Compliance Matters: Data Validation for Quality Reporting

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Objectives

At the end of the presentation the participants will be able to

- Describe how data is collected for external quality reporting
- Describe the importance of data validation for external quality reporting
- List three professional / regulatory standards that protect data integrity
Types of Measures in Current Quality Programs

- Chart Abstracted Clinical Measures - CMS Data Warehouse
- Chart Abstracted HAI Measures - NHSN Database
- Patient Satisfaction Measures - Survey-HCAHPS
- Claims- Based Measures - Medicare Claims Database
- Structural Measures - CMS Data Warehouse

Chart Abstracted Measures

**How quality measure performance in the IQR program is determined**

1. Chart Abstracted Measures Data Collection & Reporting
   1. Data abstractors review chart in detail.
   2. Data abstractors abstract data using CMS specifications.
   3. Data is reported to CMS in the form, manner and timeframe specified by CMS.
   4. Hospitals attest annually that the data submitted is complete and accurate.

**How quality measure performance is validated**

1. CMS selects a group of hospitals each year by random or targeted selection for data validation.
2. Edaptive Systems LLC is the agency that conducts the data validation.
3. Facilities are sent a random list of cases each quarter.
4. Facilities send their case level details to Edaptive each quarter.
5. Edaptive reabstract the same cases to determine if abstraction results can be reproduced.
6. Threshold of reliability required to pass validation.
7. Hospital that fail validation lose their annual payment update and cannot participate in HVBP program.
Claims-Based Measures

1. Patient admitted to the inpatient setting
2. Care provided
3. Care documented by many providers
4. Patient discharged
5. Chart coded

How quality measure performance is validated
1. There is no external validation of the specific administrative data elements that compose these claims-based measures.
2. The facility based process of secondary review of cases flagged for quality measures is guided by ethical and professional standards of organizations like AHIMA, ACDIS and CMS regulations.
3. There is no formal, external auditing to ensure that these standards are being consistently followed.

CMS publicly reports this data

CMS uses some of this data in value-based programs

Private payers use some of these data in their own performance scorecards

Independent third-party organizations use some of these data to create and post hospital rankings and grades for quality and safety
Why Data Validation is Important

REPUTATION  REIMBURSEMENT

Why Data Validation is Important

DATA
DATA

INFORMATION

Right Decision
Wrong Decision

Yes
No
Data Drives Performance Improvement

Identify Opportunity

Prioritize

Continuous Improvement Cycle

Decisive Action

Planning & Scheduling

Analysis & Understanding

Root Cause & Fixing

Good Data

Data Validation

Improve Data Quality

- Data Validity: degree to which the data conforms to defined business rules
- Data Accuracy: degree of conformity of a measure to a standard or true value
- Data Completeness

Improve Performance Measurement

- Measure Reliability: degree to which an assessment tool produces stable and consistent results.
- Measure Validity: how well a test measures what it is purported to measure.
Validating Chart Abstracted Measures

NUMERATOR documentation

PERFORMANCE RATE (%)

DENOMINATOR Coding (& documentation)

ADMISSION STATUS: INPATIENT, OUTPATIENT, ETC.

Impact of Data Validation on Performance Rates

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Compliance & Professional Standards

- Medicare Conditions of Participation*
- Compliant Physician Query*
- Specification Manual for National Hospital Inpatient Quality Measures-Version 4.4a- Introduction to Data Dictionary, page 4*

*Discussed later in presentation

Claims-Based Measures

- A Medicare Claim is defined as a request for payment for benefits or services received by a beneficiary.
- Paper Claim- CMS-1450 Claim Form (aka UB 04)
- Electronic Claim- ASC X12N 8371 Version 5010A2
- Different data fields (not complete list)
  - Admission Type
  - Discharge Status
  - Diagnosis Code(s) and Procedure Code(s)
Validating Claims-Based Measures

- Flag cases for a measure e.g. PSI
- Identify the claims data fields that place the case in the denominator and/ or numerator for the measure
- Validate the assignment of the admit type (PSI 4,10,11,13)
- Validate assignment of the code(s)
- Send case for Coding Review as needed
- If codes re-assigned, update all internal records
- Case needs to be re-billed to update payer database

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Example: Validating a case for PSI-11

PSI-11: Post-Op Respiratory Failure
- Admission Type: **Elective**
- DEN: Age 18 and older surgical discharge as defined by having at least one Operating Room ICD procedure code assigned.
- NUM: Diagnosis Codes
  - ICD 9
    - **518.51** Acute Respiratory Failure Following Trauma and Surgery
    - **518.83** Acute on Chronic Respiratory Failure Following Trauma or Surgery
  - ICD 10
    - **J95.821** Acute Postprocedural Respiratory Failure
    - **J95.822** Acute on Chronic Acute Postprocedural Respiratory Failure
Example: Validating a case for PSI-11

NUM: Procedure Codes

**ICD 9**

- **96.71** Mechanical Vent Less than 96 hours (two or more days after first major OR procedure)
- **96.72** Mechanical Vent Greater than 96 hours (zero or more days after first major OR procedure)
- **96.04** Insertion of Endotracheal Tube (one or more days after first major OR procedure)

**ICD 10**

- **5A1945Z** Mechanical Vent Less than 96 hours (two or more days after first major OR procedure)
- **5A1955Z** Mechanical Vent Greater than 96 hours (zero or more days after first major OR procedure)
- **0BH13EZ, 0BH17EZ, or 0BH18EZ** Insertion of Endotracheal Tube (one or more days after first major OR procedure)

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Example: Validating a case for PSI-11

- Is the Admission Type truly Elective?
  - If No, request review by Coding Department/Utilization Management

- Is their conflicting or unclear documentation related to one of the ICD-9/10 codes listed in the numerator?
  - If No, request CDI to send query

- Are all the ICD-9/10 codes listed in the numerator assigned appropriately per official and internal facility based coding guidelines?
  - If No, request review by Coding Department
Pre-Bill vs Post-Bill Validation

Pre-Bill Validation
- Validation & Changes done PRIOR to claim creation
- Data on payer claim is as accurate as possible when claim is created
- No need to rebill for quality purposes

Post-Bill Validation
- Validation of data elements done AFTER claim has been submitted
- Data on claim may be inaccurate for quality purposes
- Requires rebilling to update claims data in payer database

Compliance & Professional Standards

- Medicare Conditions of Participation*
- Compliant Physician Query*
- ICD-9 and ICD-10 Official Guidelines for Coding and Reporting*

*Discussed later in presentation
Claims-Based Data Validation

The Use of Claims-Based Data in Inpatient Public Reporting and Pay-for-Performance Programs: Is There Opportunity for Improvement?
Crews, Hazel R.; Chamness, Amy R.; Terry, Colin L.; Heft, Paul R. Less
Journal For Healthcare Quality, Post Author Corrections: April 09, 2016

- Surveyed NAHQ members who participated in PSI data validation process
- Self-report of PSI data validation practices
- Compared these to professional and regulatory standards

NAHQC Survey Question

The physicians are informed that the case has been flagged for a quality indicator when they are asked if they would like to amend the documentation.

- Usually
- Sometimes
- Rarely
- Never
- Don’t Know
When physicians are contacted for documentation amendments, they are instructed on how to word the amendment in the medical record.

- Usually
- Sometimes
- Rarely
- Never
- Don’t Know

NAHQ Survey Question Results
The time frame in which an amendment to the medical record can be made after discharge is

- No time limit specified
- One year after discharge
- Six months after discharge
- Three months after discharge
- Thirty days after discharge
- Don’t know
- Other- specify
Wide variation (how/when/ by whom) PSI data are validated

Inconsistency in education and training required of staff who participate in PSI data validation

Poor compliance with physician query guidelines

Poor compliance with documentation amendment standards
Amendments to the Medical Record

Medical Record Documentation
The intent of abstraction is to use only documentation that was part of the medical record during the hospitalization (is present upon discharge) and that is present at the time of abstraction. There are instances where an addendum or late entry is added after discharge. This late entry or addendum can be used, for abstraction purposes, as long as it has been added within 30 days of discharge, [Refer to the Medicare Conditions of Participation for Medical Records, 42CFR482.24(b)/42CFR482.24(c)(4)(viii)], unless otherwise specified in the data element. Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles (CMS “Medicare Program Integrity Manual” Chapter 3, Section 3.3.2.4):

- Clearly and permanently identify any amendments, corrections or addenda;
- Clearly indicate the date and author of any amendments, corrections, or addenda; and
- Clearly identify all original content.

It is not the intent to have documentation added at the time of abstraction to ensure the passing of a measure.

SOURCE: www.qualitynet.org
Specification Manual for National Hospital Inpatient Quality Measures-Version 4.4a-Introduction to Data Dictionary, page 4*

Amendments to the Medical Record

- Medicare CoP: Final diagnosis and completion of the medical record occur within 30 days of discharge (CMS, 2015c, §482.24).
- 2001: Allow use of physician query form to the extent that it provides clarification and is consistent with other medical record documentation.
- CMS deferred promulgation of specific guidelines to Health Information Management experts and organizations to address concerns about leading questions and introducing information not otherwise contained in the medical record.
What is a Physician Query

“A query is a communication tool used to clarify documentation in the health record for accurate code assignment. The desired outcome from a query is an update of a health record to better reflect a practitioner’s intent and clinical thought processes, documented in a manner that supports accurate code assignment.”


Compliant Physician Query
AHIMA Guidelines

A query is valid when the documentation meets one or more of the conditions listed below.

- It is conflicting, imprecise, incomplete, illegible, ambiguous, or inconsistent
- It describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
- It includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
- It provides a diagnosis without underlying clinical validation
- It is unclear for present on admission indicator assignment

Compliant Physician Query
AHIMA Guidelines

When appropriate includes relevant clinical indicators such as lab values and findings on diagnostic tests or procedures to support why further clarification is needed.

Uses one of the following formats
- Open-Ended- preferred format.
- Multiple choice-with all clinically significant options supported by clinical indicators as well as options for “clinically undetermined” and “other”
- Yes/No- in limited circumstance such as clarifying conflicting documentation from different providers or establishing Present on Admission (POA) status.

Non-Compliant (Leading) Physician Query

“A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure.”

A non compliant query includes the impact the response to the query will have on either reimbursement or quality reporting.

**AHIMA Recommendations**

- Effective query process is integral component of ensuring data integrity
- When a query should be initiated
- Entity have documentation or compliance policies to address situations like unnecessary queries, and leading or repetitive overuse of queries without measurable improvement in documentation
- Health care entities employ, educate and train qualified individuals to perform this process

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**AHIMA Recommendations**

- Hospitals, coders and clinical documentation specialists cannot lead health care providers with queries
- All professionals, irrespective of credentials, title or role, who are involved in the query process to adhere to these guidelines
Best Practices We Follow

- Pre Bill Review for PSI 90 measures and Post Bill for all others.

- Validation is performed by staff with training and experience in coding and compliant query process.

- Reference the Official ICD Coding Guidelines and any internal facility based coding guidelines when validating codes.

- Coding opportunities are sent to Coding Quality team for the final determination of whether a coding change is needed.

Best Practices We Follow

- Query opportunities are sent to Clinical Documentation Integrity (CDI) team who create, send and follow up on the query.

- Documentation trail is maintained for requests sent to Coding Quality and CDI.

- Decisions about corrections of claims and rebilling are determined by Revenue Cycle department.

- Decisions about status changes are determined by Utilization Management.
References


Common Healthcare Databases

- CMS Data Warehouse
- Medicare Claims Database
- National Healthcare Safety Network (NHSN)
- Private Payer Claims Databases
- State Health Departments
- Medicaid Database
- TJC ORYX
- Clinical Registries
  - NDNQI
  - NSQIP
  - ACC-NCDR
  - STS
  - GWTG: HF, STK, Resuscitation