Clinical validation, denials prevention, and appeals

by Alba Kuqi, MD, CICA, CCS, CDIP, CCDS, CRCR, CSMC

The Official Guidelines for Coding and Reporting Section I.A.19 titled “Code assignment and Clinical Criteria” says the following:

The assignment of a diagnosis code is based on the provider’s diagnostic statement that the condition exists. The provider’s statement that the patient has a condition is enough. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.

Some people have incorrectly interpreted this statement to mean that clinical validation of documented conditions is no longer required for code assignment on claims. However, CMS requires that claims submitted for payment must not include diagnoses that cannot be clinically validated. An effective clinical validation process requires the coding, CDI, and auditing team to work cohesively.

At the time of coding, if the final DRG assignment does not match the CDI professional’s working DRG, the coder/auditor and the CDI specialist should discuss the case before billing. Some mismatches such as a complication of surgery take place after CDI staff is removed from the case, and these do not have to be discussed other than for learning opportunities.

The CDI team should generate all necessary queries for a case that involved a CDI review because they have already established a relationship with the provider, and this should allow for a timelier response. Engaging a physician advisor or medical director for peer-to-peer conversations in instances where the clinical criteria do not appear to support the diagnostic statement in the record is essential because it decreases the number of unwarranted queries and avoids seeming to question the provider’s clinical judgment.

The validation process can be especially challenging when providers and payers use different clinical information or interpret the data differently. A 2015 ACDIS white paper says that “DRG validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of a claim on prospective payment services (PPS), and as appropriate, reviewing the record’s DRG accuracy.”

The format of clinical validation can vary significantly between issuing queries, engaging in discussion with the physician, elevating concerns to a physician advisor, and ultimately removing an invalidated diagnosis. It is recommended to perform clinical validation of all diagnoses that lack support, regardless of whether they impact the principal diagnosis. Anecdotally, CDI professionals are noticing that payers deny high-risk diagnoses even if the indicators are present in the record. If CDI professionals fight back, they might win.

The lack of physician buy-in is a common obstacle in obtaining documentation to support clinical validation. Turning the physician’s focus back to patient care is essential in the clinical validation query process. Furthermore, including the right clinical indicators to justify that it was appropriate for the physician to report a particular diagnosis is a good rule of thumb. Physicians need to know that their documentation affects their profile and their risk-adjusted payments. Asking physicians to attend CMS Targeted Probe and Educate sessions is a potent educational tool.

Denials prevention

CDI specialists are doing more to prevent denials than just issuing concurrent clinical validation queries. They also review for additional CCs and MCCs to “protect” cases against denials, focusing on high-risk DRGs and diagnoses, and work with payers and stakeholders in their organization to establish criteria for diagnoses.

One aim of CDI is to ensure the complete and accurate reporting of diagnoses and procedures, especially to meet revenue cycle goals such as submitting clean
claims and reducing days in accounts receivable. User-friendly improvements to the EHR, including better workflows and documentation templates, can also help prevent denials.

Denials are increasing as health plans tighten their requirements for medical necessity and conduct more reviews for this purpose. Denials may include both denial of a current claim as well as a take-back from claims already paid where a review reveals issues. This is particularly true for the CMS Recovery Audit Contractor (RAC) reviews wherein RACs are increasingly targeting providers with high claims denial rates.

Steps to manage denials include tracking their financial impact, benchmarking performance using Claim Adjustment Reason Codes, targeting the root causes of denials to determine solutions, and eliminating inconsistencies in denial processing. Once a provider has a good understanding of their denials and can apply solutions, the denials management and CDI team need to provide feedback to the health plan during contract negotiation to prevent similar problems in the future.

Clinical appeals

Appeals are an expensive undertaking not only in their processing but also in their impact on the availability of capital resources. Most CDI professionals are involved in some form of denials prevention and protection (even if just tangentially through the review process), but fewer are engaged in the appeals process post-denial. Incorporating rationale into appeal letters is essential because it’s a learning opportunity for what the payers are looking for, so CDI professionals can become more proactive in the future.

CDI professionals need to allow the physicians to participate in the process of writing appeal letters because this step helps physicians see how their documentation is being interpreted. As we’ve said, high-risk diagnoses (e.g., sepsis, acute respiratory failure, acute kidney injury, malnutrition) are a significant source of denials.

Sepsis validation

Documenting the presence of sepsis is critical to best determine each patient’s needs for care. Clinicians, however, often vary in their definitions of sepsis or fail to note the presence of sepsis in the medical record when the clinical indicators support such assessment.

These variances have led to difficulties for CDI specialists, especially when third-party payers adhere to different definition sets. To demonstrate consistency in reporting, coding, and clinical care, healthcare facilities must develop a standardized approach to the definitions of sepsis as a reference for teaching, quality measurement, clinical care, and coding purposes.

A 2017 ACDIS white paper says that the goal for medical staff is to develop a clinical policy that includes the new definitions as well as documentation expectations. The medical staff should review and discuss the new definitions and clinical criteria for sepsis and septic shock; physicians providing critical care to sepsis patients—such as emergency medicine, infectious disease, pulmonary, and hospitalist physicians—should be included in that discussion. If the medical staff is unfamiliar with these new definitions, then education must be provided. The medical staff may adopt the new criteria or define facility-specific criteria applicable to diagnosing and managing patients with suspected sepsis.

As of January 2017, sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response. The Sequential Organ Function Assessment (SOFA) has high predictive validity for sepsis but is heavily dependent on the laboratory analysis of multiple systems. The SOFA criteria are aimed at quantifying organ dysfunction. A new measure called quick SOFA (qSOFA) provides a bedside analysis not dependent on laboratory analysis with the same predictive validity as SOFA. The clinical criteria for SOFA include:

- Respiratory rate ≥ 22/minute
- Altered mentation
- Systolic blood pressure <100 mm Hg

The SOFA/qSOFA scores are not meant to replace the physician’s clinical judgment. We need to teach providers to paint a picture of accurate acuity and severity that is also internally consistent. 🌈

Editor’s note: Kuni is the CDI supervisor at Prime Healthcare in Philadelphia. Contact her at albakuni88@gmail.com. Opinions expressed are those of the author and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.