# Setting guideposts: Organizationwide clinical definitions

On February 23, 2016, the Journal of the American Medical Association *published new clinical definitions for sepsis and septic shock*, dubbed "Sepsis-3." In the three years since then, a host of analyses and conflicting documentation and coding requirements have caused not only consternation but downright confusion for clinicians, CDI specialists, coding professionals, and others.

Sepsis isn't the only diagnosis that has received updated criteria for the medical community while documentation and coding requirements for the condition remain unchanged—think Global Leadership Initiative on Malnutrition (GLIM) criteria, *released in 2018*, and the fourth edition of the universal definition of myocardial infarction, *published in 2018* in the *Journal of the American College of Cardiology*.

Some providers cling to previous clinical definitions. Others rush to embrace the new criteria. CDI and coders, however, struggle to identify what clinical indicators they need to include on physician queries and how to capture the most appropriate information to assign accurate codes for the care provided. To complicate matters, various payers have a tendency to pick and choose which clinical criteria they deem appropriate (or inappropriate) in issuing denials.



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One strategy for handling this confluence of confusion comes in developing a set of organization-wide clinical criteria for targeted, high-risk/high-volume diagnoses.

It's extremely valuable to have a list of facilitywide clinical indicators that CDI staff can leverage for query generation, along with a "works cited" list of resources supporting those clinical definitions that the person writing the appeals can reference, says Angela Geiger, RN, BSN, CCS, CPC, COC, CDI specialist at Penn State Health in Hershey, Pennsylvania, and a former auditor for an insurance company. "When you're writing those clinical indicators, though, they need to be strong and supported by industry research. Read over your clinical indicators—read them 50 times. Try writing an appeal off them, and you'll find where they are weak that way."

## Forming a clinical guidelines committee

First, identify priorities. For example, priorities may come from the CDI steering committee, if one exists, or they may come from monthly CDI and coding roundtable sessions. They may also come from the CDI physician advisor or from the providers/specialty groups themselves.

For Debbie Squatriglia, RN, CDIP, CCDS, director of CDI, patient revenue management organization, at Duke University Health System in Raleigh-Durham, North Carolina, the best first step to take when creating organizational clinical criteria is to ask around—talk to the physician leadership, coding leadership, etc.

"It seems simple, but the first step we took was that I introduced the idea," she says. "When I first began my CDI career at [my previous organization], we daydreamed about how great it would be to all be on the same page about acute kidney injury. There was a lot of cloudiness about documentation for that diagnosis, so that was my first foray."

After a few inquiries, the idea will gain supporters—after all, who doesn't want clarity around difficult diagnoses?

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Though confusing diagnoses are a great place to start, steer clear of the hot-button issues that have lots of different sides, Squatriglia says. Some of the more controversial conditions may generate conflicts between physician specialties or between departments.

It's also helpful to start with just one or two diagnoses and get the process ironed out. This will help a CDI steering committee build momentum as they approach more difficult diagnoses down the line.

"Start by agreeing on just one diagnosis to work on," Squatriglia says. "Start with some quick wins."

From there, volunteer subcommittees may be identified, or a standing criteria committee developed.

"We decided to make it a more formal process at Duke," Squatriglia says. "We gathered volunteers from the CDI team, and from the inpatient and outpatient coding teams. They drew up a charter, and now we have monthly meetings to discuss the things that are making coders scratch their heads, and we started with those diagnoses."

These teams should be empowered to devote a certain number of hours per day to research as well as to collaboration and outreach. That research should include the clinical criteria from the established medical doctrine of the day, such as GLIM and Sepsis-3, but also relevant ICD-10-CM/PCS coding regulations, related *Official Guidelines for Coding and Reporting*, and issues of AHA *Coding Clinic for ICD-10-CM*. Furthermore, the committee should determine any quality measures related to the diagnosis criteria and identify documentation concerns related to Patient Safety Indicators or severity of illness/risk of mortality, as well.

All of this will require outreach and interdepartmental collaboration. "The process brings silos together, develops relationships, and enhances understanding," Squatriglia says. "I believe in my heart that CDI is a profession built upon relationships. It's really a team

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sport between physicians, CDI specialists, and coders.”

There are essentially three steps that Duke’s committee goes through when creating and disseminating new facilitywide criteria, according to Squatriglia:

1. Researching best practices by consulting relevant medical publications and collaborating across departments
2. Contacting physicians from the relevant departments and asking for help
3. Disseminating the new criteria to the organization (Duke does this by posting it on their shared intranet)

Perhaps the most important piece of that equation, according to Geiger, is the research backing up the organizational criteria sets.

“The first time I realized that,” she says, “I was writing an appeal for acute respiratory failure and trying to write it based on the clinical indicators we had. I realized there wasn’t a works cited with our criteria. The criteria have to be from the industry, not just from your own facility. You should have a big long list of [supportive resources and documentation] at the end of your criteria.”

The clinical indicators shouldn’t only be employed during the appeals process, according to Shirlivia Parker, MHA, RHIA, CDIP, BS, interim CDI physician educator at Sacred Heart Medical Center in Spokane, Washington. After all, if the physicians at the organization don’t know about the criteria set in the first place, they’re likely not going to follow it closely, which will make it virtually useless from an appeals standpoint. Similarly, the CDI team should be using the same criteria to query the providers so that the documentation is denial-proof (or at least close to it).

“We have our clinical evidence-based definitions that we use [for queries] and appeal on,” says Parker. “We have our physician educators who present on the definitions and explain why we send out clinical validation queries. […] We make sure everyone who can make an impact knows what’s going on.”

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## Updating the criteria

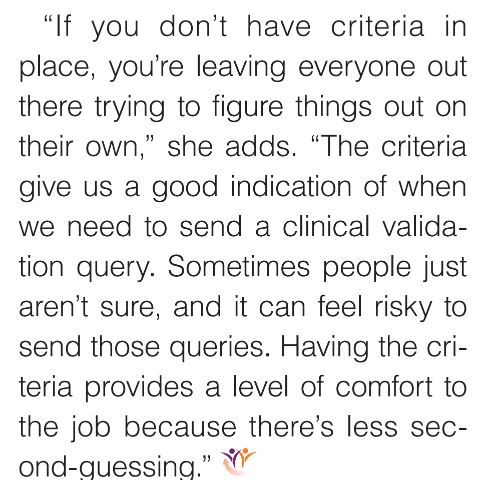
The work doesn’t end with the criteria being posted to the organization’s intranet or the physician education being completed. There needs to be a process in place to reevaluate and update the criteria on a regular basis to ensure they’re up to date with the latest best-practice clinical guidance and the current coding guidelines.

The team reviews clinical criteria every two years or as needed and rotates the committee members accordingly, Squatriglia says. When new committee members come on, they review the previous group’s work and make any amendments necessary.

While having these facilitywide criteria can help fight denials and provide much-needed ammunition for an appeal letter, they can also foster communication and collaboration within the organization’s walls.

For one thing, a clinical guidelines committee brings people from a variety of backgrounds and departments to the same table, Squatriglia says.

“If you don’t have criteria in place, you’re leaving everyone out there trying to figure things out on their own,” she adds. “The criteria give us a good indication of when we need to send a clinical validation query. Sometimes people just aren’t sure, and it can feel risky to send those queries. Having the criteria provides a level of comfort to the job because there’s less second-guessing.”





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