# 2019 IP Auditing Results & Moving into 2020 Q&A

## July 16, 2020
## Webinar FAQ Document

1. **Question** – Thank you so much for the presentation! My facility is seeing a lot of audits on newborns. For example, when the presence of meconium is documented, several payers are now denying P96.83

   **Answer** – Thanks so much for your feedback, it is definitely appreciated. Vitalware has not seen a correlation with denials for this specific code as of yet, but we are currently seeing facilities receiving denials for claims with secondary diagnoses codes from the Newborn section affected by maternal factors and by complications of pregnancy, labor, and delivery (P00 - P04). In the tabular section of ICD-10-CM, under Newborn affected by maternal factors and by complications of pregnancy, labor, and delivery (P00 - P04), Note: These codes are for use when the listed maternal conditions are specified as the cause of confirmed morbidity or potential morbidity which have their origin in the perinatal period (before birth through the first 28 days after birth).

2. **Question** – What is the coding clinic that address the consistent documentation of a diagnosis (i.e., sepsis), that cannot be omitted by the coder due to the lack of clinical validation. It is recommended that there should be a query generated.

   **Answer** – The Coding Clinic you reference appears to be one from Fourth Quarter, 2016, labeled *Clinical Criteria and Code Assignment*[1]. This Coding Clinic was referenced in slides 40-41 of our presentation and will be sent out with your CEU certificate. We do not see notation, however, about a clarification/query to be sent within this Coding Clinic, but as always, it is wise if the documentation is ambiguous or needs further clarification that a coder use their professional judgment to determine if a query should be sent for further insight. For your convenience, we have listed the Coding Clinic below:

   > Question: Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." Some people are interpreting this to mean that clinical documentation improvement (CDI) specialists should no longer question diagnostic statements that don't meet clinical criteria. Is this true?
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   > Answer: Coding must be based on provider documentation. This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. Coding Clinic and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in Coding Clinic over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose"

[1] American Hospital Association. (2016). *Clinical Criteria and Code Assignment*. American Hospital Association.

the patient. As also stated in Coding Clinic in the past, clinical information published in Coding Clinic does not constitute clinical criteria for establishing a diagnosis, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition.

The guideline noted addresses coding, not clinical validation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill. The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief ("Clinical Validation: The Next Level of CDI") published in the August issue of JAHIMA: "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. 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 may be performed by a clinician with approved coding credentials."

While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria. In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same - as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded. For example, if the physician documents sepsis and the coder assign the code for sepsis, and a clinical validation reviewer later disagrees with the physician's diagnosis, that is a clinical issue, but it is not a coding error. By the same token, coders shouldn't be coding sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria. A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.