A Clinical Bridge between the HealthCare Provider and Coding

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Objectives

1. Understand the difference between Clinical and DRG Validation

2. Understand the importance of consistent and accurate documentation

3. Know the Clinical Documentation Specialist and Coder are one awesome Team

Middlesex Health's CDI-Coding Team

- 4 Clinical Documentation Specialists
- 4 Certified Coding Specialist
- Report to HIM Director and Coding Manager
- Work as 1 Team with Coding Department
- Concurrently Review Medicare (FFS/Managed) & Medicaid
- Retrospectively support and query for Coding on all payors
- 229 Staffed Beds

CDI, The Clinical Bridge

- A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. (FY 2019 Coding Guidelines)

- At Middlesex, the CDI Staff helps fulfill this requirement for collaboration.

- It is the CDI staffs responsibility to communicate with the provider to impart education as well as obtain clarification if any ambiguity exists in the medical record.

Role of Coded Data

Then	Now
• Assignment of MS-DRGs and APR-DRGS	• Quality measure performance validation
• Statistical Reporting	• Validates Medical Necessity
• DRG Validation	• Clinical Validation

Coding Clinic 4th Quarter 2016

Halleluiah !!!!!

- Coding must be based on provider documentation. Diagnosing a condition is solely the responsibility of the legal provider

WHAT ?????

- "Clinical validation is an additional process that may be performed along with DRG validation."
- "Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record."

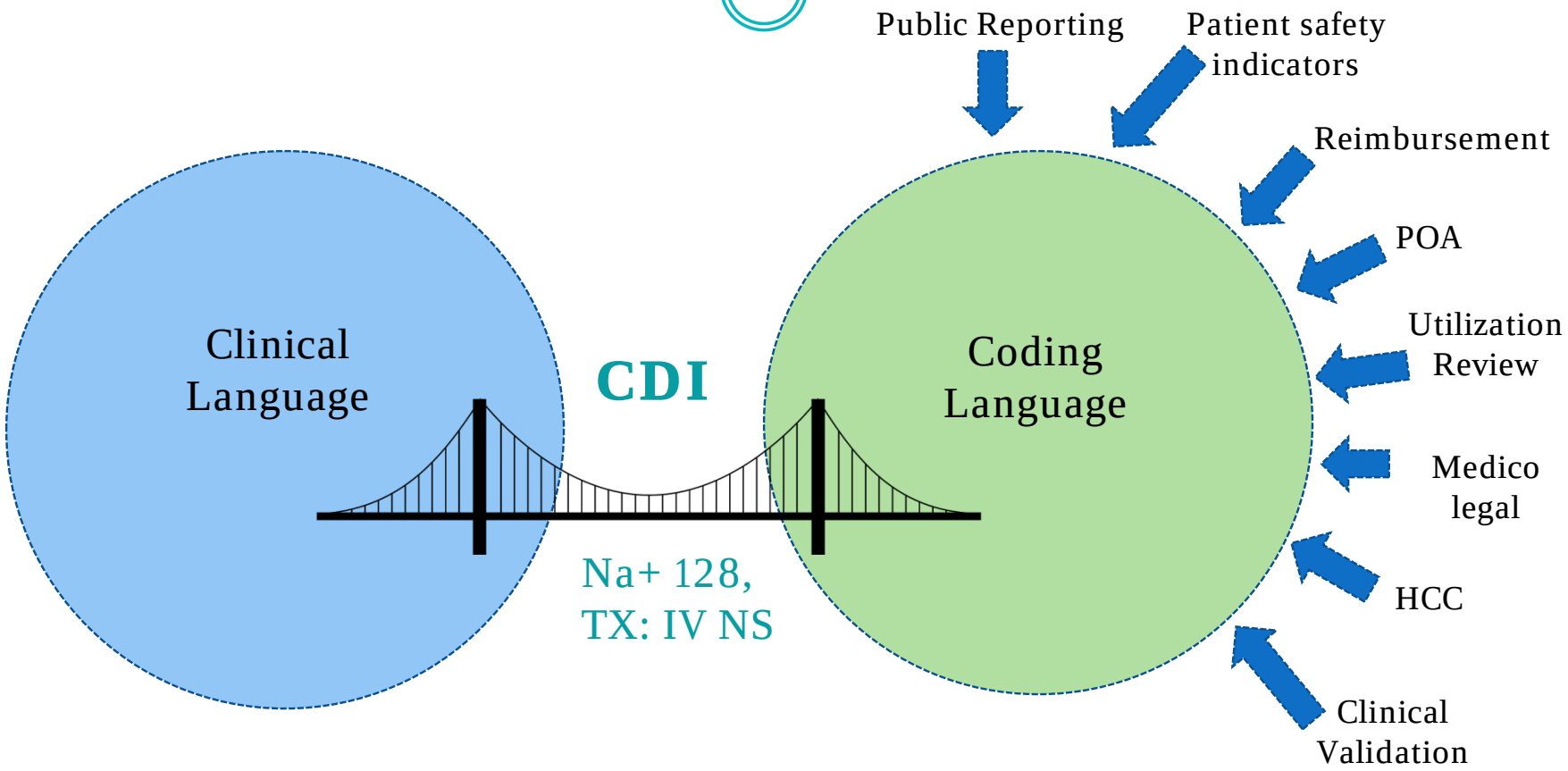
Coding Clinic 4th Quarter 2016

- "While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria."
- "In other words, 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."
- "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."

Mission of Clinical Documentation Improvement at Middlesex Health

Collaborate with healthcare providers to ensure complete documentation of the findings, diagnosis, and treatment in the patient health record to reflect the severity of illness, risk of mortality and capture accurate codes and statistical data for research, reimbursement, and clinical measures.

CDI the Clinical Bridge



Provider's Clinical Assessment

Electronic Medical Record

CDI/Coding Conundrum

- POA Status Clarity
- Etiology Specified
- Supporting documentation present
- Consistent documentation (attending, resident, consultant)
- Conflicting Documentation (Sepsis, SIRS, Oh My)
- Linking documentation between conditions/diagnosis

High Quality Documentation Must Haves

- Legible
- Complete
- Timely
- Reliable
- Consistent
- Clear

DRG Validation

"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 and as appropriate, reviewing the records DRG accuracy" (ACDIS 2015)

Accurate Principal Diagnosis assignment is vital because:

1. The PDX establishes the MS-DRG & APR-DRG

2. The PDX often influences the medical necessity of patient status determinations

CMS Contractors and other Payment Accuracy Agencies make MS-DRG adjustments because the reported principal diagnosis is "not substantiated." They have also excluded secondary diagnoses that affect MS-DRG assignment.

Reportable Conditions

Defined by the ***Uniform Hospital Discharge Data Set*** as conditions that affect patient care in terms of requiring:

- Clinical Evaluation; or
- Therapeutic Treatment; or
- Diagnostic Procedures; or
- Extended Length of Hospital Stay; or
- Increased Nursing Care and/or Monitoring

Where is the MEAT?

Ensure “MEAT” met:

- **M** = Monitoring
- **E** = Evaluation
- **A** = Assess/Address
- **T** = Treat

- Only 1 element of **MEAT** is required to support a diagnosis – not all 4
- 2 elements are better
- 3 elements is best

MEAT can be found in most sections of the patient’s current electronic medical record

MEAT

Reportable Conditions

Monitor

- ✓ Signs, symptoms, disease progression

Evaluate

- ✓ Review of tests results, medication effectiveness, response to treatment (“stable, “improving,” “exacerbation,” worsening,” “counseling”)

Assess/address

- ✓ Ordering tests, discussion, review outside records, counseling

Treatment

- ✓ Referral, medication(s), procedure(s), sitters, other modalities

CDIS Scope of Service

To clarify provider documentation whenever there is conflicting, ambiguous, or incomplete information in the medical record regarding any significant **reportable condition or procedure**.

Attending documents: Acute Demand Ischemia

Cardiologist documents: NSTEMI

CDI RN

Clinical Validation

- The Clinical Validation review process must confirm that the provider's clinical criteria can be easily linked to the corresponding diagnosis.

- A thorough clinical validation review includes searching the health record for contradictory clinical indicators that might make a diagnosis vulnerable to clinical validation denial.

Vulnerable to Clinical Validation Denials

Diagnoses

Acute Respiratory Failure

Acute Kidney Injury

Metabolic Encephalopathy

Malnutrition

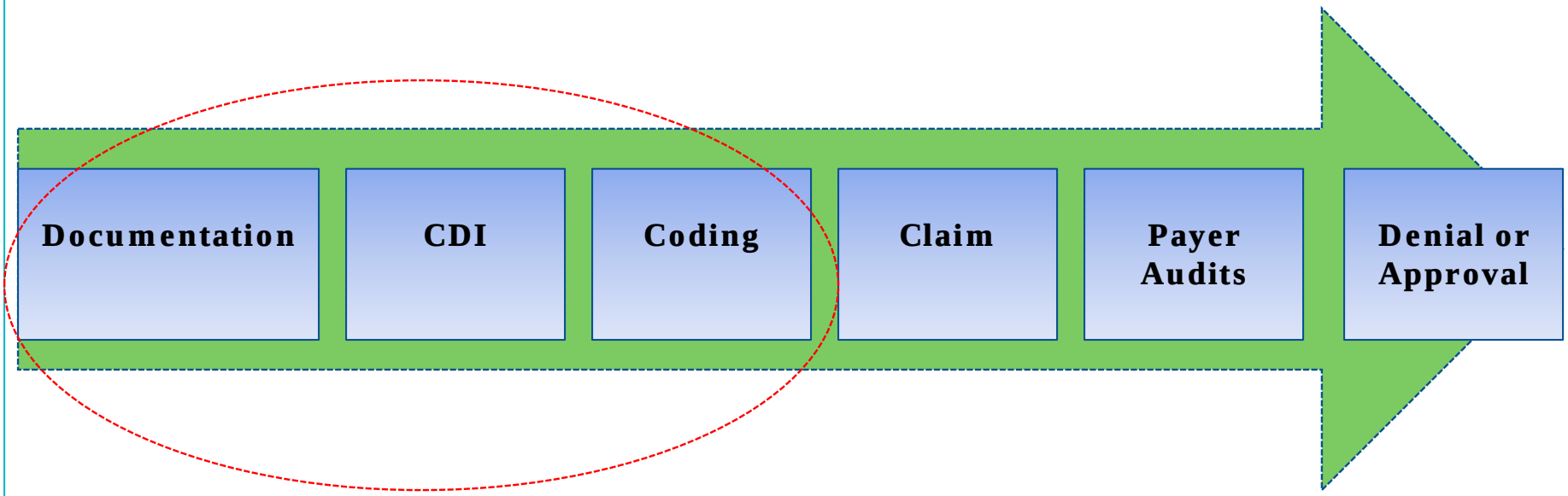
Sepsis

Documentation

Should be supportive by multiple members of health care team.

Should not cast doubt on the validity of the documented diagnosis

Substantiate Clinical Criteria Before Claim Submission



Goal of Clarification

To obtain supporting clinical data or document clinical decision-making by the provider to support a diagnosis

Clinical Validation Queries

- A query written to confirm the presence of a diagnosis is not sufficient for validation
- The query should provide an “after study” option to rule out a diagnosis
- It is ideal for a clinical validation response to be carried through discharge

Benefit of Verbal Clinical Validation Queries

- Clinical Validation may be viewed by providers as if their diagnosis is being challenged
- The CDI Staff can offer education on the importance of including clinical indicators to denial proof the medical record
- It affords real-time education using an example that directly impacts the provider

Verbal Clinical Validation Queries

- Remember, the CDI Staff should document the verbal query per the organization's established policies

- The provider needs to document their response in the medical record

Good Clinical Documentation Practice

- Evolve diagnoses
- Resolve diagnoses
- Remove diagnoses
- Recap diagnoses in discharge summary

H&P: Probable Aspiration Pneumonia with Sepsis

PN: Sepsis secondary to Aspiration Pneumonia

PN: Sepsis resolved. Continue treating Aspiration Pneumonia

D/C Summary: Admitted with Sepsis secondary to Aspiration Pneumonia.

Example #1 of Clinical Validation Queries

Clinical Indicators

- The H&P Documents “Severe Protein Calorie Malnutrition.”
- On physical exam the patient is noted to be “well developed” and “well nourished.”
- A regular diet was ordered.
- BMI 25

Example #1 of Clinical Validation Queries

1. Given the above diagnosis of “Severe Protein Calorie Malnutrition” would you please;

    - Provide the treatment and additional clinical indicators to support this diagnosis
    - Clarify if, after study, the diagnosis was ruled out
    - Document other diagnosis explaining the findings
    - Unable to clinically determine

Example #2 of Clinical Validation Queries

Clinical Indicators

- The H&P documents “COPD Exacerbation” & “Acute on Chronic Respiratory Failure.”
- The ED documents: Speaking in full sentences
- The patient is maintained on her baseline 2 L of oxygen
- Vitals: RR 18-24 Pulse Ox 89-94% 2L

Example #2 of Clinical Validation Queries

1. Given the above diagnosis of “Acute on Chronic Respiratory Failure” would you please clarify the documentation of Acute Respiratory Failure;

   - Provide the treatment and additional clinical indicators to support the diagnosis of Acute Respiratory Failure
   - Acute Respiratory Failure was ruled out after study. Chronic Respiratory Failure treated with baseline 2L oxygen
   - Document other diagnosis explaining the findings
   - Unable to clinically determine

Consistent and Accurate Documentation Ensures

- Accurate public reporting of mortality scores
- Exceed national quality benchmarks based on severity of illness
- Appropriate reimbursement for each inpatient encounter based on severity of illness
- Avoids retrospective audits “money recovery” and penalties
- Ensures regulatory compliance

Remember:

A payer may use a particular clinical definition or set of criteria when establishing a diagnosis for the purpose of reimbursement.

But a diagnosis is established based on the providers documentation, not on a particular clinical definition or criteria.

So if your providers document their diagnoses and include their clinical rationale that is all we can ask.

The world outside of your health care system will always find new moving targets but good, quality, safe care won't change.

Thank You. Questions?

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References

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