



Clinical Validation Reviews for **CDI Professionals**

Cheryl Ericson, RN, MBA, CCM, CCDS and Cathy Farragher, MS, RN, CCDS, CDIP

Clinical Validation
Reviews for
CDI Professionals

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Cathy Farraher, RN, MBA, CCM, CCDS, Author

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Clinical Validation Reviews for CDI Professionals is published by HCPro, a Simplify Compliance brand.

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ISBN: 978-1-68308-840-0

Product code: CVCDI

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About the Authors

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Cheryl Ericson, RN, MS, CCDS, CDIP, is manager of clinical documentation services for DHG Healthcare, in Charleston, South Carolina. The program at DHG expands out of Medicare Severity Diagnosis-Related Group (MS-DRG) assignment into quality concerns. Its focus on clinical clarity and complete diagnosis coding prepares CDI programs for accurate outcome measures and reimbursement under all payment models. Ericson is a CDI subject matter expert for a variety of industry publications and associations and keeps regular speaking engagements. She served as a chair of the CDI Practice Guidelines Committee for ACDIS and has served on its advisory board, as well as on the Certified Clinical Documentation Specialist (CCDS) credentialing committee.

Cathy Farragher, RN, MBA, CCM, CCDS

Cathy Farragher, RN, MBA, CCM, CCDS, is a care manager at UC San Diego Health in California and previously served as a CDI specialist for Newton-Wellesley Hospital in Newton, Massachusetts. She has experience as an intensive care unit nurse and nurse consultant in case management as well as a legal nurse consultant, a utilization review nurse, and an off-shift supervisor at a level I trauma center in Boston. Farragher served as a cochair for the CDI Practice Guidelines Committee for ACDIS and as a co-leader for the Massachusetts ACDIS local chapter.

Introduction

Those reading this volume likely well know that clinical documentation improvement (CDI) programs are an effective tool for making sure that all possible diagnoses being evaluated, monitored, or treated are included in the coded data. CDI programs began as a way to ensure information about the patient's care gets captured in the medical record and matched to that coded data, according to the rules included in the International Classification of Diseases, 10th Revision, Clinical Modification and Procedure Coding Systems (ICD-10-CM/PCS) code set.

“Documentation is an important aspect of medical care,” wrote Benjamin P. Rosenbaum, MD, in a July 2014 article titled “Improving and Measuring Inpatient Documentation of Medical Care within the MS-DRG System,” published in the journal *Perspectives on Health Information Management* (www.ncbi.nlm.nih.gov/pmc/articles/PMC4142511/). “In addition to clinical communication,” Rosenbaum wrote, “documentation is coded to provide data that support quality metrics, acuity of care, billing, and accurate representation of medical conditions.”

As the CDI industry continues to grow, its mission has expanded from a coding and data focus to a more nuanced, clinical one. What began more than a decade ago as a means of translating the physician's clinical documentation into codable language now includes a range of improvement opportunities—from quality-focused measures such as present-on-admission conditions and patient safety indicators to cross-departmental support in reducing readmissions and

Introduction

surgical complications. Today, more CDI programs interrogate medical record information not only to ensure that the existing information can be captured to the highest-degree of specificity within the code set but also to ensure that the entirety of the medical record supports all the diagnoses that are coded, billed, and reimbursed.

Clinical validation represents just that expansion of scope in CDI practices. It is interrogating the record to ensure that the diagnoses captured at the conclusion of a patient's episode of care can be supported by the information contained in medical record.

The impetus for clinical validation efforts is varied. It's been more than a decade since the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Severity Diagnosis-Related Group (MS-DRG) system. The system groups diagnoses by comparative resource consumption and allows for the capture of greater specificity regarding the seriousness of the patient's condition. At the time of the MS-DRG implementation, CMS wrote in the 2008 inpatient prospective payment system final rule that there was "nothing inappropriate, unethical, or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize [MS-DRG assignment and] Medicare payments . . . [as long as the information is] supported by documentation in the medical record" (www.federalregister.gov/documents/2008/08/19/E8-17914/medicare-program-changes-to-the-hospital-inpatient-prospective-payment-systems-and-fiscal-year-2009).

The problem arises, however, when such efforts are not supported by medical record documentation or when CDI efforts push the physician to document a condition that otherwise would not exist.

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The tug of war between hospitals and payers (both private and governmental) each attempting to protect their own viability led to the emergence of a host of claims denials and auditing programs. As the country's largest healthcare payer, government agencies pay close attention to trends in documentation and coding. CMS implemented the Recovery Audit Program in 2010, and by 2016 the agency claimed such efforts saved American taxpayers more than \$214 million, according to its fiscal year 2016 report to Congress (www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2016-Medicare-FFS-Report-Congress.pdf).

Increasingly, CDI has come to represent the first line of defense against some of these efforts, and CDI validation querying has become the way of the future if CDI professionals are to maintain compliance and ensure medical record charts contain the purest form of the diagnostic data possible. While there are many reasons for the existence of the validation query, and through the course of this book we will discuss many of them, the first and foremost is to maintain accuracy in the chart, which after all should be the result of having a clinical documentation program in the first place.

What is clinical validation and why is it important right now?

Clinical validation is a process in which diagnoses already written in the chart are reviewed by a clinical documentation specialist to ensure the corresponding clinical indicators and treatment exist alongside them, thereby “validating” the diagnoses. It is the most challenging and difficult type of review, and therefore should be performed by the CDI specialist with a strong clinical and coding background and with a seasoned history in CDI.

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With the rapid expansion of CDI programs into almost every inpatient hospital setting has come the unfortunate practice of some clinicians documenting “key” diagnoses without the clinical findings and supporting evidence to justify and support them. This can happen for several reasons—they may be trying to eliminate further queries, trying to help the hospital’s bottom line and quality metrics, trying to ensure their length of stay remains in line, or they may simply not fully understand the scope CDI efforts. This puts a lot of CDI professionals in a difficult position, one that makes many very uncomfortable.

Although the term CDI is relatively new, “HIM professionals have been retrospectively querying physicians for more complete patient information for years, and professionals working in utilization review, case management, coding, and quality assurance performed documentation improvement activities before CDI specialist positions became mainstream,” writes Mary Butler in a July 2014 *Journal of AHIMA* article titled “Reinventing CDI: Organizations Relaunching And Reworking Data Integrity Efforts, And Coding Roles, With Clinical Documentation Improvement Programs” (<http://bok.ahima.org/doc?oid=107386#.W7EAcfZFyUk>). However, Butler writes, the “difference is that in the last several years, dedicated CDI specialists have focused on documenting care delivery while the patient is still in the hospital.”

With this nuanced difference in the timing of medical record reviews comes a greater opportunity to ensure the most accurate information gets captured—in real time, not in 10 days, or 20 days, or months after the patient has left the hospital. It also provides patients, physicians, and facilities with real-time opportunities for effective communication, data analysis, and overall process improvement.

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Clinical validation takes concurrent CDI efforts a step further, requiring a deeper dive into the complexities and hidden compartments of the medical record for clues of care that perhaps weren't brought forward by the attending physician. It requires CDI professionals to continue with their reviews despite having obtained necessary documentation for CC/MCC capture, beyond even expanded reviews for quality-related payment issues, such as present-on-admission and patient safety indicators.

These reviews can be daunting, but remember how daunting it was to be new to CDI in the beginning, remember how intimidating that felt. Remember, too, that everyone in CDI has opportunities to learn and grow. It's part of what makes this profession special, challenging, and exciting.

Let's get started.

Chapter 1

Core Responsibilities and Query Progression

Incorporating clinical validation queries into current clinical documentation improvement (CDI) practices isn't just a good idea to offer seasoned staff some new challenge to keep them invested in the day-to-day work, it's an important part of maintaining compliance in coded data—a core responsibility for CDI programs. So why do clinical validation concerns even exist in a world where CDI efforts' principal aim has always been to obtain the most specific and accurate data in the chart?

Answering these questions requires a return to CDI program basics.

Program Development

As stated in the introduction, clarifying information contained in the medical record historically fell to those with purview over the medical record—the health information management (HIM) and coding teams—and took place retrospectively after the patient's discharge from the hospital. Reviewing the medical record and applying rules governing code assignment and reimbursement represents elemental skills of those employed in such positions.

Once upon a time, medical records were handwritten, and physician signatures and documented details regarding patient care were often illegible. Few physicians understood, or had the time or inclination to understand, the value of that documentation, arguing that face-to-face time assessing patients and providing care was far more valuable than needless paperwork. While it's true that physicians' responsibilities lie with assessing the patient's needs, diagnosing the

Chapter 1

patient's condition, developing a treatment plan, and caring for the individual until he or she can be safely discharged from the hospital, all of this care and more—from laboratory tests to nursing and dietitian assessments—needs to be documented in the medical record to demonstrate the level of care provided.

As the American Health Information Management Association (AHIMA) states in the foreword of its 2014 *Clinical Documentation Improvement Toolkit*, “Clinical documentation is the foundation of every health record in every setting.”

When documentation is illegible, incomplete, imprecise, inconsistent, conflicting, or unreliable, the coder or CDI specialist is expected to communicate with the physician to obtain the necessary information to clarify the medical record, according to “Guidance for Clinical Documentation Improvement Specialists,” published in the *Journal of AHIMA* (May 2010), one of the earliest examples of official guidance on physician query best practices.

For those in HIM/coding, however, obtaining clarifications frequently proved difficult and time-consuming and potentially caused delays in code assignment and billing—at significant financial cost to the facility. A new emphasis on clarifying the record in real time (concurrently) emerged as new coding and documentation requirements under the Medicare Severity Diagnosis-Related Groups (MS-DRG) took effect in 2007 and CDI programs began to emerge.

The Association of Clinical Documentation Improvement Specialists (ACDIS), which emerged at the same time, supported AHIMA's assessment of the importance of medical record documentation as well as the value in clarifying information “to increase the accuracy, clarity, and specificity of provider documentation.”

ACDIS recognized the emerging role of CDI professionals and their attempt to marry the needs of the clinical information within the medical record to the needs of the HIM/coding teams. Note that the basics of International

Core Responsibilities and Query Progression

Classification of Diseases, 10th revision, Clinical Modification and Procedure Coding System (ICD-10-CM/PCS) code assignment and assignment of MS-DRGs or other DRG types fall outside the scope of this text. Other manuals offer an in-depth look at such rules and requirements. In this book, discussion focuses on code assignment guidelines only in relation to the effect on clinical validation.

Progression of responsibilities

The 2014 ACDIS Position Paper “Defining the CDI specialist’s roles and responsibilities” says that CDI specialists must be able to apply a broad clinical and coding knowledge base to discern relevant clinical conditions. They must analyze the quality of provider documentation to understand where gaps and inconsistencies might exist between the clinical information in the health record and the information contained in associated data sets. Because of this, the CDI specialist must eventually hold a general proficiency within both the clinical and coding skill sets.

Consider some of the basic responsibilities listed in the that paper for a CDI position, such as:

- Clinical knowledge
- Familiarity with healthcare payment systems and methodologies
- Awareness or working knowledge of coding concepts and guidelines
- Knowledge of healthcare regulatory compliance
- Work experience in the hospital acute care or other setting
- Strong verbal and written communication skills

Chapter 1

The position paper also outlined daily duties such as:

- Review inpatient medical records daily, concurrent with patient stay, to identify opportunities to clarify missing or incomplete documentation.
- Collaborate with providers, case managers, coders, and other healthcare team members to facilitate comprehensive health record documentation that reflects clinical treatment, decisions, diagnoses, and interventions.
- Use the hospital’s designated clinical documentation system (electronic health record, encoder, or e-query tools) to conduct reviews of the health record and identify opportunities for clarification.
- Conduct follow-up reviews to ensure queries have been answered and physician responses appropriately documented.
- Provide or coordinate education related to compliance.

Today, programs increasingly diversify their staffing roles and responsibilities, limiting expectations for those brand-new to the role and expanding requirements for those with proven skills, experience, or expertise. In some situations, clinical validation expectations may be built into the role from the very beginning; in others, this type of review may be a specific process and duty set for second-level reviews or CDI team lead positions.

For example, a sample job description for a “level 2” CDI specialist provided to ACDIS in November 2018 by Diane Kohler, RN, CCDS, manager of the CDI department at Centura Health in Centennial, Colorado, states that the individual performing this role “will facilitate and obtain appropriate provider documentation for any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of patient care.” The job description also calls on staff at this level to “identify quality-of-care issues in documentation and ... seek resolution of issues through appropriate channels.”

Chapter 1

- Act with integrity; behave in an honest, trustworthy manner, abiding by ethical principles; elevate service to others above self-interest; and promote high standards of practice in every setting
- Ensure that the working environment is consistent and avoids any conflict of interest

AHIMA also released its “Ethical Standards for Clinical Documentation Improvement Professionals” in November 2010, which was intended to:

- Assist in decision-making processes and actions
- Outline expectations for making ethical decisions in the workplace
- Help CDI professionals demonstrate their commitment to integrity

Discussion point

Those entering clinical validation reviews should examine AHIMA’s “Ethical Standards” in light of this new review lens. The “Ethical Standards” contain nine elements, each with component parts, as follows:

- The first element states that CDI programs/specialists should “facilitate accurate, complete, and consistent clinical documentation within the health record to support coding and reporting of high-quality healthcare data.”
- The second element states that CDI programs/specialists should “support the reporting of all healthcare data elements ... required for external reporting purposes ... completely and accurately, in accordance with regulatory and documentation standards and requirements and applicable official coding conventions, rules, and guidelines.”
- The third element reiterates query directives.
- The fourth element indicates that CDI and coding staff should “refuse to participate in or support documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or distort data by means that do not comply with federal and state statutes, regulations, and official rules and guidelines.”

Chapter 2

Government Oversight and Validation Efforts for Denials Management

The relationship between clinical documentation and claims data is complicated. Independent licensed practitioners who author the clinical documentation, and coding professionals who determine which codes appear on the claim, each abide by certain guidelines for their activities. Payers who insure the populace and compensate healthcare systems for the care provided also have guidelines that affect coverage and payment for healthcare services. Unfortunately, those documenting within the record and those coding the documentation are often unaware of these various guidelines, either due to a lack of access (the payer does not share this information), lack of collaboration (physician/coder silos), or due to lack of training.

Due to a high volume of variability among private healthcare insurers, this chapter will reference applicable guidelines established by the Centers for Medicare & Medicaid Services (CMS). As stated previously, CMS represents the largest healthcare insurer, spending by far the greatest amount on that care. In 2017, federal healthcare spending represented 15% of the total U.S. budget, according to a June 22, 2018, article from the Henry J. Kaiser Family Foundation, “The Facts on Medicare Spending and Financing” (www.hfkf.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/). According to CMS’ National Health Expenditure fact sheet, the total cost of care grew 3.9% to \$3.5 trillion in 2017, or \$10,739 per person, and accounted for 17% of the gross domestic product (www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html).

Chapter 2

Not surprisingly, the government wants to ensure that the taxpayer money it does spend on healthcare gets used appropriately, for high-quality care. That's why Congress requires CMS to ensure that its money is well spent through a wide range of regulatory initiatives, guidance, and oversight.

Claims Denials

Clinical documentation improvement (CDI) professionals need to understand, and follow, the rules associated with compliant coding and keep these guidelines in mind when handling clinical validation reviews concurrently (just as they would with any other type of concurrent medical record review for coding and documentation improvement purposes). However, understanding the *Official Guidelines for Coding and Reporting* represents just part of the picture when looking at clinical validation as a part of CDI and denials management program. Why? First, the codes on the claim are only part of payment criteria for most payers, including CMS. The overarching issue for most payers, including CMS, is coverage.

In terms of Medicare, consider coverage like medical necessity (admittedly a very broad concept). Basically, Medicare payments can be made only for services that are reasonable and necessary as required under the Social Security Act. The claim must also be correctly coded, but first and foremost, the services must be medically necessary. Relying only on coding guidelines as found in *Official Guidelines for Coding and Reporting*, the Alphabetic Index, Tabular List of the code set or on those found in the American Hospital Association's (AHA) *Coding Clinic for ICD-10-CM/PCS* to challenge clinical validation denials is often insufficient, since these are two different concepts.

Government Oversight and Validation Efforts for Denials Management

Clinical validation was introduced in the joint Association of Clinical Documentation Improvement Specialists (ACDIS)/American Health Information Management Association (AHIMA) query practice brief, “Guidelines for Achieving a Compliant Query Process,” which directed those conducting medical record reviews to consider creating a query “when the health record documentation ... provides a diagnosis without underlying clinical validation.”

The justification for this new query objective was as follows:

"The focus of external audits has expanded in recent years to include clinical validation review. [CMS] has instructed coders to 'refer to the Coding Clinic guidelines and query the physician when clinical validation is required.' The practitioner does not have to use the criteria specifically outlined by Coding Clinic, but reasonable support within the health record for the diagnosis must be present."

The line instructing coders to “refer to *Coding Clinic* guidelines” comes from the *Medicare Quarterly Provider Compliance Newsletter*, Volume 1, Issue 4, July 2011, and was made regarding the recovery auditors’ (RA) findings regarding the diagnosis of acute respiratory failure, Medicare Severity Diagnosis-Related Group (MS-DRG) 189, specifically principal and secondary diagnoses affecting the DRG assignment to ensure all diagnoses “were present, correctly sequenced, coded and clinically validated.”

One of the clinical examples used in the publication is the case of an 81-year-old woman admitted through the emergency department (ED) following complaints of dry cough for a couple of weeks, and presently assessed for wheezing and coughing. The publication further described the history and physical (H&P) impression as acute respiratory failure secondary to exacerbation of chronic obstructive pulmonary disease (COPD), supported by progress notes through the stay. Final diagnosis on the discharge summary is acute respiratory failure secondary to COPD exacerbation.

Appendix A

Guidelines for Achieving a Compliant Query Practice, excerpt

Editor’s Note: This excerpt from the 2019 Association of Clinical Documentation Improvement Specialists (ACDIS)/American Health Information Management Association (AHIMA) physician query practice brief “Guidelines for Achieving a Compliant Query Practice” supersedes previous versions. The excerpt contains information relevant to this publication with permission from ACDIS. Refer to the complete publication for additional information governing compliant query practices.

This American Health Information Management Association–Association of Clinical Documentation Improvement Specialists (AHIMA-ACDIS) Practice Brief should serve as an essential resource for coding and clinical documentation improvement (CDI) professionals in all healthcare settings who participate in query processes and/or functions. It should also be shared and discussed with other healthcare professionals, such as quality, compliance, revenue cycle, patient financial services, physician groups, facility leaders, and any others who work with health record documentation, clinical coding, and/or coded data.

This Practice Brief’s purpose is to establish and support industry-wide best practices for the function of clinical documentation querying. Its intent is to integrate best practices into the healthcare industry’s business and workflow processes and the overall function of querying. This Practice Brief should be used to guide organizational policy and process development for a compliant query practice that implements the directives of the *ICD-10-CM* and *ICD-10-PCS Official Guidelines for Coding and Reporting* and official advice in

Appendix A

the *American Hospital Association (AHA) Coding Clinic® for ICD-10-CM/PCS* promoting the legible, consistent, complete, precise, nonconflicting, and clinically valid documentation essential to the integrity of the ICD-10-CM/PCS code sets. It is also intended to provide a resource for external reviewers (e.g., the Office of Inspector General (OIG), government contractors, payer review agencies, etc.) in their evaluation of provider queries and the documentation they provide.

Some specific use examples include:

- Orient new employees and educate current staff
- Assist with query audits
- Review of query policies and procedures annually
- Utilize during coding and CDI education and training
- Standardize query practices across the organization
- Provide data analytics and information governance
- Compliance and legal assistance
- Share with external or third-party staff and/or consultants

The distribution of this Practice Brief should enhance the importance of adherence to its contents and guidance while improving results, outcomes, and compliance with ethical practice.

Who Should Follow This Brief?

With the evolution of reimbursement methodologies that move beyond resource use and instead focus on severity of illness, medical necessity, risk adjustment, and value-based measures, specific documentation related to diagnosis capture, acuity, and clinical validity have become even more important. The need for clear

Appendix C

Sample Clinical Validation Job Descriptions

CDI Specialist Job Description

The following CDI specialist job description was donated by Cathy Farraher, RN, MBA, CCM, CCDS, care manager at UC San Diego Health in California. It includes clinical validation expectations alongside typical CDI daily efforts.

Clinical documentation improvement (CDI) specialists are expected to perform the following tasks as part of their ongoing concurrent medical record review activities:

- Review all assigned new cases for potential query opportunities intended to increase diagnostic specificity, acuity level and/or verify the need for inclusion or removal of diagnoses that are missing or inadvertently present in the current chart.
- Validate the level of care (setting) ordered for the patient as appropriate and notify the case manager if it does not appear to be accurate.
- Identify the need for nursing involvement as it pertains to pressure injury staging and present-on-admission status and follow up after they have had a chance to document their findings for use in a future query if needed.
- Follow up on all sent queries to either note the response or further explore for a response per hospital policy and escalate to the physician advisor as per policy.

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- Re-review cases previously seen for additional query opportunity.
- Reconcile cases to validate all appropriate diagnoses have been coded and that the DRG assigned is most accurate. Discuss with the coder if there is not agreement and escalate to management or the coding validator in the case of ongoing disagreement.
- Perform mortality reviews on all deceased patients not under the palliative or inpatient hospice teams' purview.
- Perform ongoing education to physician staff as able.
- Maintain ongoing educational requirements by obtaining membership in related industry association, participating in continuing education, and obtaining/maintaining related certifications in the CDI field.
- Other duties as assigned by leadership.

CDI Clinical Validator Job Description

The following job description was donated by Cathy Farragher, RN, MBA, CCM, CCDS, care manager at UC San Diego Health in California. It includes clinical validation expectations specifically related to an advance role/position within the CDI team. Titles for such a position may be CDI auditor, CDI clinical validator, CDI second level reviewer, or CDI educator depending on the additional responsibilities assigned and the level of experience of the professional.

This advanced CDI role includes all responsibilities of the CDI specialist as indicated, with additional responsibilities focused on:

- Random audits of all queries sent by the team with follow-up education and tracking as needed.

Appendix F

Resources

Introduction

Butler, M. (2014). Reinventing CDI: Organizations relaunching and reworking data integrity efforts, and coding roles, with clinical documentation improvement programs. *Journal of AHIMA*, July 2014. Retrieved from <http://bok.ahima.org/doc?oid=107386#.W7EAcfZFyUk>

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"The assignment of the diagnosis code is based upon the provider's diagnostic statement that the condition exists. [...] Code assignment is not based on clinical criteria used by the provider to establish the diagnosis," according to the 2018 *Official Guidelines for Coding and Reporting*.

For some, this guidance meant that coders cannot question the physician's documented diagnosis. However, government auditors frequently cite lack of clinical validation for documented diagnoses in their claims denials. This leaves coding and CDI staff with a professional conundrum: Should they simply code a clinically unsupported diagnosis or query the provider?

While the choice for CDI professionals may seem clear, such record reviews require a deeper understanding of pathophysiology, query practices, and coding regulations. Formulating these queries effectively takes additional review time to identify the supportive clinical evidence. Additionally, CDI staff need to spend time on physician education and program policy development for query escalation and reconciliation.

In this book, industry experts Cheryl Ericson, RN, MBA, CCM, CCDS, and Cathy Farraher, MS, RN, CCDS, CDIP, tackle the nuances of this critical concern for CDI professionals.

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