

Preventing Denials Through Clinical Validation

By Amanda Suttles, BSN, RN, CCDS, Angela Brisson, BSN, RN, CCDS, and Mary H. Stanfill, MBI, RHIA, CCS, CCS-P, FAHIMA

Clinical validation is the process of reviewing documented diagnoses to determine if clinical criteria generally accepted by the medical community are present to support each diagnosis. It ensures there is sufficient documented clinical evidence to support coding and reporting diagnoses. In most situations, clinical documentation integrity (CDI) professionals are charged with the task of making these determinations and querying physicians for clarification when necessary.[1]

Clinical validation may result in an increase, a decrease, or no change in revenue for a particular case. Regardless, it is important to review for clinical validity to ensure complete and accurate representation of a patient's clinical condition in the health record. It is appropriate to query a physician for clarification, regardless of the financial outcome. *AHA Coding Clinic for ICD-10-CM/PCS* offers the following advice on clinical validation: "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 should also work with their medical staff to ensure conditions are appropriately diagnosed and documented." [2]

Using Second-Level Clinical Review

Though CDI specialists and physicians have varying experience and comfort levels with the clinical validation process, clinical validation is important. There is significant financial and compliance risk in charting diagnoses that cannot be independently validated. High-risk inpatient cases include, for example, cases with a single comorbid condition (CC) or major comorbid condition (MCC) and cases with short lengths of stay and highly weighted diagnosis-related groups (DRGs). An example of the latter is a patient with a one-day length of stay and a diagnosis of sepsis due to urinary tract infection who was discharged to their home. It is becoming increasingly common for these cases to be targeted and denied by third-party payers. Such costly and time-consuming denials can be avoided by incorporating robust clinical validation in the inpatient CDI process.

Clinical validation can be incorporated in the regular inpatient concurrent review process. This is achieved by issuing concurrent clinical validation queries, when warranted, at any point during the inpatient stay. However, to ensure that all reported diagnoses are supported by documented clinical evidence, a second-level clinical review process is recommended.

Second-level clinical review is performed after final coding, before an inpatient claim is submitted. Clinical review at this point is performed on targeted inpatient cases to ensure there is sufficient clinical evidence for the diagnoses that impact DRG assignment. Second-level clinical review should be performed on inpatient cases that meet defined criteria indicative of high risk. An example of inpatient cases that should be targeted for second-level clinical review are cases with a single CC/MCC and high reimbursement principal diagnosis (e.g., sepsis, non-ST-elevation myocardial infarction, congestive heart failure exacerbation, and respiratory

failure) but with a short length of stay. Based on this review, action may need to be taken before submitting the claim. Actions might include an additional physician query and/or revising the final code assignment.

Case Scenario #1

One of the outcomes of clinical validation is reduced clinical denials. Case Scenario #1 is an example where a clinical validation query may have prevented a denial. In this case, acute postoperative respiratory failure was a single MCC driving the DRG, but clinical evidence for this diagnosis was not explicit and documentation of a normal postoperative course seemed to contradict the diagnosis of a postoperative condition. Clinical validation was not performed on this case, however, and the diagnosis of acute postoperative respiratory failure was coded and submitted on the claim without obtaining any further clarification. The third-party payer denied payment on the claim based on insufficient clinical criteria to support the diagnosis of acute postoperative respiratory failure. The hospital determined they did not have sufficient clinical documentation to appeal the denial after discussing the case with the attending physician.

Case Documentation

Consider the following documentation excerpt for Case Scenario #1:

“Ms. Sue Smith, a 72-year-old morbidly obese patient who has a medical history of COPD, obstructive sleep apnea on home bipap, HTN, hyperlipidemia, and diabetes type II, was admitted on 5/18 for a planned aortic valve placement. She underwent the procedure and was admitted to the critical care unit in stable condition. She was extubated 18 hours after surgery. Her postoperative course went as expected and she was discharged on 5/23 being transferred to an inpatient rehab facility.”

The physician documented “acute postoperative respiratory failure” as a secondary diagnosis in the discharge summary. If a second level clinical review had been performed for this case before submitting the claim, the attending physician could have responded to a query and either acknowledge that acute postoperative respiratory failure was not a valid diagnosis for this encounter or confirmed it is appropriate and added the documentation to support that. Assuming the physician acknowledged the diagnosis was not appropriate, the diagnosis would not have been submitted, avoiding the denial and the re-work that ensued.

Sample Clinical Validation Query

The following is a sample clinical validation query for this case:

Dear Dr. Jones,

Ms. Sue Smith underwent an aortic valve replacement and was admitted to the critical care unit in stable condition. She was subsequently extubated 18 hours after surgery. Additional documentation notes her postoperative course went as expected. The discharge summary notes acute postoperative respiratory failure. Is acute postoperative respiratory failure an accurate diagnosis for this encounter?

- No, acute postoperative respiratory failure is not a valid diagnosis during this admission.

- Yes, acute postoperative respiratory failure is present/active during this admission (please include additional clinical indicators): _____
- Other, please specify: _____
- Unable to determine

Case Scenario #2

Another outcome of clinical validation is to ensure that unavoidable clinical denials can be defended and overturned. Case Scenario #2 illustrates how a clinical validation query can help strengthen clinical evidence for a reported diagnosis.

Case Documentation

Consider the following documentation excerpt for Case Scenario #2:

“Ms. Betty Brown, 75 years old, was admitted with Systolic CHF Exacerbation. Patient noted with history of hypertension and breast cancer. On admit patient had a creatinine of 1.3 with an increase to 1.5 on hospital day 2.”

The physician documented “acute kidney injury” as a secondary diagnosis in the discharge summary.

Sample Clinical Validation Query

The following is a sample clinical validation query for this case:

Dear Dr. Jones,

Ms. Betty Brown, a 75-year-old, was admitted with Systolic CHF Exacerbation. Patient noted with history of hypertension and breast cancer. On admit patient had a creatinine of 1.3 with an increase to 1.5 on hospital day 2. On the discharge summary, the diagnosis of Acute Kidney Injury was documented.

For the diagnosis of Acute Kidney Injury, KDIGO notes the patient has to have an increase greater or equal to 0.3mg/dl from a measured baseline within 48 hours or less. Is Acute Kidney Injury an accurate diagnosis for this encounter?

- No, Acute Kidney Injury is not a valid diagnosis during this admission
- Yes, Acute Kidney Injury is present/active during this admission (please include additional indicators): _____
- Other (please specify) _____
- Unable to determine

The physician response was:

“Yes, Acute Kidney Injury is present/active during this admission due to the patient being seen in my office the day before admission with a creatinine of 1.1. Additionally, patient has a known baseline creatinine of 0.9. The use of Lasix on this admission contributed to the diagnosis of AKI.”

In Case Scenario #2, assigning the code for acute kidney injury (AKI) provided a lone CC that determined the DRG. Therefore, a second-level clinical review was performed and the case was held to obtain the physician’s response on the clinical validation query. The physician’s

response provided additional information that supported coding and reporting AKI. Though this case was subsequently denied by the payer, the hospital used the validation query in the appeal letter and the denial was overturned.

Notably, the physician query for Case Scenario #2 references clinical guidelines for AKI. The Kidney Disease Improving Global Outcomes (KDIGO), defined by the National Kidney Foundation, are the diagnostic criteria currently used for AKI.[3] Working with medical staff representatives to establish or adopt approved clinical guidelines for high-risk diagnoses (such as acute respiratory failure, sepsis, acute tubular necrosis, and encephalopathy) provides tools to aid the clinical validation process and to defend reported diagnoses.

Clinical Validation Can Help Avoid Denials

The mere act of reviewing a denial is time-consuming and costly, and many times it does not result in a favorable outcome. A robust clinical validation process can help avoid denials. In addition, it can help anticipate and more effectively over-turn unavoidable denials. Effective clinical validation requires strong reciprocal working relationships with physicians as well as between the inpatient coding and CDI teams. Clinically validating high-risk diagnoses prior to submitting claims can significantly improve a hospital's denial rate.

Notes:

1. Denton, Debra Beisel et al. "Clinical Validation: The Next Level of CDI" *Journal of AHIMA* 87, no.7 (July 2016): extended web version. <https://bok.ahima.org/doc?oid=301756>
2. American Hospital Association. "Omitting ICD-10 Codes" *AHA Coding Clinic for ICD-10-CM/PCS* (Fourth Quarter 2017).
3. Kidney Disease: Improving Global Outcomes. "Acute Kidney Injury." <https://kdigo.org/guidelines/acute-kidney-injury/>

Amanda Suttles (amanda.suttles@uasolutions.com) is supervisor of CDI and UR

Angela Brisson (angela.brisson@uasolutions.com) is supervisor of CDI and UR

Mary H. Stanfill (mstanfill@uasolutions.com) is vice president of consulting services at United Audit Systems, Inc.