You Got Proof? Payers, Auditors Increase Clinical Validation Checks

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By Mary Butler

Healthcare providers and health information management (HIM) departments have been learning the hard way—for some time—that no good deed goes unpunished.

Case in point is how providers embraced clinical documentation improvement (CDI) programs when it became clear they were losing out on reimbursement because their claims lacked the specificity required to support the assigned codes. To recoup the lost revenue, CDI specialists started to work alongside coding professionals and physicians to make sure that diagnoses such as congestive heart failure were well supported by the documentation in the chart. Additionally, CDI programs started focusing on capturing complications and comorbidities (CCs) and major complications and comorbidities (MCCs), which were high-dollar secondary diagnoses.

This movement toward CDI meant that more specificity was getting added to the health record to back the assigned codes. This had the intended result—a drop in auditors denying claims and revenue back in the provider's pocket, not to mention the improved specificity meant medical records were better at telling the complete patient story, which helped with care. The CDI strategy worked.

Ironically, this led auditors to adopt a new tactic—when they can't deny a claim based on a lack of specificity (due to CDI), they're increasingly looking in the record for evidence to support the actual clinical diagnosis.

In these new "clinical validation reviews," Medicare Recovery Audit Contractors (RACs) and other private payer auditors are now looking for clinical evidence that supports why a diagnosis is made by a provider. In turn, CDI specialists now need to up their game and increase this element of their health record review—and ensure proof of why a diagnosis was made is included in the record.

CDI specialists, coding professionals, and physicians play a key role in preempting and responding to clinical validation checks, so it's important for HIM departments to understand the impact these checks have on claims and to strategize ahead of them.

What to Expect from a Clinical Validation Review

During traditional Medicare audits, reviewers look at the discharge summary to see if the codes reflect the discharge diagnosis. The coding audits to which most coding professionals and CDI specialists are accustomed evaluate whether, for example, a surgeon was specific enough in documenting a procedure, says William Haik, MD, who is board certified in internal medicine, pulmonary care, and critical care medicine, and is the director of DRG Review.

"Say a surgeon takes out the colon. And in his final discharge diagnosis he lists the colon cancer and he lists the resection but fails to list extensive lysis of adhesions. When you go back through the operative report, which confirms he did extensive lysis of adhesions, those codes can be reported. That would be just a coding or documentation audit," Haik says. Those additional details reflect a higher degree of complexity of the patient's condition, which requires more time and effort by the surgeon and an opportunity for higher reimbursement.

Clinical validation audits, which for the most part are performed by RACs on Medicare Advantage and other nontraditional Medicare claims, determine whether diagnoses documented in a patient's record are substantiated by clinical criteria generally accepted by the medical community. The auditors are homing in on diagnoses that tend to come with the most complications, and as a result have the biggest impact on DRG assignment and HCC capture—such as malnutrition, sepsis, acute kidney injury (acute kidney failure), respiratory failure, heart failure, pneumonia, pancreatitis, and encephalopathy—and looking to see if the coding and documentation in the chart meet accepted clinical guidelines. Auditors look for cases where the physician

wrote the diagnosis down and the proper code was assigned, but the clinical details in the record don't back up the diagnosis. The matter of exactly *whose* guidelines are used, however, presents a challenge—especially in sepsis cases.

"If the reviewing entity required sepsis 3 criteria and only sepsis 1 criteria was met, they'd deny the reporting of sepsis," Haik says. "The *Coding Clinic* and CMS (Centers for Medicare and Medicaid Services) say third-party reviewers can devise their own criteria, and that's been a bit problematic because we don't always agree with the validating criteria they use. A lot of us use ASPEN criteria from 2012 to validate malnutrition or severe malnutrition."

Providers can always challenge the auditor denials. Amy Czahor, RHIT, CDIP, CCS, vice president of optimization and analytics services at RecordsOne, has experienced audits from the provider side as an HIM director and as an auditor. When she was the HIM director in a hospital her team took RAC appeals all the way to the Administrative Law Judge (ALJ) level, which is under the US Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals, and is independent of CMS.

"And what we unanimously found at the ALJ Level is that [the judge] will say 'I'm not a doctor, but, neither frankly is this auditor in most cases.' Basically, if you have an attending physician or a healthcare executive, or physician executive testifying and saying 'this is what was documented, this is why it was documented' and come at it that way, we didn't typically have a judge that's going to overturn that," Czahor says. "One hundred percent of the cases we took all the way to the ALJ level were always found in favor of the hospital."

Ultimately, an auditor didn't treat a patient—a physician did—so the burden of proof is on the auditor, Czahor says, and it is more difficult for RACs to make their case at the ALJ level.

Overly Aggressive CDI Comes with Great Risk

In this regulatory environment CDI specialists and coding professionals might feel pressured to query physicians more frequently, but they do so at their own risk. Physicians can grow weary and complacent if they receive more queries than they feel are clinically relevant. Worse than that are cases where providers violate the False Claims Act by repeatedly coding and documenting conditions that don't actually exist. In one whistleblower case that reached a settlement recently, Banner Health hired a clinical documentation consultant who said she witnessed repeated instances of inflated numbers and falsified documentation all in an effort to net higher reimbursement, according to an article by *HealthLeaders Media*. Banner agreed to an $18 million settlement with the Department of Justice.[1]

Amy Czahor, RHIT, CDIP, CCS, vice president of optimization and analytics services at RecordsOne, says these types of cases are industry outliers. But that doesn't mean providers shouldn't make every effort to ensure false claims don't happen. She says it's ingrained in the ethos of coding professionals and CDI specialists to ask themselves whether every condition listed on a chart is monitored, evaluated, and treated. CDI specialists themselves also need to make sure they don't pressure physicians to over-document or inflate the documentation through their queries.

"We need to make sure these conditions are reportable and a physician wasn't just in a hurry to get someone off their back," Czahor says. "It's just like when we started being paid by MS-DRGs, they started auditing the DRGs. Now that we're being incentivized on CC and MCC capture, you're seeing increased scrutiny on that."

To counter this mindset and incentive structure, it's important for coding professionals and CDI specialists to perform their own clinical validation reviews to prepare for third-party audits. In this case, the best defense is a good offense. Czahor says providers are starting to think more critically when they query on a diagnosis such as respiratory failure. For example, if a patient is diagnosed with respiratory failure and the patient has normal arterial blood gas levels, a clinical validation query may be needed to confirm the diagnosis.

"We're seeing a lot of programs and departments expand into that [clinical validation] because program leaders have said, 'We want you to look at these cases and maximize reimbursement, but we also want you to mitigate

risk if a physician is saying something that does not to appear to be clinically supported and would be seen in an audit,'" Czahor says.

Preventing and Responding to Clinical Review Audits

Without a doubt, CDI professionals are best positioned to help stave off clinical validation denials by reacting to these audits. This requires CDI specialists to have a higher level of clinical knowledge so that they can tell if the documentation specificity is enough to justify a diagnosis—upon which a code is based. They also will need to be able to teach doctors to document in a way that they are using evidence to support their diagnosis without actually leading doctors to a diagnosis with their queries—a tricky balancing act. In anticipating reviews CDI specialists need to forge stronger connections with physicians, empower coding professionals to query more thoughtfully, and iron out their own criteria for problem diagnoses.

"It's not just about getting illness that's not documented, documented, it's also about validating diagnoses that are documented but not clinically supported. Queries will definitely go up," in anticipating audits, says Suraj Bossoondyal, MBChB, CDIP, CCDS, CCS, CPC, director of the CDI program at Sutter Health Valley Area.

Bossoondyal leads a CDI team comprised of foreign-trained physicians as well as registered nurses. "It's kind of like peer to peer. Even though you're not side by side with the physician, it's kind of like shadowing, an observer, so you know how the physician is approaching a case. You can follow providers and understand how to approach him based on the specific point you're trying to raise," Bossoondyal says.

To prevent audits, Bossoondyal says it's important to have regular education sessions with physicians and suggests getting a physician champion involved. For clinical validation reviews, practicing evidence-based medicine is important—having providers and CDI teams updated on the most current clinical criteria. Bossoondyal favors a strategy that lets the CDI specialists take responsibility for identifying the documentation gap, while letting coding professionals fully focus on final coding. There should be a strong partnership between the two teams, CDI and coding, to ensure a smooth process with the common goal of accurate, compliant documentation and accurate, compliant coding, Bossoondyal says.

Richard Pinson, MD, FACP, CCS, principal of the consulting firm Pinson and Tang, LLC favors a similar strategy with CDI specialists since they are usually the ones querying physicians and pressing them to follow established clinical guidelines. And CDI specialists, for example, are the ones noticing if physicians are frequently over-diagnosing certain conditions like acute kidney injury (AKI) without providing the documentation that meets the clinical criteria for the diagnosis.

"Go to those guys and get someone who's a peer to say 'Here's the diagnostic standard. If your diagnosis doesn't have these criteria, the diagnosis is not going to stand up'… A simple example is if there's a diagnosis of pneumonia but there's nothing on the X-ray. There are good reasons why it may not be on an X-ray, so the doctor needs to explain why he put down pneumonia," Pinson says.

This is why experts recommend that CDI teams and physicians come together and nail down the clinical criteria they use to support a diagnosis on commonly disputed conditions. Haik recommends, for example, that CDI teams work with a provider's pulmonologist to develop the provider's own standard for respiratory failure.

"They should develop criteria that's evidenced based. So you can go to the medical journals text and come up with what are industry standard, evidence-based definitions," Haik says.

In his consulting practice, Haik educates physicians on the latest evidence-based clinical definitions for respiratory failure, kidney injury, and all of the most frequently debated definitions. Specialty societies such as the Surviving Sepsis Campaign can be a resource for determining the most authoritative source for sepsis criteria, for example.

"You need to have specific medical references you can point to when you're dealing with a third-party reviewer. That's the best way to educate your medical staff, so you can then rebut any adverse determinations," he adds.

As CDI specialists know all too well, educating physicians is challenging in the best of circumstances, so Pinson recommends trying to do educational outreach at times and places where physicians are generally available, such as medical staff meetings or section meetings.

"Your most important people are hospitalists because most hospitals handle the bulk of cases and they consult on surgical cases. They're a big focus. Even your chief medical officer ought to do a little leaning on people to get the word out there," Pinson advises.

Sample Clinical Validation Query

Acute kidney injury (AKI), also known as acute renal failure, is among the most commonly disputed diagnoses by clinical validation auditors, according to CDI experts. Clinical documentation improvement specialists (CDIS) can help providers submit claims that pass muster by querying physicians for more information before the claim goes out the door. Below is an example of a query that a CDI specialist might send to a physician, provided by Richard Pinson, MD, FACP, CCS, principal of the consulting firm Pinson and Tang, LLC.

Dear Doctor,

AKI (acute kidney injury) was documented within the medical record.

Clinical Indicators: Admitted with UTI and dehydration; creatinine 2.0 / BUN 30; mild chronic kidney disease with baseline creatinine 1.5; creatinine returned to baseline of 1.5 with IV fluid

Treatment: IV Fluids

Based on the clinical indicators and your professional judgment, can this diagnosis be further specified? Please complete by selecting one of the options below:

- This diagnosis is not confirmed and/or it has been ruled out.
- This diagnosis is confirmed (if confirmed, please add additional supporting information to the medical record).
- Other explanation of clinical findings; Click here to enter text.
- Unable to determine

Resources: http://kdigo.org/guidelines/

Thank you!
Clinical Documentation Specialist

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Note

1. Porter, Steven. "Whistleblower Suit Costs Banner $18.3 Million." *HealthLeaders Media*. April 12, 2018. www.healthleadersmedia.com/finance/banner-health-settles-whistleblower-suit-18m.

Note: The opinions expressed by Suraj Bossoondyal in this article are his own and not on behalf of Sutter Health. Mary Butler (mary.butler@ahima.org) is the associate editor of the Journal of AHIMA.

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