Q&A

CDI and denials management

As part of the 10th annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics.

Lori Dellinger, BSN, RN, CCRN-K, CCDS, a CDI specialist at WellSpan Health Summit in Chambersburg, Pennsylvania, a member of the Central Pennsylvania chapter of ACDIS, and a member of the 2020 CDI Week Committee, answered these questions. Contact her at *Ldellinger3@wellspan.org.*

Q According to the 2020 CDI Week Industry Survey, 59.19% of respondents are currently involved in the denials management process. Is your CDI team involved in this process?

A Our CDI team is not currently involved directly in the denials process. But we were involved about two years ago when compliance asked us to assist with clinical validation denials on cases we reviewed during the inpatient visit. This changed when compliance added additional RN staff to be used for the clinical review. I do continue to assist the auditors on clinical validation questions and other documentation questions when asked, though.

Q When did the CDI team first get involved? How have you seen the denials landscape/trends change over time during that involvement?

A We first became involved about five years into our CDI program implementation. That seemed to be the time when [*Official Guidelines for Coding and Reporting*] Section I.A. Convention 19, Code Assignment and Clinical Criteria, became the "hot topic" for denials. Our role in supporting the providers' statement with clinical validation was the focus of our involvement in the denial process at that time.

I think the denial process has become more about picking and choosing clinical indicators to support nonpayment rather than following coding guidelines as they are written today. It would appear each payer has their own set of criteria regardless of what the provider documents or what may be clinically supported in the medical record.

Q Does your CDI team help with all types of denials, or just a particular subset? How did you decide where to help out?

A Most of the denials we cover are clinical validation. On occasion, however, I have also assisted with ICD-10-PCS denials and coding errors.

The initial discussion on helping with denials centered around our clinical comfort level and the cases we reviewed. If compliance asked us to review a chart, we would focus on what we were comfortable with using the existing documentation. If we were asked to review

a chart, say from pediatrics or obstetrics, and were not comfortable due to our lack of clinical experience, we would inform the auditor and refer the case back to someone more clinically experienced if possible.

Q According to the Industry Survey, the largest group of respondents (38.2%) said the majority of their denials originate from private payers. Does it surprise you that private payers seem to be surpassing Medicare as the biggest group denying claims? Why or why not?

A No, it does not surprise me. CMS is one of the Cooperating Parties that develop the coding guidelines, and they are clear in their stance that they do not determine clinical indicators for a diagnosis code. That is the responsibility of the provider.

Technically, the private payers follow CMS in their payment practices, but I have seen that private payer denials often use clinical criteria to support nonpayment that is in direct contradiction of CMS guidelines. That is not to say they are incorrect since often CMS guidelines take a while to catch up to current medical practice terminology. But it does make the denial defense process more challenging.

Also, unless private payer contracts include clinical indicators for certain diagnoses at each institution (which is time consuming and not always part of the negotiation), the review of the documentation is wide open for any interpretation of what is needed to support the diagnosis, making denials easier for private payers to pick and choose.

Q What types of diagnoses do you see more frequently denied? How have you worked to fight against these denials?

A Sepsis, malnutrition, hyponatremia, and acute kidney injury tend to be our most frequent denials. Reviewing charts looking for clinical criteria and treatment to support the diagnosis has been our biggest defense in addition to provider education.

With sepsis, since many payers are either using Sepsis-2 or Sepsis-3 criteria, and because CMS is still using systemic inflammatory response syndrome criteria/provider statement that a condition exists, it has made denial defense challenging. Our focus is to demonstrate the dysregulated host response in the denial process to support the sepsis diagnosis. This could be the tachycardia, tachypnea, elevated white blood cell count that does not respond to fluid resuscitation, along with the organ dysfunction demonstrating the patient's inability to bounce back from a simple infection. You must dig deep into the documentation to support the patient's response or inability to respond appropriately in the sepsis diagnosis.

As for malnutrition, most of the denials come from lack of treatment, according to the payer; severe malnutrition needs total parenteral nutrition, per certain payers. That is not necessarily the case, and each patient's treatment plan should be individualized. The clinical indicators of a body mass index of 15, intake of 25% to 50%, skin breakdown, cachexia, weakness and a nutrition consult with Megace®, nutritional supplementation, may be all the patient can tolerate at that point in time. We strive to demonstrate the effects of the malnutrition on the patient's condition, again digging deep into the documentation to support the diagnosis.

Hyponatremia and acute kidney injury denials also focus on treatment and baseline. It is well documented in the industry that hyponatremia can have adverse effects on a patient's overall severity of illness and risk of mortality depending on the underlying cause. We bring in supporting evidence of the adverse effects of hyponatremia as well as the treatment and supporting evidence of the effects of the hyponatremia and the need for the treatment even if it is just IV fluid and serial labs. Following the guideline of a secondary diagnosis—clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, or increased nursing care and monitoring—all help to support an appeal. As for acute kidney injury, the evidence of possible dehydration, change in creatinine and urine output from the baseline sometimes is hard to defend retrospectively.

We strive to be especially observant when reviewing charts that have these diagnoses and make sure we clarify before discharge regarding the treatment and clinical indicators that are lacking in order to support the provider's documentation. Being proactive and making sure providers are aware of what and why denials happen is just as important as writing an appeal.

Q What other departments or groups does CDI collaborate with on the denials management and appeals process? In what capacity do they collaborate (e.g., through monthly meetings, during the appeal writing process, etc.)?

A Our denials are handled by our compliance auditors. We will work with them in this process. If asked to review a chart, we offer our clinical evaluation of the medical record, supporting documentation found, and any clinical support for the effects on the patient of the diagnosis in question. This can include nursing notes, nutrition notes, physical therapy, etc. Even though coders cannot use these notes to support all diagnosis codes, these notes can be used to support clinical criteria and effects of a diagnosis on a patient during the appeal process.

Our compliance auditors also provide a report at least biweekly on our current denials. The report includes denials won, denials lost, and denials not appealed and why. This provides us with information as to what is being denied and why and offers education as to what was missed due to coding error, missing clinical indicators per the payer, missing treatment, as well as medical necessity support.

Q According to the Industry Survey, nearly 41% of respondents' CDI departments are not involved in the denials management process. Why do you think it's important for CDI to be involved?

A Denials management and CDI go hand in hand. The auditing process of denials shows where the integrity of documentation was lost. When not defended, a denial can be an expensive proposition for the institution. The role of the CDI professional is to facilitate documentation integrity within the medical record. The CDI professional has a direct link to the provider's documentation; having CDI involved in the denial process would enable communication with the provider as to what is being denied and why and how to improve their documentation. The providers should have this information since this impacts their performance scores and reimbursement as well.

The CDI specialists, because of the work they do in chart review, could also serve as an excellent source in the appeal process to weed out those hidden criteria that would support a diagnosis being denied. If denials occur and CDI specialists are unaware of why, or what a payer is finding that could be corrected through improved documentation, the institution will lose reimbursement and the same mistakes will happen repeatedly.

CDI should learn from the denial management staff, review what and why cases are being denied before jumping in to defend. If you are looking to get involved or ramp up your current involvement in denials management, start slow, review different payer denials, look for comparisons on what is being denied and why. Once you have an appreciation for what is being denied, work with the providers to improve their documentation to support those high-risk diagnoses.

Q What can CDI professionals do on the front end to prevent denials on the back end? What can they do even if they don't work directly with the denials management/appeals process?

A CDI professionals should be proactive when they review any medical record. Do not just look for single CCs or MCCs, but look for multiple CCs or MCCs to support the severity of illness and risk of mortality. Also search for missing documentation that may be needed to strongly support a diagnosis that is already documented. If it is missing, clarify for additional indicators to be noted by the provider. This is not to challenge the provider's opinion, but to strengthen the integrity of the documentation. If the indicators are not there, then the diagnosis documented should change to support the indicators. CDI professionals should know what is being denied and why. This knowledge provides them ammunition to take to the provider and reinforce why the integrity of their documentation is so important.

Stay informed through ACDIS, reviewing any literature pertaining to denial trends. The ACDIS website is an excellent resource for this information. Then, be proactive and speak to providers about their documentation and why it is so important to be accurate and consistent. Review the medical record with an investigative eye and look for what's missing that could be a reason to prompt a denial, then query for what is missing.

CDI and denial management

by Anne Robertucci, MS, RHIA, and Krystal Haynes, RHIA, CCS, CDIP

CDI professionals, by nature of their daily duties, are uniquely positioned to aid in denial prevention. CDI specialists possess deep clinical understanding, record review savvy, and knowledge of coding and reimbursement, all of which can help support retrospective appeal efforts.

However, their value to denial management isn't limited to retrospective support. Hospitals can leverage them to proactively avoid denials. CDI specialists possess heightened detective skills when it comes to documentation discrepancies and are already engaged in record review at the point of care. By expanding CDI efforts to watch for common denial causes, hospitals can leverage the query process in its denial prevention efforts. This subtle shift of CDI responsibility can reduce rework costs downstream and protect reimbursement.

CDI leaders need a seat at the table when negotiating payer contracts. Not only do CDI professionals possess an intimate knowledge of organizational policies and clinical guidelines, but they also understand the varying payer clinical criteria used in the denial process.

Additional resource allocation

Shifting the focus of CDI to include denials prevention will naturally require some resource adjustments. First, hospitals need to educate CDI staff about the complexity of clinical validation and the kinds of deficiencies that lead to denials.

Education should also cover the policies that govern the clinical validation query process, as explored in the 2019 ACDIS/AHIMA "Guidelines for Achieving a Compliant Query Practice" brief. Allocate sufficient time to ensure your staff understands these concepts thoroughly before having them conduct reviews for denials prevention.

Secondly, clinical validation reviews for denial prevention will take more time than traditional reviews. CDI specialists will be interrogating the documentation not only to determine whether the physician documented a diagnosis, but also whether the diagnosis can be supported by the clinical evidence contained in the medical record. Hiring additional resources or leveraging technology that increases efficiency can help to mitigate this pressure.

Increased complexity of each review may reduce individual staff productivity metrics. For some CDI teams, delegating one staff member as the denialsmanagement lead who handles all clinical validation reviews may mitigate this decreased chart review productivity for the rest of the department.

Data analysis and return on investment

Because much of CDI programs' work is preventive, it may not have the same obvious return on investment as traditional chart reviews. However, proactively preventing the denial helps hospitals preserve the reimbursement they're owed and saves them the hefty reworking cost of appeal on the back end.

Prior to expanding, leaders should open cross-departmental lines of communication and ask the denial management team for the current denial rates and appeal overturn rates. Tracking the effect CDI has

on these metrics will help to determine the value the CDI review process brings to the table.

Additionally, the positive impact shown through decreased denial rates and increased overturn rates may justify additional CDI resource allocations.

Denial management and technology

Technology will never replace CDI staff, but the proper technology can greatly improve the efficiency of your staff. High-functioning technological solutions can identify those cases at the highest risk for denial and advance them to the front of CDI professionals' work queues. Spared of the need to hunt down these cases, CDI specialists can instead spend their time conducting reviews and strengthening records against denials. By improving efficiency, technology can allow the same staff resources to review many more cases. In some circumstances, technology can even fully compensate for the additional workload of adding outpatient CDI without requiring additional resources.

When evaluating an existing or potential CDI technology vendor, ask probing questions. Understand how their software automates the process of identifying cases at risk for denial during the CDI record review process. The most effective natural language processing technologies use artificial intelligence to think clinically and make connections through sophisticated algorithms. Without this clinical intelligence, technology can provide only a marginal benefit.

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