HRS

ICD-10 Code Quality:
Making the Case for Clinical Validation

CODING ELEVATED

White Paper - November 2016

Coding Quality in the Crosshairs

Reports of ICD-10 coding quality range from extremely low[1] to on par with ICD-9 benchmarks[2] . As healthcare organizations enter the second year of ICD-10, vigilant HIM, clinical documentation and revenue cycle executives remain watchful for claims denials due to inaccurate or nonspecific coding.

The conclusion of CMS's one year grace period for code specificity also adds a new layer of concern as organizations brace for denials by performing more coding audits and documentation reviews. Along this journey, four new best practices for coding and documentation audits have emerged:

- Conduct frequent internal reviews and quarterly external coding audits to identify and address any coding accuracy issues
- Combine coding audits with clinical documentation reviews since clinical validation is a frequent reason for payment denials
- Extend reviews beyond DRG assignment to include clinical validation—clinical indicators must also support the DRG
- Apply data mining and analytics to coded data to target corrective action

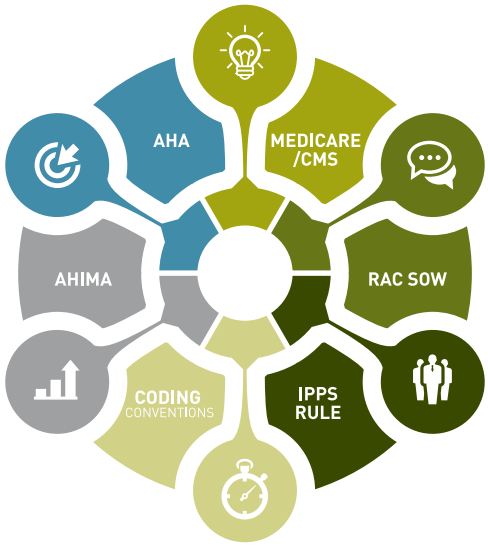
INTRODUCTION

Health information coders, coding managers and revenue cycle executives all understand the need for ICD-10 coding accuracy. When codes are improperly assigned, reimbursement is compromised, recoupments increase, and quality reporting goes awry. Responding to subsequent claims denials and managing payer appeals drains human resources and escalates operational costs. Coding quality matters. It must be upheld throughout the entire healthcare organization.

However, faulty ICD-10 codes are not the only reason for denials. Failure to meet medical necessity due to missing clinical indicators is another common culprit. Here lies the conundrum for clinical coding teams.

Given the new guidelines from CMS how can organizations continue to mitigate risk by validating clinical indicators? Is there a continued role for coders in this process or does this call for the expanded involvement of clinicians?

In 2016, HIM, CDI and revenue cycle leaders continue to debate coders' roles in the clinical validation process. Industry guidelines vary and are in direct contradiction to long-standing correct coding initiatives.



This white paper guides organizational efforts to define coders' roles in clinical validation. It also outlines best practices for building a compliant coding query and explores six diagnoses that carry unique risk for denials, audits and reimbursement recoupment.

Clinical Validation:
A Coding Conundrum

Clinical validation is defined by CMS and referenced in the RAC Scope of Work[3] as an additional process that may be performed along with DRG validation. According to CMS, clinical validation "involves clinical review to determine if the patient truly possesses the conditions that were documented in the medical record."

CMS adds that clinical validation is beyond the scope of a coder and should only be performed by a clinician. AHIMA[4] also recommends that clinical validation is the responsibility of CDI professionals with clinical background. HRS believes that it is also important for coders to have a strong clinical knowledge in order to provide quality coding and formulate appropriate and meaningful queries.

Many coders today are capturing only what is documented by the physician with no regard to other clinical indicators contained within the patient record. But at what cost? What will coders lose?

"RAC auditors deny Medicare claims based on insufficient clinical indicators, but the recently restated coding guidelines may deter coders from sending physicians a query for additional clarification in the clinical documentation. This conflict places healthcare facilities in a difficult situation."

Jonathan LaFleur, BSN, RN, CCS

"There is never a bad outcome from writing a great query. Coding quality always advances when coders grow their knowledge of clinical care and collaborate with CDI specialists."

Kimberly Janet Carr
RHIT, CCS, CDIP, CCDS,
AHIMA-Approved
ICD-10-CM/PCS Trainer

"We know coders aren't clinicians. But strong clinical knowledge fosters better coders, which in turn drives accurate reimbursement and reduces denials. By advancing their clinical understanding, coders gain insight into disease processes that leads to stronger, more confident coding decisions."

Barbara Hinkle-Azzara, RHIA

The added specificity inherent in ICD-10 is critical for data integrity, reflecting severity of illness and risk of mortality, setting future MS-DRG rates, and capturing the quality of care provided. When warranted, coding queries to meet ICD-10- CM/PCS specificity requirements are important regardless of whether those details ultimately affect MS-DRG assignment. When creating queries, coders must remain compliant with query best practices and published industry standard guidelines.

Components of a Compliant Query

Six Common Conditions for RAC Denial Due to Missing Clinical Indicators

Given the disparity between Medicare guidelines and quality coding practice, a new clinical validation workflow is required. The path forward includes clinical validation audits performed by CDI specialists with coding credentials or teams of CDI and coding professionals working collaboratively towards the same goal—high quality clinical coding and DRG assignment.

To initiate the process, HRS experts suggest the following six diagnoses for targeted clinical validation audits.

Acute Kidney Injury (AKI) - Criteria sets for this diagnosis are firmly established. RACs and other auditors cite AKI criteria in their denial letters. Clinical indicators require a marked increase in serum creatinine over baseline (>1.5 x baseline) and a demonstrated decrease in urine output (<0.5mL/kg/hr for 6+hours)

Encephalopathy - Auditors target encephalopathy because it is a relatively vague diagnosis and often doesn't have robust documentation support. Encephalopathy can be inherent to a number of underlying conditions. Treatment, evaluation, and management for encephalopathy may not differ from treatment for the underlying process. Furthermore, there are multiple types of encephalopathy. Coding the incorrect type could inaccurately add a CC or MCC. Capturing an encephalopathy diagnosis can have significant financial implications. Encephalopathy in diseases classified elsewhere, hypoperfusion for example, is captured with ICD-10- CM code G94, Other disorders of brain in diseases classified elsewhere, and is not a CC or MCC. Acute encephalopathy documented without an underlying cause should be queried. Documentation should also support the independent monitoring, evaluation, assessment, and treatment of the encephalopathy.

Respiratory Failure - There is no uniformly accepted definition of respiratory failure. This makes clinical validation difficult. Best practice is to compare the patient's baseline and treatment protocol. It is often difficult to diagnosis a COPD patient with respiratory failure since many COPD patients have a baseline abnormal blood gas. These patients are often the focus of auditor's reviews and denials. The clinical validation goal is to determine what is normal for the patient versus what is an acute episode. For example, if the patient is receiving the same amount of O2 in the hospital as being administered at home, it is not a case of acute respiratory failure.

Malnutrition - This diagnosis remains a challenge. RACs and other third party auditors cite the lack of clinical assessment that suggests malnutrition, and instead still focus on the BMI score and lab values. However, hospitals are moving away from BMI and lab values and are using a more standardized approach such as the A.S.P.E.N (American Society for Parenteral and Enteral Nutrition) guidelines. The A.S.P.E.N guidelines recommend that the diagnosis of adult malnutrition be based on the presence of two or more of these characteristics: Insufficient energy intake, weight loss, loss of muscle mass, loss of subcutaneous fat, localized or generalized fluid accumulation, and diminished functional status as measured by hand grip strength. Without seeing the patient in person, it is difficult to navigate the complex volumes of malnutrition criteria and clinical indicators.

Congestive Heart Failure (CHF) - Similar to respiratory failure, clinical indicators should demonstrate a change from the patient's baseline condition. Treatment that is appropriate for the acute phase of heart failure must also be described. Acute CHF is often denied by RACs when the focus of evaluation and management does not differ from a patient in chronic or compensated CHF.

Sepsis - Clinical indicators for sepsis underwent a major overhaul in early 2016. According to the 2016 Third International Consensus Definitions for Sepsis and Septic shock, sepsis is a life-threatening organ dysfunction due to dysregulated host response to infection. Today's sepsis cases must document expansion of the disease sign and symptoms beyond the original infection AND have a new focus on organ dysfunction or failure and altered mental status to be considered sepsis. For example, if a patient is admitted with cellulitis, auditors want to see clinical indicators beyond the fever and leukocystosis that may be inherent to cellulitis before sepsis can be substantiated.

CONCLUSION

For complete and accurate coding, coders should continue to improve their clinical knowledge in order to achieve three critical outcomes: advance their coding expertise, ensure correct code assignment, and formulate appropriate and clinically significant queries.

HRS has been providing expert coding, auditing and documentation services to the healthcare industry since 1979.

Learn more about how HRS can work for you.
800.329.0365 | **info@hrscoding.com**
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1. "Coding Contest Reveals Accuracy Issues": ICD-10 Watch. October 22, 2016. **http://www.icd10watch.com/blog/icd-10- coding-contest- reveals-accuracy- issues**

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3. Statement of Work for the Recovery Audit Program: CMS. 2013. **https://www.cms.gov/Research-Statistics- Data-and- Systems/Monitoring-Programs/recovery- audit-program/downloads/090111racfinsow.pdf**

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