Using Clinical Validation to Prevent Denials

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SC ACDIS Conference

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Learning Objectives

- Define the importance of clinical validation in the CDI arena
- Identify key definitions and practice guidelines that relate to clinical validation
- Define diagnoses that commonly require clinical validation
- Suggested ongoing educational recommendations for Coding and CDI Professionals

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Introduction to Clinical Validation

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What is Clinical Validation?

Record Review

- Generally accepted diagnostic criteria

Process of Determination

- Diagnosis clinically present
- Appropriate treatment

Research

- Other supporting data

H&P
79 y/o female admitted w/sepsis, PNA, dehydration, COPD
V/S- T 102, RR 38, HR 98, BP 126/82
CBC & chemistry unremarkable
AOx3, no distress, cap refill WNL, no edema
CXR + infiltrates
SOB, productive cough w/green sputum
Fortaz 500mg IV Q8hrs, Cefepime 1gm Q12hrs
IVF – NS @125cc/hr
Cont home nebs

Centers for Medicare and Medicaid Services, 2013.

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Concept or Process? BOTH!

- Provider Documentation
- Coding
- Claims Submission
- Payers
- Regulatory Compliance
- Sanctions and Legal Consequences

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What are Clinical Indicators?

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Agencies & Laws

- Centers for Medicare and Medicaid Services (CMS)
  - www.cms.gov
- Recovery Audit Contractor (RAC)
  - https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs
- The False Claims Act
  - American federal law that imposes liability on persons and companies who defraud governmental programs. It is the federal Government's primary litigation tool in combating fraud against the Government.
- Fraud Enforcement and Recovery Act
  - Submitting for payment or reimbursement on a claim known to be false or fraudulent

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Clinical Validation Purpose

- Enhance clinical documentation improvement efforts
- Address instances where the clinical information/picture does not appear to support a documented condition or procedure
- Address varying clinical criteria that payers are applying to inpatient claims
- Mitigate/prevent inpatient clinical denials

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DRG vs. Clinical Validation

DRG

- Record review to ensure *coding and sequencing are supported* by physician documentation
- Utilizes coding conventions in the ICD-IO -CM as well as the Uniform Hospital Discharge Data Set (UHDDS) to compare code assignment

Clinical

- Clinical review of a record to ensure the *documented diagnoses are supported by subjective and objective data* – the facts
  - Severity of illness/intensity of service *(met inpatient criteria)*
- Queries for SOI/ROM, HAC's, specificity of disease processes

Clinical Validation and the Role of the CDI Professional, 2017.

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What is our Responsibility?

- Help facilitate a clean and accurate reflection of the documentation and treatment of each patient
- Proactively work toward preventing questionable diagnoses and denials, and develop a plan
  - Education, Meetings, Discussions, Committees, etc.
- Seek Clarification
  - The updated AHIMA 2016 Query Practice Brief states that when there is a diagnosis without supporting clinical indicators, a query should be sent to the provider
- Provide a chart that is ready for coding

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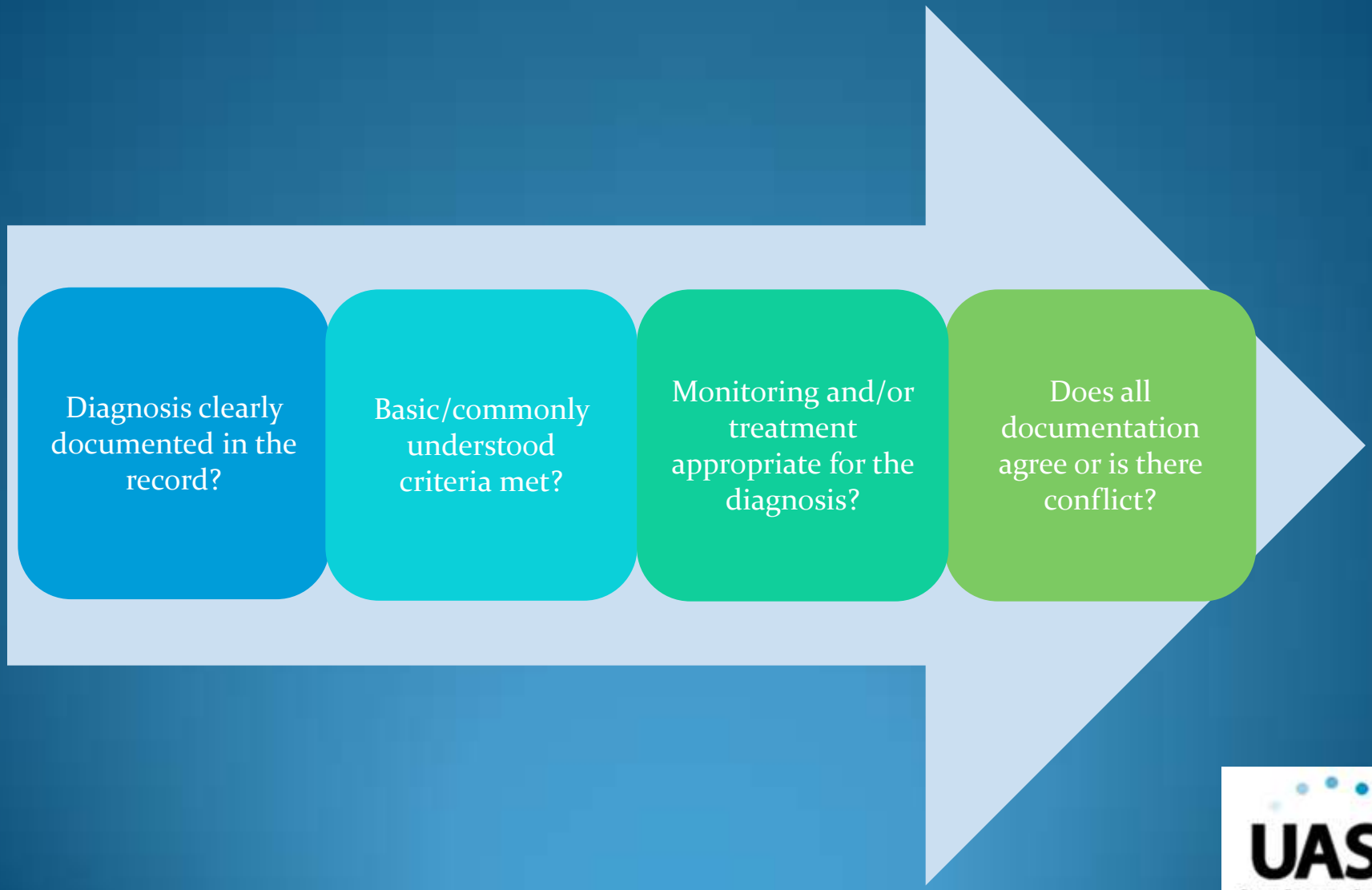
To Query or Not to Query?



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Guidelines for Achieving a Compliant Query Practice (2016)

- The generation of a query should be considered when the health record documentation:
  - Is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
  - Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
  - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
  - Provides a diagnosis without underlying clinical validation
  - Is unclear for present on admission assignment

AHIMA Practice Brief. "Guidelines for Achieving a Compliant Query Practice (2016 Update)"

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MEAT Criteria

M

Monitor

- Signs/Symptoms
- Disease progression or regression

E

Evaluate

- Test results
- Response to medication and/or treatment

A

Assess

- Discussions, Counseling
- Ordering tests

T

Treat

- Medication
- Referral
- Therapy, planned surgical procedures, etc

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Targeted Diagnoses

Sepsis
AKI
UTI
Acute MI
Acute Resp Failure
Pneumonia
Severe Malnutrition
Encephalopathy

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Sepsis

SIRS Criteria

- Temp >38.3C or <36
- Heart Rate >90 bpm
- Respiratory Rate >20bpm
- WBC > 12k or < 4k or >10% bands

Denial Alert:

When other conditions are present (respiratory, localized infections, cardiac arrhythmias, medications, other disease processes), third party payers or auditors such as RAC will eliminate these criteria.

Report on Medicare Compliance Volume 26, Number 18, May 22, 2017 – Payer denials hit sepsis amid conflicting clinical protocols; diagnosis is doubted.

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Sepsis Validation

Unsubstantiated Findings	Substantiated Findings
No distress	Toxic appearing
Alert and oriented	Encephalopathy, AMS/GCS results
Multisystem organ failure	List failing organ systems and link to sepsis
Hypotension	Vasopressors required to maintain MAP <70
Absent bowel sounds	Ileus related to sepsis
Abnormal lactic acid	Serial lactic acid levels to show more than 1 abnormal result

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Sepsis Validation (cont'd)

Unsubstantiated Findings	Substantiated Findings
Decreased/low platelets	Thrombocytopenia <100k
Elevated total bilirubin	Hyperbilirubinemia >4mg/dl
Decreased urine output	Acute oliguria >2hrs despite IVF resuscitation OR Creatinine >0.5mg/dl
Elevated glucose	Hyperglycemia ≥ 140 (in persons without Diabetes)
Elevated procalcitonin	Procalcitonin > 2 SD above normal
Elevated CRP	CRP > 2 SD above normal

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Sepsis Validation (cont'd)

Unsubstantiated Findings	Substantiated Findings
Coagulopathy	Hypercoagulopathy with INR > 1.5, not explained by anticoagulant therapy
No documented circulatory issues	Decreased capillary refill or mottling
No documentation of fluid accumulation	Significant edema (list sites) or positive fluid balance (>20ml/kg over 24 hours)

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Acute Respiratory Failure

Acute Respiratory Failure Validation

Unsubstantiated Findings	**Substantiating Findings**
Respiratory WNL or RRR (regular rate & rhythm)	Short of breath (SOB), Dyspnea on exertion (DOE), work of breathing,
Lungs CTA	Wheezing, stridor, rales/rhonchi,
Able to speak in complete sentences	Answers in monosyllables, unable to speak in complete sentences
No evidence of accessory muscle use	Accessory muscle use, retractions, nasal flaring, grunting
No skin discoloration	Cyanosis, mottling
Intubated for airway protection, or due to no gag response	Intubated for respiratory distress

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Acute Respiratory Failure Validation

Hypercapnic

- pCO_2 increase by 10 mmHg from baseline, or
- ABG: pCO_2 >50 mmHg with pH <7.35
- VBG: pH ≤ 7.33 and pCO_2 >53-58
- Capnography: End-tidal CO_2 level ($ETCO_2$) >45mmHg
- With known pCO_2baseline, expect a 10-15 mmHg increase

Hypoxemic

- pO_2 <60 mmHg or SpO_2 <91 on room air
- P/F ratio (pO_2/FiO_2) <300
- pO_2 decrease 10 mmHg from baseline if known

****Confirmation of diagnosis by a Pulmonologist is preferred.*

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Acute Kidney Failure

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Acute Kidney Injury

National Kidney Foundation (KDIGO) defines AKI as any of the following:

- Increase in creatinine level to ≥1.5x baseline (historical or measured), which is known or presumed to have occurred within the prior 7 days; or
- Increase in creatinine ≥ 0.3mg/dl from a measured baseline within 48 hours or less; or
- Urine output <0.5 ml/kg/hr for 6 hours (based on weight)

Kidney Disease Improving Global Outcomes (KDIGO) clinical practice guidelines, Journal of International Society of Nephrology guidelines

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Acute Kidney Injury

When baseline creatinine is unknown, KDIGO advises:

"The lowest SCr (Creatinine level) obtained during a hospitalization is usually equal to or greater than the baseline."

Kidney Disease Improving Global Outcomes (KDIGO) clinical practice guidelines, Journal of International Society of Nephrology guidelines

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Acute Kidney Injury Validation

Examples of 1.5 times the baseline:

- Creatinine on admission is 2.2 and decreases to 1.2 after IV fluids
- Creatinine of 2.6 on admit with decrease to 1.7 after IV fluids

Example of ≥ 0.3 criteria within 48 hours

- Creatinine of 1.3 on admission with increase to 1.7 within 48 hours following CT with contrast
- Creatinine of 1.2 on admission with increase to 2.0 after a cardiac catheterization

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Acute Kidney Injury Validation

Remember….

BUN is not considered when evaluating the validity of AKI. BUN levels can be elevated for a number of other reasons unrelated to acute kidney injury.

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Pneumonia

Diagnostic Findings

CT scan or chest X-ray shows consolidation, infiltrate, or interstitial changes.

Pneumonia

Types

- Viral
- Influenza
- Bacterial
- Aspiration
- Fungal
- Mycoplasma
- Interstitial
- Ventilator associated

Common signs/symptoms

- Fever
- Chills
- Cough
- Short of Breath
- Sputum Production
- Pleuritic Chest Pain
- Wheezing
- Rhonchi/Rales

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Pneumonia Validation

- When a patient is dehydrated it may take a day or two for a chest x-ray to show evidence of pneumonia. If documentation is not clear, a query will be necessary to clarify if the diagnosis was present on admission.
- If radiology findings are negative for pneumonia, there should be documentation of this fact, as well as evidence of other clinical indicators supporting the diagnosis of pneumonia.

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Malnutrition

Severe Malnutrition Validation

Search ROS for Substantiating Documentation
Poor Appetite
Weight loss
Malnourished
Dietary Consult with Malnutrition findings
Nutritional supplements
Grip strength
Temporal wasting
Loss of muscle mass

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Severe Malnutrition

ASPEN Criteria defines Malnutrition in adults as under-nutrition with a further breakdown of severe or non-severe.

This is based on six characteristics in the setting of three clinical contexts.

Adapted from: Consensus Statement of the Academy of Nutrition and Dietetics and A.S.P.E.N, May, 2012

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Severe Malnutrition Validation

Characteristics

- Insufficient energy intake
- Weight loss
- Loss of muscle mass
- Loss of subcutaneous fat
- Localized or generalized fluid accumulation
- Diminished functional status measured by hand grip strength device

Contexts

- Chronic illness
- Social/environmental circumstances
- Acute illness or injury

Adapted from : Consensus Statement of the Academy of Nutrition and Dietetics and A.S.P.E.N, May, 2012

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Severe Malnutrition Validation

- Low Prealbumin/Albumin – could be the result of other acute conditions
- BMI considerations
  - Obese patients can be malnourished
  - Underweight patients may not be malnourished

Adapted from : Consensus Statement of the Academy of Nutrition and Dietetics and A.S.P.E.N, May, 2012

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Encephalopathy

Encephalopathy

Acute

- Alteration in brain function due to a systemic underlying cause usually resulting in altered mental status
- Reversible
- Resolves when the underlying cause is corrected
- Structural changes do not occur

Chronic

- May be generalized or focal
- Irreversible
- Structural

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Encephalopathy Types

Acute

- Metabolic
- Toxic
- Toxic Metabolic
- Septic
- Hepatic
- Hypertensive
- Hypoxic or anoxic
- Hypoxic Ischemic

Chronic

- Due to alcohol
- Vascular Dementia
- Traumatic
- Viral
- Chronic Toxic (exposure solvents or heavy metals)
- Hereditary Metabolic Disorders

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Encephalopathy w/Dementia

An acute or sub-acute mental status alteration associated with metabolic or toxic factors, that improves or returns to baseline status when the causative factors are corrected

Improvement = probable encephalopathy

No improvement = less likely encephalopathy

Pinson, R. D., & Tang, C. L. (2018). *2018 CDI pocket guide*.

Myocardial Infarction

Myocardial Infarction

Myocardial Ischemia	
Type I	STEMI, Q Wave MI, or NSTEMI
Type II	Coronary vasospasm, anemia, hypotension
Type III	MI with no Troponins/CK-MB levels in cases of death
Type IV	MI due to PCI Stent Thrombosis
Type V	MI associated with CABG
Demand Ischemia	Ischemia resulting from a lack of sufficient oxygen supply to the heart muscle
Unstable Angina	Related to CAD and demand ischemia

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Myocardial Infarction Validation

- New Ischemic changes noted on EKG
- Symptoms of Myocardial Ischemia
- Pathological Q Waves noted
- New loss of viable myocardium or new regional wall motion abnormality on imaging
- Coronary Thrombus noted on angiography or autopsy

ESC: MI Redefined in International Guidelines, Aug 2018

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Myocardial Infarction Validation

- "Myocardial Injury" documented without identifiers of MI
- Troponin levels do not rise above 99th percentile lab reference range
- Evidence of Myocardial Injury in the context of another acute illness

ESC: MI Redefined in International Guidelines, Aug 2018

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Ongoing Education

- Be aware of targeted diagnoses
- Review denied claims
- Establish multidisciplinary committee meetings
- Develop collaborative relationships
- Utilize escalation policies
- Query as appropriate

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Thank you!

Questions?

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