# CDI Clinical Validation: Validate Now or Pay Later

## Ciox Roundtable

Geoff New, MBA, RHIA, CHFP, CRCR, FHFMA, FAHIMA
Vice President, Provider Solutions – Revenue Cycle

Tarman Aziz, MD, CCDS
CDI Physician Advisor, Provider Solutions – Revenue Cycle

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# Presenters

Geoff New
MBA, RHIA, CHFP, CRCR, FHFMA, FAHIMA

Geoff is an experienced leader with more than 28 years of professional experience in the healthcare industry. He excels at delivering quality services that improve fiscal performance for hospitals and health systems, and he has spent his career working collaboratively with senior leadership, vendors, colleagues, staff, and facilities to exceed operational objectives.

Geoff joined Ciox Health in 2017 as the company's Vice President of Provider Solutions for the Revenue Cycle. In this role, he is responsible for designing, implementing and operationalizing revenue cycle solutions with a team of revenue cycle professionals, registered nurses, and physicians.

Prior to joining Ciox Health, Geoff led a team of employees across 130 locations and focused on Revenue Cycle, HIM operations, process re-engineering, regulatory compliance, and performance improvement initiatives for leading hospital systems around the country.

Tarman Aziz
MD, CCDS

Tarman is a medical doctor with 12 years of health information management consulting experience, primarily focused on improving the efficiency of clinical documentation integrity programs. Tarman also works with hospital systems to address payment denials through proactive documentation efforts and physician-to-physician education sessions.

Tarman joined Ciox Health in 2019 as the company's CDI Physician Advisor of Provider Solutions for the Revenue Cycle. Tarman's recent focus areas include highlighting the impact of key secondary diagnosis capture on quality metrics, particularly the expected mortality component of the mortality index.

Tarman earned a bachelor's degree in molecular biology from the University of California at Berkeley, followed by a medical degree from St. George's University School of Medicine in New York. Tarman received further training in the Internal Medicine residency program at the University of Oklahoma Health Sciences Center in Tulsa. He is certified as a CDI Specialist through ACDIS. Tarman and his fiancée Anna are active members of their local church, teaching music in youth programs and playing the guitar and piano at Saturday evening and Sunday morning Mass.

# Objectives

1. Learn Validation Now
2. Understand How Paying Later Impacts You
3. The Now and Later Correlation
4. Identify the Most Common Discharge Diagnoses Requiring Clinical Validation Queries from CDI and Coding Departments
5. Clinical Validation Query Content Best Practices for Compliance
6. Action Items / Next Steps

# Focus on Validation Now

# Validation

- Clinical Documentation is Main Focus For EVERYONE!!!
  - Patients
  - Payers
  - Health Plans
  - Providers
  - Quality/Risk
- Risk Adjustment and HCCs
  - RAF Scores
  - Underlying Conditions
- Validation Integration
  - Setup Validation Points Throughout Documentation Process
- Inspect What You Expect
  - Quality Is Important
- Why Put Off Till Tomorrow What Needs to Occur Today??

# Avoid Paying Later Downstream Impacts

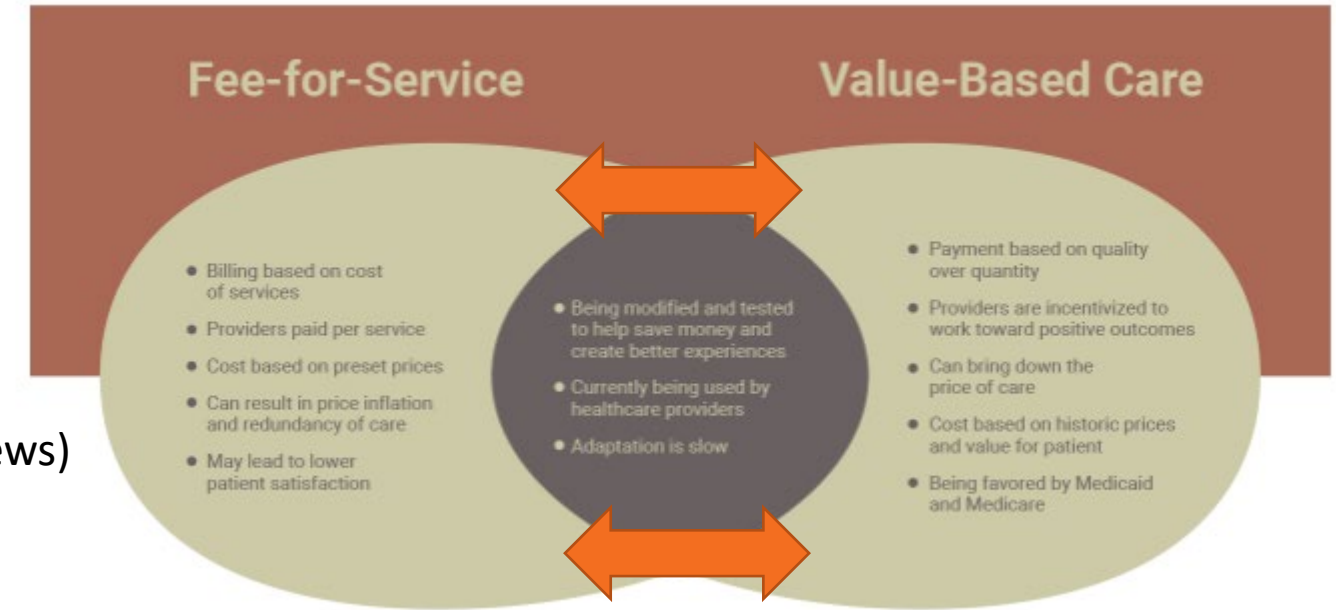
# Payer and Downstream Impacts

- Patient Impacts
- Payer Impacts
- Reimbursement Impacts
- Staffing Impacts
- Productivity Impacts
- System Impacts
- Physician Impacts
- Financial Growth Impacts
- Bad Debt Impacts
- Patient Consumer Impacts
- The List Continues…….

# Correlating
# The Now and Later

# Correlation

- Defined
  - Mutual Relationship or Connection Between Two or More Things
  - Process of Establishing a Relationship or Connection Between Two or More Things
- Lack of Documentation and Denials
  - Direct Relationship and Connection
  - A Relationship Will Continue to Strengthen Going Forward Between Payers and Denials
- Risk Adjustment
  - HCCs
  - RAF Scores
- Outpatient CDI
  - Physician Office Documentation and Denials
  - Incorrect Coding and Revenue Leakage
- Health Plans
  - Increased Activities (Focus Audits/Focus Reviews)
  - Payment Methodologies



# Correlation – Payment Models (Be Familiar with the Models)

1. **Accountable Care Organization (ACO)** – A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high-quality care to their Medicare patients.
2. **Fee-for-Service –** A system of provision of care where the health provider is paid a fee for each service or supply provided. Fees are billed at rates established by the provider. Fee for Service is not a form of managed care. Retrospectively, patients may receive reimbursement for health care services under a fee schedule. Fees and reimbursements from any applicable insurance arrangement based on a complex variety of factors, including the number and type of services provided, standardized coding system, the geographic area of service, and certain office and training expenses of the provider.
3. **Fee-for-Service with Utilization Review –**This is like Fee-for-Service, with the addition that the third-party payer assumes the power to authorize, deny, or limit payment for health care interventions.
4. **Health Maintenance Organization (HMO) –** A managed care arrangement consisting of a health care organization that acts as both insurer and provider of comprehensive but specified medical services. Most services are financed through prospective per capita (capitation) payments. The organization has responsibility for managing the provision of comprehensive health care services and typically provides preventive care. Depending on whether the services are organized under a staff or group model versus being contracted with clinicians separately, services are provided at organization's own facility or those hospitals, clinicians, and clinics with which it has a network agreement for the provision of care. Typically, primary care clinicians coordinate and refer patients for treatment while acting as the gatekeeper through whom the patient has to go to obtain other health services such as specialty medical care, surgery or physical therapy.
5. **Independent Practice Association (IPA) –** A network of private physicians, other health care professionals, and facilities in which insurers contract with the provider or facility. Rates for fees are negotiated separately with each provider or facility.
6. **Managed Care –** An organized way to manage the cost, use, and quality of the health care system. There are several major forms of managed care that are described below.
7. **Pay-for-performance (P4P) –** A payment model that links quality of care with the level of payment for healthcare services. Reimbursing agencies, including Medicare, have various initiatives to encourage improved quality of care in all healthcare settings, including physicians' offices and ambulatory care facilities, hospitals, nursing homes, home health care agencies and dialysis facilities.
8. **Point-of-Service (POS) –** A managed care arrangement consisting of a hybrid network model that combines features of an HMO and PPO. Like an HMO or PPO, the patient only pays a co-payment or low co-insurance for contracted services within a network of preferred providers for what is termed in-network care. However, like traditional fee-for-service insurance, enrollees have the flexibility to seek out-of-network care under the terms of traditional indemnity plans with a deductible and a percentage co-insurance charge.
9. **Preferred Provider Organization (PPO) –** A managed care arrangement consisting of a group of hospitals, physicians, and other providers who have contracts with an insurer, employer, third party administrator, or other sponsoring group to provide health are services to covered persons. The preferred providers are often subject to other stipulations regarding the monitoring of utilization, the appropriateness of care provided, and the terms of the provision of care allowed under the arrangements. While the patient does have some flexibility in health care decisions and selecting providers, through self-referrals both inside and outside the network of PPO providers, patients have financial incentives to select PPO network providers.
10. **Prepaid Group Practice –** A multi-specialty group of physicians or other health professionals who contract to provide services on an ongoing or continuous basis to a group of enrollees.

# Clinical Validation Query Targets

# Clinical Validation Supports DRG Validation

## DRG Validation

- "Was the encounter coded correctly"?
- Reviewing the encounter's provider documentation to assess the accuracy of code selection and sequencing.
- Example
  - The attending physician documents sepsis due to aspiration pneumonia as the reason for admission in the discharge summary.
  - All other provider notes are scrutinized for the consistency of these diagnoses throughout the admission.
  - The decision to discharge under DRG 871 is validated, based on POA status, code sequencing, and all the appropriate official coding guidelines.

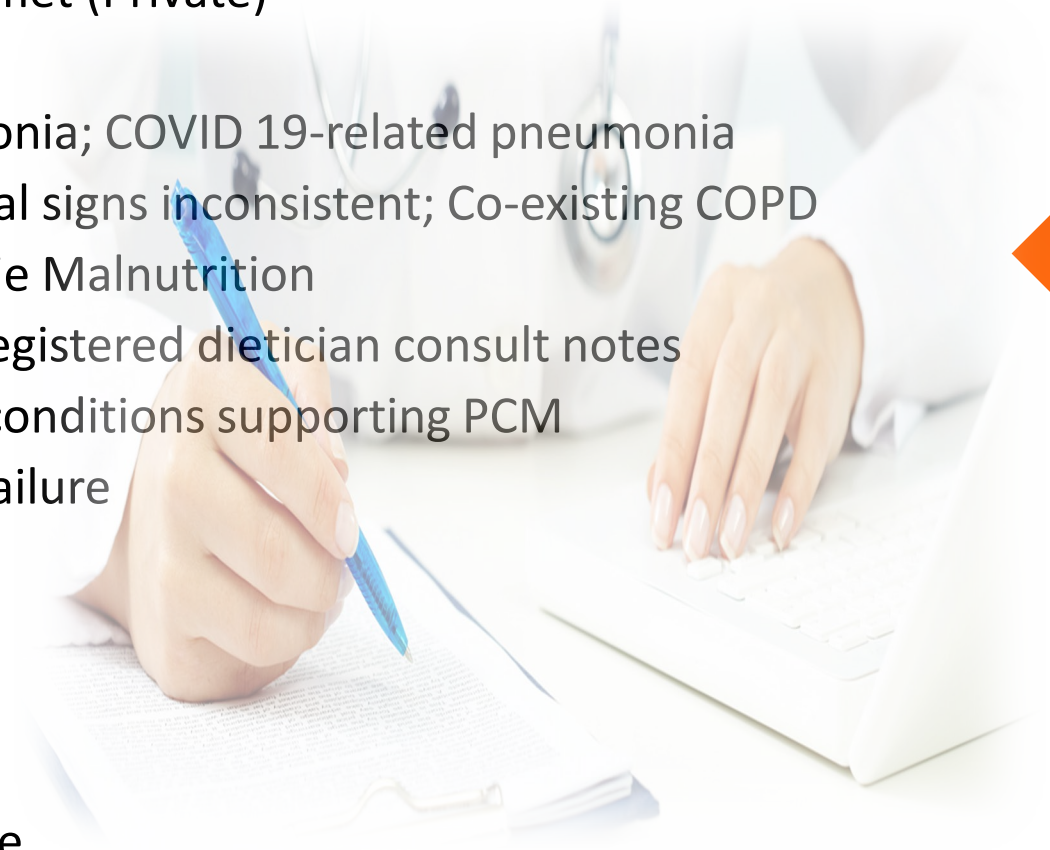
## Clinical Validation

- "Does the encounter data support the reported diagnoses and procedures"?
- Reviewing the clinical indicators to ensure key diagnoses can withstand targeted probes and audits.
- Contributes to DRG Validation.
- Example
  - The attending physician documents sepsis due to aspiration pneumonia as the reason for admission in the discharge summary.
  - The chart is scrutinized to ensure sepsis criteria are met and that risk factors, vital signs, lab data, and treatment are present for aspiration pneumonia.
  - The decision to discharge under DRG 871 is further validated.

# Ensuring Optimal Coding With Clinical Validation Queries

## Key Diagnoses for Clinical Validation

- Sepsis
  - SIRS attributed to localized infection (Medicare)
  - Sepsis 3 criteria / SOFA score not met (Private)
- Pneumonia
  - “Concern for”…aspiration pneumonia; COVID 19-related pneumonia
  - Lack of radiographic evidence; Vital signs inconsistent; Co-existing COPD
- Moderate and Severe Protein Calorie Malnutrition
  - Primary team provider notes vs Registered dietician consult notes
  - Orders for supplements; Related conditions supporting PCM
- Acute Kidney Injury / Acute Renal Failure
  - Monitoring and Treatment
  - Lab data fail criteria
- Shock
  - Etiology unclear; Lack of pressors
- Acute Hypoxemic Respiratory Failure
  - Inconsistent vital signs and exam findings



# Clinical Validation Queries

# Treatment vs Prevention

# Will I Ensure Optimal Coding with Clinical Validation Queries?

## Clarification of Clinical Findings

By submitting this query, we are merely seeking further clarification of documentation to accurately reflect all conditions that you are monitoring, evaluating, treating, or that extend the hospitalization or utilize additional resources of care.

Dear Provider,

Per the medical record, the patient's Clinical Indicators include:

- 75-year-old man with admitted with UTI, Pneumonia, and SIRS present on admission.
- H&P 6/30/21 – Assessment and Plan "1...**probable sepsis**, suspect urinary source, doubt CXR findings represent true pneumonic process".
- Hospitalist Progress Note 7/2 – "1...**probable sepsis**, suspect urinary source, doubt CXR findings represent true pneumonic process; Appreciate ID input, will maintain IV antibiotics given worsened infiltrate on repeat CXR…"
- ID Consult note 7/1 and 7/2 – Assessment and Plan – "3. Infiltrate noted, clinically doubt pneumonia" and "4. Leukocytosis from home / ED steroids, culture represents a contaminant. **Not septic**.
- Discharge summary 7/3 – Assessment and Plan – "1. UTI with SIRS noted on admission".
- Vital signs, patient afebrile throughout admission, without tachypnea, or need for supplemental oxygen, $O_2$ sats 98% +. Mild leukocytosis x 1 reading at 12.9, and 1 elevated heart rate reading of 103 bpm on admission, with HR 70-90 throughout remainder of admission.
- Per EMAR, patient received intravenous ceftriaxone (ED) and intravenous ampicillin / gentamicin (medical unit)

Conflicting documentation exists regarding the diagnosis of sepsis. For further clarification and specificity of the medical record, please use your independent medical judgment to address if Sepsis was:

- Ruled in for this admission

- Ruled out for this admission

- Other (please specify _____)

- Unable to determine clinically / Unknown

# Clarification of Clinical Findings

By submitting this query, we are merely seeking further clarification of documentation to accurately reflect all conditions that you are monitoring, evaluating, treating, or that extend the hospitalization or utilize additional resources of care.

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Conflicting documentation exists regarding the diagnosis of sepsis. For further clarification and specificity of the medical record, please indicate the condition you monitored and treated for this admission, along with any relevant clinical indicators.

- UTI with Sepsis

- UTI only

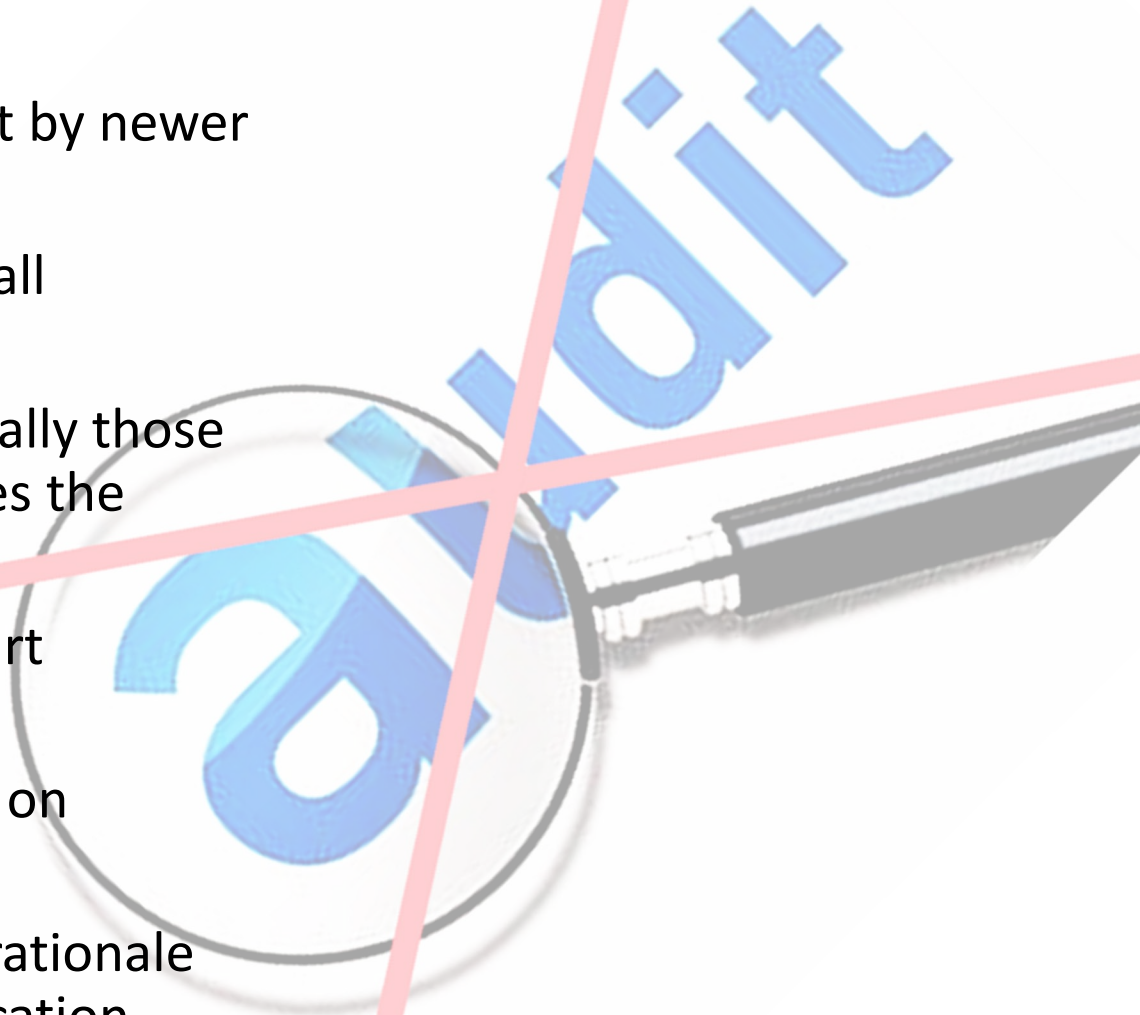
- Other (please specify _____)

- Unable to determine clinically / Unknown

Clinical Indicators:

# Ensuring Optimal Coding Requires Clinical Validation Queries and Education.

- “An ounce of prevention is worth a pound of cure”!
- Clinical validation queries are the least commonly sent by newer CDI specialists.
- Encourage and empower CDI team members to send all reasonable and compliant clinical validation queries.
- Where no indicators support a given diagnosis, especially those typically targeted by auditors, ensure the provider cites the relevant clinical indicators in the query response.
- Limit query answer choices to those supported by chart indicators.
- Unless addressing a chronic condition, add a “Present on Admission” question for each queried item.
- Expect the need to reinforce clinical validation query rationale and your local escalation policy through provider education.
- Be persistent with your efforts. The culture of thinking takes time to change.



# Action Items
# Next Steps

# Key Stakeholders in CDI Program Goals and Outcomes

- **Patients**
  - Quality of Care
  - Contributions to History of Present Illness, Current Medications, Active Problem List
- **Providers**
  - Resident Physicians
  - Nurse Practitioners and Physician Assistants
  - Hospitalists / Internists
  - Subspecialty Consultants
  - Department / Service Line Leadership
  - Attending Physicians
- **Administrators**
  - Chief Financial Officer and Revenue Cycle Team - CMI
  - Chief Quality Officer and Quality Improvement Team - Mortality Index, SOI, ROM
  - Chief Medical Officer – Query Response Rate
  - Chief Nursing Officer – Team compliance with recording core metrics (BMI, Urgent Care COVID results)
  - Emergency Department Administrators – POA status; Medical Necessity for Admission

# Thank You