Taking Coding to the Next Level through Clinical Validation

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Health information management (HIM) is a discipline that has rapidly evolved toward roles of increasing complexity and demand in recent years and the coding profession has been one area at the center of this growth. Even though the HIM profession is currently rethinking their coding and clinical processes due to widespread industry changes and initiatives, it has always been essential for coding professionals to have ongoing professional development. Enhancing clinical knowledge through education and resources is essential.

The Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractor (RAC) Scope of Work 2013 includes the following statement:

> "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. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). 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 maybe performed by a clinician with approved coding credentials."[1]

Most identified improper payments due to the coding/DRG assignments were in cases where only one complication/comorbidity (CC) or major complication/comorbidity (MCC) were coded without clinical validation.[2]

AHIMA's "Guidelines for Achieving a Compliant Query Practice" advised that a query should be generated to address conflict between diagnosis and clinical indicators included in the health record, noting that reasonable support within the health record for the diagnosis must be present.[3]

It is essential for coding professionals to enhance their clinical skills. This article discusses approaches to achieving accurate coding/documentation, supported by clinical validation.

Developing Clinical Education

HIM educators can trend and review audit results that reveal common coding errors, as well as focus on error trends in principal diagnosis selection. In many cases it is possible that an alternate principal diagnosis will be chosen by the auditor based on clinical findings within the medical record of which the coding specialist may not be aware. By incorporating clinical education into the coding education for a particular topic, coders will learn what clinical indicators to search for within medical record documentation.

The following are some best practices to consider when developing coding education:

One-hour Topics

Coding departments can incorporate clinical information sharing during one-hour meetings on particular diagnosis topics. For example, a topic can be chosen such as "acute renal failure" and each participant can be assigned to bring relevant information to the meeting. For example, one participant can be assigned to bring common symptoms and laboratory findings, another can bring common treatments for the diagnosis or the official coding guidance regarding the diagnosis. A time allotment can be assigned for a group discussion on each area.

Discuss and Test Clinical Knowledge

Following an action plan assignment or meeting to discuss clinical findings pertaining to a diagnosis, test the participants on knowledge gleaned.

Follow-up and Repeat Testing

Continually refresh the coders' knowledge on all topics covered through continued discussion and repeat testing.

One effective method to achieve a greater level of expertise is to use clinicians from your facility to present classes on new surgical or diagnostic procedures, various clinical disease processes, or how certain surgical instruments are utilized. This type of training can serve to educate both the coders and the clinicians. Prior to the training, ask the coders to list their clinical questions that impact coding on the topic to be presented. This helps the presenter know what to cover and increases his or her understanding of the relationship of clinical documentation to coding. As noted in the *HPMP Compliance Workbook*, the questions can also point out areas where improved physician documentation is needed.

The Push for Productivity

With coder shortages, pressure to reduce accounts receivables for increased cash flow, and the challenge of learning a new coding system on the horizon, there is no question that HIM professionals are looking for ways to improve coder efficiency and productivity. And yet, several industry studies indicate that inpatient coding productivity has declined over the past few years. There are several potential reasons for this drop in productivity:

- Increased regulatory reporting requirements such as present on admission (POA) indicators and quality indicators impacting reimbursement for hospital-acquired conditions and other value-based purchasing initiatives
- Increased scrutiny of coded data from regulatory and government audit entities, including clinical validation of codes reported
- Constant improvements in medical practice, changing the way conditions are diagnosed and medical interventions are delivered, necessitating that coders stay abreast of these clinical developments
- More emphasis on physician queries to clarify documentation
- Implementation of new technologies, impacting workflow processes and creating new challenges (i.e., hybrid records, cut-and-paste documentation)
- With the implementation of the 5010 electronic data transmission standard, the ability to report 24 diagnoses and 24 procedures marks a significant increase from nine diagnoses and six procedures

Coding professionals must "step it up" to survive in this new environment. Enhancing clinical knowledge through education and resources is essential. The availability of Internet resources such as drug references, anatomy and physiology charts, professional medical society websites, and online pathophysiology resources can increase productivity by making knowledge available at the coder's fingertips. Clinical documentation improvement programs have gone a long way to reduce physician queries by collaborating with physicians up front for accurate and complete documentation. Finally, productivity can be increased by eliminating the rework of denials through clean claims on the front end.

One way to increase clean claims is by implementing a second level pre-bill review process for high risk inpatient and outpatient cases. Develop a list of high risk MS-DRGs, diagnoses, and services that warrant a second coder review prior to dropping the bill. Include high risk post-payment target areas that have become pre-payment targets for the RAC and Medicare Administrative Contractor (MAC). These government initiatives have found that pre-payment reviews "help lower the error rate by preventing improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur."[4] MS-DRGs included in the CMS Prepayment Review Demonstration are currently being reviewed prior to payment in eleven states (California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas). Research MAC websites to identify prepayment reviews currently being performed by the local MAC. At a minimum, consider the following for your own pre-bill reviews:

- RAC Prepayment Review targets (see http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html for the CMS prepayment edits schedule)
- Review areas identified by MAC
- Short-stay medical cases

- Cases with only one complication/comorbidity (CC) or major complication/comorbidity (MCC)
- Unrelated Operative Procedure MS-DRGs (981-983, 987-989)
- Outpatient procedures on the inpatient-only list
- Level 5 emergency department visits with discharge to home
- Services with high denial rates at your facility

Cases for pre-bill review can be identified simply by the coder or through software with sophisticated algorithms. The second level review may be performed by peer review from experienced coders, by a lead coder or coding manager. Whatever your process, it should include documentation of the second level review for future reference in defending a potential payment denial. Include official references such as *AHA Coding Clinic, ICD-9-CM Official Guidelines for Coding and Reporting*, and *CPT Assistant* in documentation. A CMS prepayment edits schedule is available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html.

Implementing and Addressing Clinical Coding Validation Denials

Successfully reducing clinical coding denials requires a joint interdisciplinary team effort. The key individuals are physicians, clinical documentation improvement staff, coders, and other key clinical areas. This process not only requires a solid retrospective denial review process but also a proactive analysis process that involves determining risk, concurrent review via CDI or other method, ongoing process improvement, and education. HIM professionals possess a well-rounded background to manage, assess, address, and facilitate audit improvement. Denial focus areas include ICD-9-CM codes, CPT and HCPCS codes, and application of those rules as related to code assignment and billing, chargemaster maintenance and set up, transfer DRGs with discharge disposition assignment, and utilization and readmission review. Outside of these areas, clinical validation review has arisen as a key area where coders should increase awareness.

Working to Prevent Denials

A good audit management process manages denials as they come in but also works proactively to prevent them. Coders are now more than ever faced with the question of how to handle validating clinical denials from a coding perspective. As mentioned above, queries are a way for coders to confirm the validity of coding a diagnosis or procedure. Clinical validation is no different. In the day to day, coders must question the clinician and/or utilize internal escalation process when resolution of uncertainty is needed. Clinical validation review requires utilization of this process more than ever before.

Steps for success in clinical validation denial prevention audits include:

- Know and understand how clinical validation relates to code assignment
- Implement and effectively manage a CDI program
- Work as a team with coding, CDI, and physicians/clinicians
- Focus on documentation
- Identify holes/shortcomings
- Query, query, query
- Know targets
- Know deficiencies and correct them
- Educate key players in targets and trends within facility
- Analyze to determine success
- Continue to grow coding and clinical knowledge
- Identify coder problem areas
- Stay current with coding risk areas through the OIG, MAC, and CMS Compliance Newsletter communications

Defending Clinical Denials

Defending clinical denials can be challenging. Coding professionals must not only ensure they are within the parameters of official coding guidance, they must review the record to justify the clinical significance of the chart coding. HIM professionals have a background built for this, however, and with proper training should be able to negotiate the path between exercising

coding judgment and clinical judgment. The query process and collaboration with the physician is key as they have the ultimate keystroke for accurate and quality code assignment. Work with CDI and physicians as needed to build the case to support the code assignment clinically.

Steps for success in clinical validation audits include:

- Know risk areas
- Run and analyze data
- Identify process constraints
- Educate key team members
- Ensure notifications for medical records are being communicated to HIM
- Reroute accounts following code assignment related to audit target areas for quality review
- Track and trend audits
- Communicate
- Know, analyze, and act on denial reasons
- Decrease denials with teamwork
- Share coding denials with clinical documentation staff
- Allow case management to share medical necessity denials
- Track physician medical necessity denials due to incorrect coding/documentation

Advancing the Coding Profession: Communication Skills, Clinical Skills, and Credentials

A coding professional must have a solid base of medical terminology, anatomy, pathophysiology, and pharmacology. It's not enough to see a diagnosis, sign, or symptom documented in the medical record. Coding professionals must take the time to look it up in the book or encoder and add it to the list of codes. Clinical knowledge is put to use continuously along with coding rules and guidelines to make the proper code assignment.

Consider the following scenario for example: a 23-year-old female presents to the emergency room with the sudden onset of severe pelvic pain, vaginal bleeding, and lightheadedness. She has a history of multiple abdominal surgeries. Positive smoker, 1 pack per day. Serum ?-hCG levels were elevated. The patient was diagnosed with an ectopic pregnancy and transferred to the OR.

Without knowing the pathophysiology and clinical picture of an ectopic pregnancy, an untrained person may code the pain, bleeding, lightheadedness and abnormal lab values in addition to the ectopic pregnancy, where a trained coder knows all of these are signs and symptoms of the definitive diagnosis and are not coded.

Communication skills, both oral and written, are essential, as well as the ability to effectively interact with all types of clinical staff including physicians, mid-level providers (i.e., physician assistants, nurse practitioners), nurses, technicians, and therapists from many different specialty areas:

- Surgical/Operating Room
- Cardiovascular/Catheterization Lab
- Orthopedics/Physical Therapy
- Neurology/Rehabilitation
- Critical Care/Respiratory Therapy
- Emergency Department
- Hematology/Oncology

Where many professionals are well versed in one or two specific areas, a coding professional must be knowledgeable in all body systems and know how to convey the information concisely and in several different styles:

- Face-to-face or written queries
- Coding education to providers and staff
- Appeal letters

- Day-to-day interaction
- Coding questions

The ability to formulate a query with clinical evidence from the medical record will garner the attention of the provider and decrease the likelihood of an unanswered question. The ability to speak with a provider in clinical terms about disease processes and formulate intelligent questions will gain the respect of the provider and increase the likelihood of successes in the future. Providers will also be more likely to listen to those who are clinically knowledgeable when being educated about coding issues, which is of utmost importance as we move closer to the implementation of ICD-10-CM/PCS.

The ability to speak to or query a provider or write an effective appeal letter with the clinical knowledge of a disease process further supports the importance of and the need for a coding professional in the clinical validation process.

In the transition to ICD-10-CM/PCS, coding documentation will be even more important as will the need for coders to translate that clinical documentation to the new code set. Just the sheer volume of added codes will require more analysis and research by coders. This is the time for coders to take the opportunity to expand their skills on the clinical side of coding and strengthen their position in the industry. Most coders are being given the chance to sharpen their clinical knowledge by their employers and they should all take that opportunity to grow their skills. It is a great time to increase their confidence in the very important position that they are in and capitalize on the opportunities that ICD-10-CM/PCS will bring.

One way for coding professionals to demonstrate their advanced clinical knowledge is by attaining the Certified Documentation Improvement Practitioner (CDIP) credential. Professionals earning the CDIP credential will be distinguished as knowledgeable and competent in clinical documentation in patient health records and be positioned as leaders and role models in the HIM community.

Notes

1. Centers for Medicare and Medicaid Services. “Statement of Work for the Recovery Audit Program-DRG Validation vs. Clinical Validation.” 2013. http://racmonitor.com/downloads/Recovery%20Audit%20Scope%20Of%20Work%202013%20copy.pdf.
2. Wilson, Donna D. “Five RAC Coding Targets: Demonstration Program Identified Key Areas of Improper Payment” *Journal of AHIMA* 80, no.5 (May 2009): 64-66.
3. AHIMA. “Guidelines for Achieving a Compliant Query Practice.” *Journal of AHIMA* 84, no.2 (February 2013): 50-53.
4. Centers for Medicare and Medicaid Services. “Prepayment Review Demonstration.” December 2013. http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/RecoveryAuditPrepaymentReview.html.

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Article citation:
AHIMA Work Group. "Taking Coding to the Next Level through Clinical Validation" *Journal of AHIMA* 85, no.1 (January 2014): web extra.

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