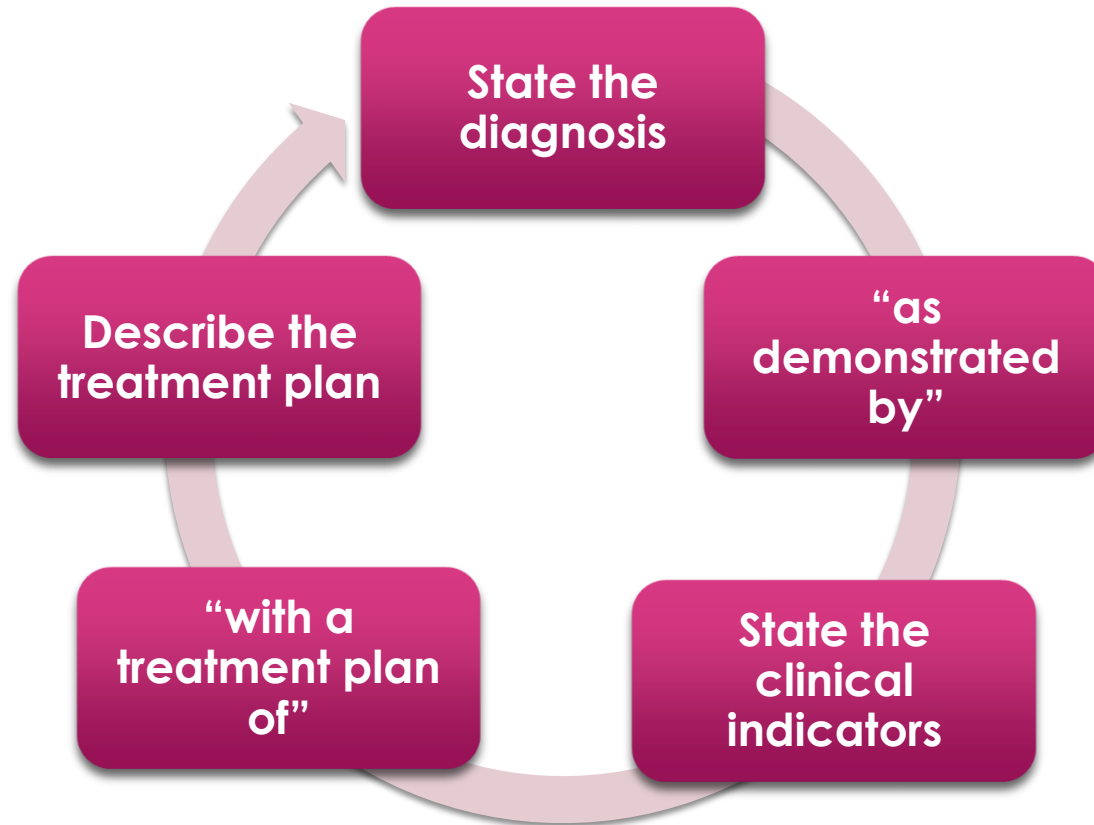
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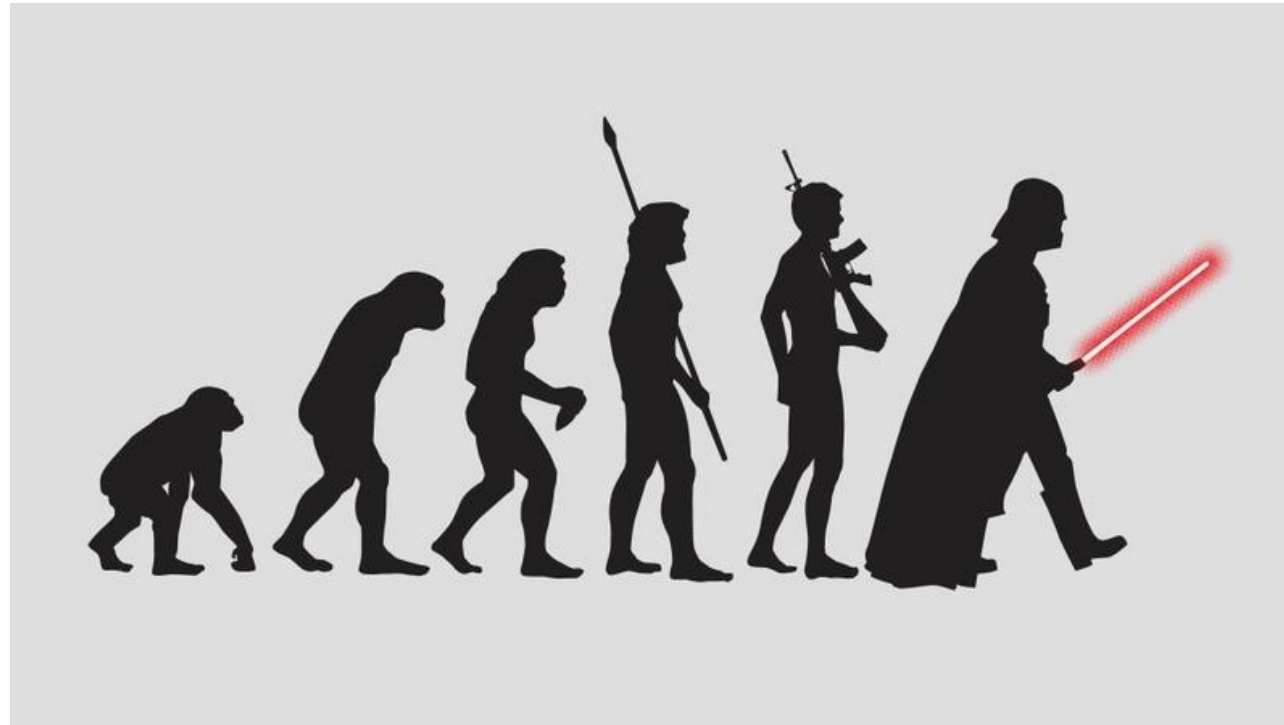
Are we physicians caring for the patient?

Quality Documentation is Important



Progress Notes Must Demonstrate...

► PROGRESSION !



To Conclude:

- ▶ Establishing clinical indicators to support query for missing diagnoses is an important part of our record review
- ▶ The record should demonstrate clinical evidence to support established diagnoses within the record
 - ▶ When that clinical evidence is not present we must query to verify
- ▶ Escalation policies should be in place to support CDIS/coders when they encounter road blocks in obtaining clinical validation of diagnoses
 - ▶ Identify patterns in documentation issues
 - ▶ Assistance by administration or physician advisor as needed



Questions?

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