Clinical Validation: Do We or Don't We?

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Understand the controversies and compliance issues associated with clinical validation
- Apply concepts for organizing and implementing a clinical validation process
- Utilize consistent definitions for top clinical validation targeted diagnoses
Outline

- Who is Vidant Health?
- Why should we care about clinical validation?
- Guidance on clinical validation
- Outlining a process for clinical validation
- Clinical examples of common diagnoses targeted for clinical validation and denials
Vidant Health

- 8 hospitals (3 CAHs)
- 1447 beds
- Affiliated medical school
- Over 30 IP coders and 18 CDSs
- Over 36 quality staff
- 11,899 employees
- Over 1,000 providers
- 64,388 admissions
- 46,544 surgeries
- 5 physician advisors
Why Should We Care About Clinical Validation?
## Medicare Contractors

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<td><strong>MAC – Medicare Administrative Contractors</strong></td>
<td>Process claims from physicians, hospitals, and providers and submit payments according to Medicare rules and regulations (includes identifying and correcting under- and overpayments)</td>
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<td><strong>ZPIC/PSC – Zone Program Integrity Contractors/Program Safeguard Contractors</strong></td>
<td>Perform investigations that are tailored to specific circumstances and occur only in situations where there is potential fraud, and take appropriate corrective actions</td>
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<td><strong>SMRC – Supplemental Medical Review Contractor</strong></td>
<td>Conducts nationwide medical reviews as directed by CMS (includes identifying under- and overpayments)</td>
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<td><strong>CERT – Comprehensive Error Rate Testing contractors</strong></td>
<td>Collect documentation and perform reviews on a statistically valid random sample of Medicare FFS claims to produce an annual improper payment report</td>
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<td>Medicare FFS Recovery Auditors</td>
<td>Review claims to identify potential under- and overpayments in Medicare FFS, as part of the Recovery Audit Program</td>
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## Claim Review Programs

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<td><strong>RAC</strong> – Recovery Audit Program/Contractors</td>
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CMS Fee-for-Service 2017

- CMS believes that over $36 billion in payments were made improperly.
- Auditing programs recouped approximately 1% ($500 million) of the overpayment estimate.
Improper Payment Rate Error Categories

- Other: 3.6%
- No Documentation: 1.7%
- Incorrect Coding: 13.1%
- Medical Necessity: 17.5%
- Insufficient Documentation: 64.1%
RAC Activity FY 2016

• Less than 50% of denials were appealed
• 47.3% of appeals were overturned
  – Leaves over 75% of appeals intact for recoupment
  – Return on investment (ROI) of $4.57:1
    • ROI for FY 2015 was $2.48:1

Expect RAC activity and denials to increase
Additional Factors

- OIG activity
  - Malnutrition
    - Recoupment of $1m+ per audit
    - Subsequent TPE audits by CMS contractors
  - Assessing inpatient hospital billing for Medicare beneficiaries (Dec 2018)
    - Should be interesting
- Private payers
  - Similar activity for recouping/denying payments
Auditor Basics

• Claims are screened for high-yield denials
  – Single CC or MCC cases
  – Highly vulnerable diagnostic codes

  Tip: include all diagnoses with detail

• Auditors receive a percentage of what they recover
• Doctors are not good at documentation
• Hospitals do not always appeal
Common Denial Rationales

- Inherent to another condition
- Reportability (lacks evidence it was evaluated, treated, worked up, or impacted LOS or nursing care)
  
  **Tip:** include diagnoses in assessment and plan with an associated plan of care, and/or statement of status or significance

- Conflicting documentation
  
  **Tip:** clarify or rectify differences in diagnoses between attending and consulting services
Common Denial Rationales

- Diagnosis is missing from the discharge summary
  - CMS considers the discharge summary to be the FINAL DIAGNOSTIC STATEMENT
  
  Tip: Include all diagnoses (chronic, resolved, or active) in the discharge summary

- The diagnosis does not exist in this patient – ‘clinical validation’
  - Auditors may use outdated or custom/alternate criteria, or find missing/conflicting diagnostic statements
  - Auditors may locate missing criteria for a diagnosis
  - Auditors identify inconsistencies in clinical documentation
Guidance on Clinical Validation
19. Code assignment and Clinical Criteria

• 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 particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.
Guidance: CMS

Statement of Work for the Recovery Audit Program

“Clinical validation is a separate process, which involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented. 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.”
Clinical validation and the role of the CDI professional

Summary: This paper discusses the concept of clinical validation as it has evolved through CMS regulations and coding guidance. It also attempts to establish consensus about how CDI professionals should incorporate clinical validation into their practice.
The focus is the same: ensuring documented conditions are supported by the totality of the health record. The goal of clinical validation is ensuring that ‘the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record’ (Denton et al., 2016). A thorough clinical validation review includes searching the health record for contradictory clinical indicators that might make a diagnosis vulnerable to clinical validation denial.”
“Clinical validation review processes must confirm that the provider’s clinical criteria can be easily linked to the corresponding diagnosis. Regardless of their professional background, not all CDI professionals will feel comfortable with this task.”
“Organizationally established guidelines and clinical indicators created in collaboration with the medical staff, CDI specialists, and coders for problematic or high-risk diagnoses can help support CDI professionals and coders in the clinical validation process.” ... “not to limit how a diagnosis can be defined, but rather to promote consistency among CDI specialists in determining whether a minimal threshold of support is present within the health record. CDI specialists may wish to encourage providers who use nontraditional criteria to include the rationale for their conclusion.”
Guidance: ACDIS

“The query process ... can only attempt to clarify the status of what appears to be an unsubstantiated diagnosis. A provider cannot be forced to recant a questionable diagnosis to avoid its reporting when it meets UHDDS criteria.”

“Organizations should strive to implement a pre-bill clinical validation process rather than a post-bill process so that needed changes can be made prior to claim submission.”
"CDI professionals may wish to issue verbal queries for clinical validation. Verbal queries allow the CDI professional to discuss a documented diagnosis with the attending provider."

"Providers hold the ultimate responsibility for both establishing a diagnosis and documenting the criteria that led to the establishment of said diagnosis. When the medical record appears to lack evidence-based clinical criteria for a diagnosis, CDI specialists must query the provider."
Guidance: AHIMA

Clinical Validation: The Next Level of CDI

Review: 2016 Practice Brief

The generation of a query should be considered when the health record documentation:

Provides a diagnosis without underlying clinical validation
Guidance: AHIMA

“A query may not be appropriate simply because the clinical information or clinical picture does not appear to support the documentation of a condition or procedure.” ... “In situations where the provider’s documented diagnosis does not appear to be supported by clinical findings, a healthcare entity’s policies can provide guidance on a process for addressing the issue without querying the attending physician.”
Guidance: AHIMA

“It is also important to note that clinical validation is a somewhat subjective concept as practitioners often disagree how to define conditions such as severe malnutrition and acute respiratory failure.”

“Based on CMS’s guidance, it appears clinical validation may be most appropriate under the purview of the CDI professional with advanced clinical education and a background in conducting clinical reviews.”
Guidance: AHIMA

“Organizations are well served to clearly define the expectation of both CDI and coding efforts in regard to clinical validation.”

“Failure to establish a precise process can negatively impact collaborative efforts as CDI professionals might feel ignored and coding professionals may feel compromised.”
Guidance: AHIMA

Taking Coding to the Next Level Through Clinical Validation

Notes opportunities for coders to raise their knowledge base and education regarding clinical validation. Also advocates for a collaborative approach to the issue.
Guidance: Coding Clinic

Clinical criteria and code assignment

ICD-10-CM/PCS Coding Clinic, Fourth Quarter 2016
Pages: 147–149 Effective with discharges: October 1, 2016

“The guideline noted addresses coding, not clinical validation.”

“It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill.”

“Regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded.”

“A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.”
Guidance: Coding Clinic

Omitting ICD-10-CM codes

*ICD-10-CM/PCS Coding Clinic*, Fourth Quarter 2017
Page: 110 Effective with discharges: October 1, 2017

“It is not appropriate to develop internal policies to omit codes automatically when the documentation does not meet a particular clinical definition or diagnostic criteria. Facilities may review documentation to clinically validate diagnoses and develop policies for querying the provider for clarification to confirm a diagnosis that may not meet particular criteria.”
Opinion

• **HIM Coding Professionals Told They’re Not Qualified to Query for Clinical Validity**
  
  – Although it might be tempting for both CDI and coders to want to define diagnoses for a provider, it is not within the scope of either a CDI, registered nurse, or coding professional to do so.
  
  – The statement was made that clinical validation is beyond the scope of DRG (coding) validation, or the skills of a certified coder.
  
  – To say that seasoned coding professionals are not clinically competent or trained well enough to interpret clinical terms and concepts from the medical record is absurd.

Guidance: CMS Program Integrity Manual

“The purpose of DRG validation is to ensure that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician's description and the information contained in the beneficiary's medical record.”
Controversies/Questions

• Is clinical validation questioning the treating physician’s judgment?
• What definitions do we use?
  – Can we impose definitions?
  – Who decides what definitions we use?
• Who can/should perform clinical validation? Coders? CDI?
• What is the policy for escalation?
  – Who are the players to involve?
• What about coding guidelines?
• Do all issues need a query?
  – Can we remove a code without querying?
  – Should these be verbal in most cases?
Clinical Examples of High-Target Diagnoses
Steps for Attendees to Answer/View POLLING QUESTIONS

1. Navigate to the event Agenda in the main menu
2. Tap the name of the current session to view the session details page
3. Tap Polls
4. Tap the name of the poll
5. Tap your answer choice and then tap Submit
Polling Question #1

• If a diagnosis is deemed not clinically valid but is documented consistently and affirmed with a written query, what should be done?
  – Offer an additional modified written query
  – Verbally query/discuss with the provider
  – Code the diagnosis as documented and affirmed
  – Do not code the diagnosis
Clinical Validation Example #1: Encephalopathy

94-year-old female who experienced acute-onset right-sided weakness, aphasia, and facial droop; given tPA. In the ICU, neurology noted patient had agitation – “Appears to be more sundowning vs. ICU psychosis but can’t r/o aphasia as contributing.” Medicine note states “Alert and awake but demented at baseline.” On day of discharge neuro note reports “Agitation: Appears to be more sundowning vs. ICU psychosis but can’t r/o aphasia as contributing.”

*Encephalopathy was not documented in the chart.
Clinical Validation Example #1: Encephalopathy

A 94-year-old female with pmhx of Afib, HTN, dementia, and dCHF who experienced acute-onset RSW, aphasia, and facial droop. Head CT was negative for a hemorrhage and tPa was given. Progress notes revealed: CVA s/p tPA – Maintain standard tPA precautions per tPA order set. Ever since being here, patient has not had any right-sided weakness per nursing but has been agitated and does not follow. Patient agitated and pulling at lines/IVs. Will use non-violent restraints.

• Can the patient’s agitation be specified further as:
  – Encephalopathy
  – Dementia with behavioral disturbances
  – Both
  – Other, please specify
  – Clinically indeterminable – This option will close the query with no clarification of the current documentation, thereby limiting accurate representation of the patient's care delivery and complexity
**Encephalopathy**

Global cerebral dysfunction in the absence of primary structural brain disease

- Clinical features
  - Underlying illness, disease, metabolic dysfunction, toxin
  - **Altered mental status**
    - Confusion
    - Lethargy
    - Loss of coordination or strength
  - **Reversible**
    - Caution if the patient has dementia
Encephalopathy

• Supporting factors
  – Clinical evaluation (CT, labs, EEG, further workup)
  – EEG with diffuse slowing
  – Medication changes (should not be the only factor)
  – Examination consistent with dx

• Documentation issues
  – Inconsistent documentation (AMS, delirium, encephalopathy)
  – Unspecified encephalopathy
Clinical Validation Example #2: Malnutrition

92-year-old male admitted with CP and MI. CKD with elevated CR above baseline. Weight loss of 12% over last 10 months. Wt 52 kg, BMI 17. Treated with IVF/hydration. Dietitian evaluation on day 2: Severe protein calorie malnutrition. Severe wasting of mm and fat. Rx with supplements and dietary modifications. Cardiology initial eval reports patient appears “anorectic.” D/C at day 6.

- ED note: “well developed well nourished”
- Subsequent cardiology notes: “well developed well nourished”
- Hospitalist notes: “well hydrated well nourished,” “well hydrated, elderly, thin”
- D/C summary: “not able to eat, weight loss,” “well hydrated, well nourished”
- Query on day 3 answered “severe protein calorie malnutrition,” no diagnosis in any following notes or d/c summary
Clinical Validation Example #2: Malnutrition

“Progress notes state the patient is well hydrated, well nourished” ... “The discharge summary states well hydrated, well nourished ... and does not contain the diagnosis of malnutrition” ... “Although the physician responded to the query stating severe protein calorie malnutrition, the same doctor documented that the patient was well nourished in the discharge summary”
Malnutrition

- 2012: AND/ASPEN published criteria for the diagnosis of malnutrition in adults
- 3 main classes of diagnostic categories by etiology
  - Starvation-related (social)
  - Chronic disease-related
  - Acute disease or injury-related
- 2 of 6 required features for Dx
  - Muscle or fat wasting
  - Weight loss
  - Poor intake
  - Diminished function (measured with hand grip)
  - Edema due to malnutrition

Tip: Serologic markers do not correlate with nutritional status in hospitalized patients.

Tip: Malnutrition may occur at any BMI.

Tip: Clinical history and exam should be consistent with risk factors for developing malnutrition.
Malnutrition

• Clinical features
  – Acute or chronic illness should be present (occ social)
    • Risk factors and mechanism for contracting the condition
    • Weight loss
    • Inadequate intake or increased metabolic activity (e.g., cancer)
  – Examination findings should support the diagnosis
    • Cachectic, wasted, emaciated
    • Obese patients can be malnourished
  – Treatment plan should be consistent with the diagnosis
    • Dietitian involvement, supplements, discussion/counseling
Malnutrition

• Documentation issues
  – Failure to include the diagnosis in provider documentation and discharge summary
  – Inaccurate examination and history
  – Failure to involve the dietitian
  – No follow-through on treatment plan
  – Bad templates
  – Lack of severity
  – Lack of statement of clinical significance
Clinical Validation Example #3: Sepsis

24-year-old male admitted with cellulitis of the foot with an ulcer, admitted after failing treatment with OP antibiotics. No other PMhx. On admission T 98.8, P 78, RR 20, WBC 13.8. Vitals remained normal. No LA measured. No IVF boluses received. Received antibiotics, ID consult, and discharged with oral rx after 7 days.

- ED note “no fevers or chills,” “no distress,” “cellulitis ... failed outpatient treatment”
- H&P states “laying on a stretcher, no distress,” “cellulitis and abscess”
- Day 3 and subsequent MD prog notes “cellulitis and abscess, sepsis”
- D/C summary “sepsis secondary to LLE cellulitis”
Clinical Validation Example #3: Sepsis

“The evidence in the medical record does not support the assignment of sepsis as the principal diagnosis” ... “To validate sepsis, we look for consistent documentation of the condition in the medical record; evidence that the patient’s presentation can not be explained by a local infection alone, or by a non-infectious condition; and that their treatment and LOS are consistent with the diagnosis” ... “On admission no documented temperature, pulse ranged from 53 to 70, RR ranged 16 to 17, WBC 13.8, glucose 97 in a patient without DM, no lactic acid found” ... “Upon further investigation the diagnosis of sepsis was not supported by the clinical evidence.”

**INITIAL DRG: 854 INFECTION**

**LOS:** 7.7  **RW:** 2.39  **MORT:** MOD  **REIMB:** $18,400

**WITH OR PROCEDURE WITH CC**

**FINAL DRG: 572 SKIN DEBRIDEMENT**

**LOS:** 4.3  **RW:** 1.18  **MORT:** MILD  **REIMB:** $9,100
Sepsis

• General criteria
  – Fever
  – Leukocytosis
  – Tachycardia
  – Tachypnea
  – Altered mental status
  – Hyperglycemia in the absence of DM

• Clinical features
  – Ill appearance
    • Looks toxic
    • Appears acutely ill
    • Mild/moderate distress

Tip: Criteria used to define sepsis should not be due to another condition. For example, do not use tachycardia as a criterion in a patient with atrial fibrillation or WBC elevation in a patient recently dosed with steroids.
Sepsis

- Additional sepsis criteria
  - Inflammatory
    - Elevated CRP
    - Left shift
  - Hemodynamic
    - Hypotension
  - Organ dysfunction criteria
    - Acute oliguria/AKI (CR increase)
    - Ileus
    - Thrombocytopenia
    - Shock
    - Metabolic acidosis (lactic acidosis)
    - AMS/encephalopathy
    - DIC

Tip: If criteria for severe sepsis are present, document severe sepsis. Severe sepsis carries a higher expected risk of mortality and will help prevent denials based on SOFA scoring.

Tip: If sepsis is not present, do not document it. If it is ruled out, note that it has been ruled out.
Sepsis

- Documentation issues
  - Beware of “SIRS/sepsis criteria met” or “SIRS due to pneumonia”
    - “Sepsis due to pneumonia”
  - Missing criteria used to make the diagnosis
  - No treatment plan consistent with sepsis
  - Missing source of sepsis/infection (due to)
  - Documentation related to a device or line infection
  - Present on admission status
  - Examination inconsistent with the diagnosis
    - “Pleasant female in NAD sitting on a stretcher”
Sepsis

• Documentation issues (cont.)
  – Missing documentation of sepsis consistently throughout the record
  – Term “sepsis criteria no longer present”
    • Does this mean it wasn’t sepsis?
    • Prefer “sepsis-resolved” instead
  – Bad query responses
    • You do not need to be present when the vitals are taken or labs are measured to determine that sepsis is present

TIP: Sepsis may be due to infections other than bacterial (e.g., sepsis due to influenza B).
Clinical Validation Example #4: Acute Respiratory Failure

58-year-old female admitted with seizure following recent CVA. On continuous EEG monitoring, on day 3 found to have ongoing seizures. Lungs clear, normal respiration, and on room air. After intubation, normal ABG results.

**MD note:** Dr. A. Yerway called for assistance with intubation in preparation to start high-dose Versed drip.

**Procedure note:** Required placement of a non-emergent artificial airway secondary to impending need to protect airway.

**MD note:** Seizures are worse with development of status epilepticus resulting in respiratory failure.
Clinical Validation Example #4: Acute Respiratory Failure

The patient was admitted with seizure and altered mental status. Was intubated electively for airway protection. ABG results were unremarkable. No distress, no hypoxia. Subsequent notes document acute respiratory failure. This diagnosis may be challenged by an external reviewer on a clinical basis. Can you clarify if the patient had:

- Intubation for airway protection
- Intubation and MV for acute respiratory failure (please clarify)
- Other
- Clinically indeterminable – This option will close the query with no clarification of the current documentation, thereby limiting accurate representation of the patient’s care delivery and complexity
Acute Respiratory Failure

• Clinical exam findings
  – Accessory muscle use
  – Unable to speak in complete sentences
  – Confusion/altered level of consciousness
  – Respiratory distress
  – Tachypnea (RR > 26)
  – Abnormal lung exam

• ABG
  – PaO2 < 60
  – pH < 7.3 or > 7.5
  – pCO2 > 50

Tip: Values for a patient with COPD or chronic respiratory failure may be different than those for a patient with normal lung function at baseline.

Tip: An ABG is not needed for the diagnosis of acute respiratory failure.
Acute Respiratory Failure

• Treatment for acute respiratory failure
  – High-flow oxygen (4L NC or higher)
  – BiPAP or CPAP
  – Facemask or NRB
  – Mechanical ventilation
  – Treatment of underlying cause
    (antibiotics, steroids, bronchodilators, diuretics)

Tip: Not all patients on a ventilator have acute respiratory failure. Beware of documenting acute respiratory failure in the setting of intubation for airway protection or for staged surgical procedures.
Acute Respiratory Failure

• Documentation issues
  – Missing acuity: acute, chronic, acute on chronic
  – Missing type: hypoxic or hypercapneic
  – Due to: should include the underlying condition/cause
  – Treatment rendered not consistent with the diagnosis
  – Conflicting documentation
    • Insufficiency vs. failure
  – Lack of supporting clinical exam findings
Clinical Validation Example #5: Acute Kidney Injury

Patient is an 89-year-old with pertinent history of stroke, 4-vessel CABG that presents with influenza and elevated CR.


MD note: Acute kidney injury: Patient's baseline creatinine is 1.5 and today creatinine is 1.85.

D/C summary: Acute kidney injury: Patient's baseline creatinine is 1.5 and creatinine on admission was 1.85.
Clinical Validation Example #5: Acute Kidney Injury

The patient was admitted with influenza. Noted to have CKD 3. H&P reports baseline CR as 1.2–1.4, later notes report baseline as 1.5. CR on admission was 1.61 with peak of 1.85. AKI was documented in the chart. This diagnosis may be challenged by an external reviewer based on clinical validation depending on stated baseline. Can you clarify if the patient had:

- Aki on CKD (please clarify baseline and criteria)
- CKD without AKI
- Other
- Clinically indeterminable – This option will close the query with no clarification of the current documentation, thereby limiting accurate representation of the patient’s care delivery and complexity
AKI

• KDIGO
  – Widely accepted as official criteria
  – Rise in CR of 0.3 over 48 hours (documented)
  – Change in CR of 1.5x baseline presumed within 7 days
    • Increase or decrease
    • If baseline unknown, may use lowest value recorded during the stay
  – Decreased urine output < 0.5 ml/kg/hr x 6 hours

Tip: A decrease of 0.3 in CR over 48 hours does not meet the definition of AKI.
AKI

• Documentation issues
  – Definitions are not met when documenting AKI
  – Missing documentation of CKD and stage when present
  – Lack of uniform verbiage
    • Acute-on-chronic kidney disease does not equal AKI and CKD
    • Renal insufficiency does not equal AKI
    • Pre-renal azotemia does not equal AKI
  – Failure to document when ATN is present
    • Lack of rationale and underlying cause (prolonged hypotension, toxin, casts)
Outlining a Process/Summary
Outlining a Process: Key Elements

- Identify key players
  - Collaborate
  - Be transparent
  - Include compliance
- Determine answers to controversial issues at the start
  - Tread lightly with medical staff and be respectful
- Start simple
  - Limited scope/diagnoses
  - Limited population
  - Limited staff
- Use your experiences to formulate a process
- Decide on definitions and indicators
  - Keep it consistent with medical staff practice
  - Balance payer patterns with caution (patients come first!)
Summary

• The chart should tell one consistent story
  – Do all notes, tests, treatments, and studies fit the diagnosis?
  – Are the history and examination consistent?
  – Are there conflicting diagnoses?

• Are the common factors and diagnostic criteria present to support the documented diagnosis?
  – Partially met?
  – Not met at all?

• Approach
  – Query? Verbal or written?
  – Watchful waiting?
1. **Clinical Validation Process of Review/Revalidation (DVd)**

   a. **Clinical Validation Identified by Clinical Documentation Specialist (CDS):**
      i. Engage with physician for diagnostic support.
      ii. Ensure documentation reflects the patient's clinical condition.
      iii. Perform a detailed review of the medical record.
      iv. Confirm the diagnosis is appropriate and clearly documented.
      v. Document findings and recommendations in the medical record.

2. **Clinical Validation Identified by Coding Auditor, OS or Physician Reviewer:**

   a. Identify conditions for which validation is needed.
      i. Review the medical record for accuracy.
      ii. Confirm the diagnosis is appropriate and clearly documented.
      iii. Document findings and recommendations in the medical record.
      iv. Provide feedback to the provider for clarification.

   b. **Coding Auditors**
      i. Engage with provider or physician for clarification.
      ii. Ensure documentation reflects the patient's clinical condition.
      iii. Document findings and recommendations in the medical record.

   c. **Physician Reviewer**
      i. Review the medical record for accuracy.
      ii. Confirm the diagnosis is appropriate and clearly documented.
      iii. Document findings and recommendations in the medical record.
      iv. Provide feedback to the provider for clarification.

   d. **ADH Accountant**
      i. Review the medical record for accuracy.
      ii. Confirm the diagnosis is appropriate and clearly documented.
      iii. Document findings and recommendations in the medical record.
      iv. Provide feedback to the provider for clarification.

   e. **Report findings to Manager for tracking purposes.**
Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section of the program guide.
I. PURPOSE: To establish guidelines for Clinical Validation reviews for Vidant Health.

II. POLICY: The overall goal of this policy is to help standardize and define the process of validation of clinical content and its direct support of coded data for the specific clinical scenario and/or encounter.

From the 2018 Physician Query Policy for Vidant Health

Clinical Validity — The CDI Specialists will be consulted to assist with drafting the query to the provider when:

- A diagnosis is present on the chart without supportive clinical indicators.
- The documentation outlines supporting clinical indicators present during the encounter without a definitive relationship to an underlying diagnosis in the chart.
- The documentation includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure.

Both the Coder and CDI Specialist will add their names to the query signature line. If further assistance is needed, a physician advisor will be consulted. If no CDI Specialist is assigned to the case, the coder can work with the CDS of their choice.

CMS defines Clinical Validity as a clinical review of the case to see whether or not the patient truly possesses the condition as documented in the medical record.

Per the new FY 2017 ICD-10-CM Official Coding Guideline A.19. and reitered in the AHA Coding Clinic (Fourth Quarter 2016, pp. 147-149), clinical validation is a separate function from the coding process. The codes assigned by the coding professional are based on the documentation by the physician, not on a particular clinical definition or criteria. This guidance emphasizes the need for facilities to have a process in place to validate the patient’s clinical conditions prior to completing the coding process.

The goal of clinical validation is to ensure that the health record is not only coded accurately, but also accurately reflects the clinical scenario within the health record, which requires collaboration among providers, CDI professionals, and coding professionals. The importance of accurately capturing the clinical scenario through the available code set continues to grow as CMS revises its payment methodologies, tying quality of care to reimbursement. Clinical validation is also a frequent reason for payment denials. (AHIMA, 2016)

The Vidant Health (VH) Office of Audit and Compliance (OAC) collaborated with VH Health Information Management (HIM) leadership and concurs with the clinical validation review process established in this policy/procedure.

Clinical Validation Process of Review (Concurrent - CDI)

1. Clinical Validation Need Identified by Clinical Documentation Specialist (CDS).
   a. CDS will:
      i. Reference documentation tips for our adopted clinical standards for diagnosis.
      ii. Engage with Physician Advisor (PA) for expert support on clinical standards for diagnosis as needed.
   b. Clinical Data not supportive of condition.
      i. CDS will utilize these steps:
         1. Engage in discussion with documenting provider to explore clinical support and encourage inclusion of indicators into the provider’s documentation for the episode of care.
         2. Follow-up with query if clarification not added to provider documentation after discussion.
            a. Clinical Validation Query Template
               i. Open Ended Response format with no diagnosis selection options in order to generate greater detail in clinical explanation.
   c. Determination to close CV process.
      i. If response clarifies the support needed, apply code for Working DRG described in the documentation, CV process is complete and noted in detail in the CDI tracking tool for reference by Coding.
      ii. If response does not clarify the support needed, but provider still upholds condition as documented, refer to your manager for review. Note, in detail, in the CDI tracking tool for reference by Coding.
      iii. If provider response nullifies the condition as documented do not report code to determine Working DRG, CV process is complete and noted in detail in the CDI tracking tool for reference by Coding.
         1. CDS will monitor for potential copy and paste of clarified condition and assist in correcting with provider.
   d. Add Account Note in Epic for Clinical Validation Review to summarize CV activity for case and for future reference.
      i. In Epic open the HAR, click Account Note in left side menu.
      ii. In New Note field add pertinent information related to activity.
      iii. Change Note Type to Clinical Validation Review and click Add.
   e. Report HAR to Manager for tracking purposes.
Clinical Validation Process of Review (Post Discharge - Coding)

1. Clinical Validation Need Identified by Coder
   a. Coder will:
      i. Review CDI findings in CDI tracking tool for possible support or prior attempt at clarification.
      ii. Reference documentation tips for our adopted clinical standards for diagnosis.
      iii. Engage with assigned Coding Auditor for expert support.
      iv. Collaborate with CDI for clinical insight and/or for possible query as needed.
   b. Coding Auditor will:
      i. Engage with Physician Advisor for expert support on clinical standards for diagnosis as needed beyond discussion with Coder/CDS.

2. Clinical Validation Need Identified/Verified by Coding Auditor, CDS, or Physician Advisor
   a. Clinical Data not supportive of condition.
      i. Auditor, CDS, or PA will follow these steps:
         1. Possibly engage in discussion with documenting provider to explore clinical support. Follow-up with query after discussion.
         2. Consider submission of CV Query to validate.
            a. Develop a recommended query for Coder to send to provider.
               i. Clinical Validation Query Template
                  1. Open Ended Response format with no diagnosis selection options in order to generate greater detail in clinical explanation.
      b. Determination to close CV process:
         i. If response clarifies the support needed, report codes as described in the documentation, CV process is complete.
         ii. If response does not clarify the support needed, but provider upholds condition as documented, refer to your manager for review.
         iii. If provider response nullifies the condition as documented, do not report code, CV process is complete.
   c. Auditor, CDS or PA, will add Account Note in Epic for Clinical Validation Review to summarize CV activity for case and for future reference.
      i. In Epic open the HAR, click Account Note in left side menu.
      ii. In New Note field add pertinent information related to activity.
      iii. Change Note Type to Clinical Validation Review and click Add.
   d. Report HAR to Manager for tracking purposes.

Provider Engagement for Denial Review
If a denial is received related to clinical validation, the documenting provider that was previously engaged in a discussion for the denied case will be notified and possibly requested to review and submit supporting documentation to aid in the decision making process for filing an appeal. After internal review, the Physician Advisor team will be asked to initiate the conversation with the documenting provider. The Denial Auditor will coordinate collection of any supporting material from the documenting provider for review prior to appeal.

Tracking of CVR Cases (Management):
1. Staff are to notify Managers of any cases that require Clinical Validation Review as outline in the process above.
2. Access CVR Tracker on Shared Drive
3. Input required data for tracking of activity on CVR Worksheet.
4. If Denials received, reference tracking tool for reconciliation, add denial detail to spreadsheet on Denial Activity Worksheet whether previously reviewed or not.
5. Save.

References:
AHIMA. “Clinical Validation: the Next Level of CDI.” December 2016.