Clinical validation reviews defense against denials

Historically, organizations—primarily hospitals—tended to focus on diagnosis-related group (DRG) validation and limit their clinical validation to utilization review efforts, says Cheryl Ericson, MS, RN, CCDS, CDIP, CDI education director at HCPro in Danvers, Massachusetts, who spoke during the “Defining the Role of CDI Through Clinical Validation” webinar earlier this year.

But the Social Security Act requires CMS to protect the Medicare Trust Fund against inappropriate payments. To do so, it hires contractors to perform not only DRG reviews but clinical validation as well. And these contractors are getting more adept at performing such reviews and identifying errors.

The CDI specialist’s role is changing. It’s no longer enough to query for diagnoses and report corresponding codes. The diagnosis must be backed up by clinical indicators and thorough documentation—or it risks being overturned by an auditing agency. Organizations have a lot of revenue at risk, and incorporating clinical validation into CDI efforts can be the first line of defense.

Let’s talk about the differences between DRG and clinical validation.

**DRG validation**

DRG validation is the process of reviewing physician documentation and determining whether the correct codes and sequencing were applied to the billing of the claim.

Contractors perform DRG, or coding, validations using certified coders. The contractors base DRG validation on:

- Accepted principles of coding practice, consistent with *Official Guidelines for Coding and Reporting*
Decoding auditor alphabet soup

Although CDI professionals most frequently hear about Recovery Auditor reviews and claim denials, several other agencies may also request and review medical records and deny claims. Medical review is the process performed by Medicare contractors to ensure that payment is made only for those billed items or services that meet all Medicare coverage, coding, and medical necessity requirements. The goal of the medical review program is to reduce payment errors by identifying and addressing billing errors concerning coverage and coding made by providers.

The Medicare Program Integrity Manual refers to review contractors as the following entities:

**Recovery Auditors (RA)/Recovery Audit Contractors (RAC):** RAs review claim data and conduct medical record reviews on targeted diagnoses to identify improper claims. Often the claim can be defended by the hospital if the appropriate documentation can be captured in the medical record up front, while the patient is still in the hospital.

**Medicare Administrative Contractors (MAC) and Zone Program Integrity Contractors (ZPIC):** MACs and ZPICs both have governmental authority to audit facilities in search of overpayments or potential fraud.

MACs are the fiscal intermediaries, go-to contractors who collect payment information from hospitals and process transactions and payment on behalf of CMS for inpatient, outpatient, and physician services and fee-for-service (FFS) claims. MACs also serve as an appellant venue when facilities or physicians do not agree with rulings made by RAs.

ZPICs, formerly known as Program Safeguard Contractors, serve the same jurisdictions as the MACs, but their role is more aggressive. They investigate instances of suspected fraud, waste, and abuse, provide support to law enforcement, and conduct audits of Medicare Advantage plans.

**Comprehensive Error Rate Testing (CERT) contractors:** CMS calculates the Medicare FFS improper payment rate through the CERT program. Each year, CERT contractors evaluate a statistically valid random sample of claims to determine whether they were paid properly under Medicare coverage, coding, and billing rules.

**Supplemental Medical Review Contractors (SMRC):** SMRCs are contracted by CMS through StrategicHealthSolutions, LLC, and provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions. They conduct nationwide medical reviews as directed by CMS, and evaluate medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment, and billing practices.

- The Uniform Hospital Discharge Data Set (UHDDS) data element definitions
- Coding clarifications issued by CMS

When performing a DRG validation, the contractor also determines whether the primary diagnosis listed on the claim is the diagnosis that, after study, is determined to have occasioned the beneficiary’s admission to the hospital (as required by the UHDDS). The principal diagnosis, as evidenced by the physician’s entries in the beneficiary’s medical record, must match the reported principal diagnosis. The principal diagnosis should be coded to the highest level of specificity.

Auditors can deny an item or service if it does not meet any of the conditions listed below:

- The item or service does not fall into a Medicare benefit category
- The item or service is statutorily excluded
- The item or service is not reasonable and necessary
- The item or service does not meet other Medicare program requirements for payment

**Clinical validation**

When performing clinical validation, the contractor determines whether the beneficiary required an inpatient level of care, whether the patient truly possessed the conditions documented in the medical record, and whether such care was medically necessary, reasonable,
and appropriate. The beneficiary must have demonstrated signs or symptoms severe enough to warrant inpatient medical care, and he or she must have received services of such intensity.

During clinical validation reviews, the reviewer considers preexisting medical problems and extenuating circumstances that make admission of the beneficiary medically necessary. Factors existing solely out of convenience to the beneficiary or family (such as admitting an elderly patient because the family is taking a weekend getaway) do not, by themselves, justify inpatient admission.

The medical necessity of a claim supersedes the DRG validation—if the service was not supported by the medical record, the applicable codes are irrelevant.

Then, the reviewer determines whether procedures and diagnoses were coded and sequenced correctly. If the medical record supports the coding, the claim will be paid and billed. If the medical record does not support the coding, the reviewer will use coding guidelines to adjust the claim and pay at the appropriate DRG.

The contractor may determine that the beneficiary did not require an inpatient level of care on admission, but that the beneficiary’s condition changed during the stay and inpatient care became medically necessary (at a later point during the stay). They review the cases in accordance with the following procedures:

- The first day on which inpatient care is determined to be medically necessary is deemed to be the date of admission
- The diagnosis determined to be chiefly responsible for the beneficiary’s need for covered services on the deemed date of admission is the principal diagnosis

The claim is adjusted according to the diagnosis that made inpatient care medically necessary.

Claims are denied in full when the contractor determines the beneficiary did not require an inpatient level of care at any time during the admission. If the medical record does not support the coding, the claim is denied. Hospitals have the opportunity to appeal claim denials.

**Create defensible claims**

CDI specialists at Catholic Health Services of Long Island, a six-hospital network, perform both types of reviews ahead of government contractors’ efforts, says Adelaide La Rosa, RN, BSN, CCDS, its corporate director of HIM, CDI, and clinical data management. The team looks through the record for accuracy of:

- Level of acuity
- Severity of illness
- Clinical indicators
- Utilization of resources

During the DRG validation review, the CDI specialists work with the coders to ensure all diagnosis and procedure codes are supported by documentation in the medical record, resulting in appropriate DRG assignment prior to bill drop.

In the clinical validation review, CDI specialists look for clinical indicators that support the diagnosis and procedure. They generate queries when a diagnosis or procedure is not supported in the medical record and, once again, make sure proper codes have been assigned.

The chief medical officers (CMO) at Catholic Health Services support the CDI team, acting as physician champions and keeping the medical staff at each facility engaged in the CDI program and compliant with CDI requests. Their support was the first step in expanding to more complex reviews, La Rosa says, adding that the CMOs review charts, outstanding physician query reports, and quality metrics with the CDI team on a weekly basis. In addition, the CDI directors can request impromptu meetings with their CMO counterparts.

While many programs may not have the level of support that La Rosa’s does, everyone can rally physician support by exploring how such efforts positively affect the physicians themselves and adjusting query efforts with that in mind. In fact, clinical validation–focused reviews also help with pay-for-performance and quality measures, she suggests.

If a claim gets denied, La Rosa says her team “RACs them back,” appealing as many times as necessary. The staff performs a second
New York system shows denials management success

Here is an example where Catholic Health Services of Long Island, a six-hospital network, successfully appealed a denied claim by presenting thorough and accurate records, says Adelaide La Rosa, RN, BSN, CCDS, its corporate director for HIM, CDI, and clinical data management.

Excisional debridement

The issue was whether the beneficiary had an excisional debridement of her scalp wounds. The type of debridement was the key determinant of whether the beneficiary’s hospital stay met the criteria for the DRG listed on the claim. La Rosa’s office felt confident the documentation supported medical necessity. Their case was brought before a U.S. Administrative Law Judge (ALJ), who rendered on the following facts:

- The beneficiary was admitted with an “extensive second-degree burn” on her scalp.
- The appeal file contained a “Report of Consultation” that described the performed procedure as follows: “Wounds … debrided, cauterized, and smeared with Bacitracin.”
- The appeal file contained “Patient Progress Notes” that indicated “Multiple scalp wounds … debrided, cauterized …”
- The debridement procedures were code 86.22, excisional debridement of wound, infection, or burn. Removal by excision of: devitalized tissue, necrosis, and slough.
- The auditor revised the procedure code for the debridement procedures to 86.28, non-excisional debridement of wound, infection, or burn. Debridement, not otherwise specified. The change in the type of debridement resulted in a change in the DRG.
- The appeal file contained a discharge summary, which indicates the procedures performed include “excisional debridement of wound by …”
- The appeal file contained correspondence that indicated the treatments performed throughout the hospital stay, including excisional debridement.

The Recovery Auditor felt the clinical indicators did not support the diagnosis, and “excisional” was not used explicitly enough in the report or procedure notes. But La Rosa and her team proved the term “excisional” was used throughout the record. Based on these findings, the ALJ ruled in their favor, stating “the documentation of the beneficiary’s admission to an inpatient stay at their facility … and related evidence and testimony support that she underwent excisional debridement procedures of her scalp wounds by her treating physician.” The Recovery Auditor was directed to process the claim in accordance with the decision.

Appeals take time—sometimes up to a year—before a final decision is made. CDI departments must stay strong and learn from denials, La Rosa says. Foundationally, CDI specialists should ensure the clinical indicators support the principal and secondary diagnoses and procedures before the claim is submitted. They should be confident that the documentation provided supports the billing. If a claim is denied, La Rosa suggests meeting as a team to review and decide how to respond. Sometimes that means learning from mistakes, but overall it will help facilities defend future claims and prevent costly denials. 🌟