



Denial trends and CDI involvement

As part of the twelfth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Ashley Wells, MN, RN, CMSRN, CCDS**, is a CDI specialist III at Methodist Health System in Dallas, Texas. She is a member of the Texas ACDIS chapter and the 2022 Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Associate Editor Jess Fluegel (jfluegel@acdis.org).



Q Nearly 68% of 2022 CDI Week Industry Survey respondents are currently involved in the denials management or appeals process, up nearly 10% from the last time this topic was covered in the CDI Week Industry Survey in 2020 (59%). Why do you think this percentage has jumped over the last two years? Do you think the COVID-19-related financial implications had an impact?

A I think the percentage has jumped because of the unprecedented challenges and hurdles of this pandemic. The ripple effect of emerging and rapidly changing information and treatment modalities led to increased workloads for all those involved, global supply chain issues at times adversely affected the quality, and timeliness of care definitely impacted denials!

An example is the “new documentation” that our providers had to do during this time. At the start of the pandemic, providers felt the pressure to paint a vivid, yet cautious clinical picture as new treatments, procedures, and manifestations emerged. As a result, I believe there were widespread documentation omissions or gaps. The acuity and complexity of the patients they were treating in front of them as well as competing time management practices due to staffing shortages and the patient volumes may have resulted in missed secondary

diagnoses or additional supporting findings that they otherwise would be documenting routinely.

Q How is your CDI team involved with denials? Is it informally on a case-by-case basis, directly helping appeal letters, or something else in between? Who on your team is involved with denials management and/or appeals?

A While I am the designated team member who works on clinical validation appeals, I would be remiss if I didn’t give a shoutout to my team! So many moving parts and a “trickle effect” of all the work we do with each other and for the providers, as well as other key departments. Our team has different levels of CDI specialists—I, II, and IIIs—where each job role has different integral responsibilities. The reviews, the provider and staff education, the queries, the different clinical backgrounds, and varying involvements in quality projects and interdisciplinary work truly help with denials management proactively and even retrospectively.

Q According to respondents, 30.22% 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? Does this mirror your experience?

A I am not surprised that private payer denials are surpassing Medicare. CMS requires a level of transparency in data reported that private payers may not have to oblige. Payers can manipulate diagnostic criteria and journal articles to their advantage to deny a diagnosis.

This survey result definitely mirrors my experience too. The references that these payers cite in their denial rationale definitely can make you furrow your brow from the blatant manipulation of research articles or omission of medical record findings.

Q **Nearly 70% of respondents reported that sepsis is one of their top denied diagnoses, followed by 52.52% who said respiratory failure was in their top list. Why do you think these two diagnoses pose such a denial risk? What types of diagnoses do you see most frequently denied? How have you worked to fight against those denials?**

A Our team works on fighting sepsis denials through ongoing educational sessions with providers and query practices. Our focus isn't on getting providers to use the clinical definition that payers use (e.g., Sepsis-3), but rather we work on educating and querying providers on optimal documentation practices (source, present on admission [POA] status, clinical indicators, and if it's actually severe sepsis). We emphasize the need that they "paint the full clinical picture" in their documentation.

Diagnoses that I see most frequently denied are ones I assume are typical at other facilities: severe malnutrition, acute metabolic encephalopathy, and acute tubular necrosis.

Our team works against these denials through a multiprong approach: provider education, coder collaboration, and staff discussion/education at a minimum.

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

A Our team collaborates and has ongoing dialogue with our coding staff. During our reconciliation process, the CDI specialists review coding to ensure

query responses, risk-adjusting conditions, reportable conditions, and POA statuses are accurately reflected and captured in the coding. If there are any discrepancies, the coders or CDI specialists have no problem reaching out to one another to problem solve and discuss that code set until a resolution is agreed upon. This is another defense mechanism against potential denials on the pre-bill end.

Retrospectively, we collaborate with providers, coders, and the quality department to share denial case studies or overturns.

Q **The most common denial mitigation tactic was clinically validating high-risk diagnoses concurrently (46.88%), followed by reviewing denials on a case-by-case basis upon request (39.24%). What methods do you think are most effective and the best use of CDI time? If a CDI team doesn't have access to denial volumes, how can they effectively choose a focus area?**

A I definitely agree with the survey results that the best use of CDI time involves clinically validating high-risk diagnoses in real time. Time can be of the essence in not only clarifying problematic documentation, but also seizing an opportune moment to educate those you are querying. The efficacy of those collaborative dialogues and educational tidbits lessens over time when you put distance (and many more patients!) between you, the provider, and the coder.

If a CDI team doesn't have access to denial volumes, a couple strategies I think would be helpful that I've used personally would be analyzing query trends and data from your facility and comparing it with industry statistics to create an action plan. Read the industry trends from ACDIS and other healthcare industry leaders related to CDI/coding/revenue cycle. An example for this is seeing that at one of our campuses, CDI specialists were querying for clinical validity of acute respiratory failure more frequently than previous months. Studying the nature of the queries (and the documentation that resulted from the queries) coupled with that industry knowledge that this is a frequently denied diagnosis, it can help us streamline some educational efforts and provider conversations regarding this diagnosis.

Q How do you measure the success of CDI's involvement with this process? What metrics do you track, and how are you tracking them?

A Some of the metrics I report to my CDI director include how many clinical validation reviews were done, how many of those reviews resulted in us agreeing with the auditor, how many appeals we submitted at the first, second, third levels, and overturns.

As the team member handling denials and being involved in educational efforts within the department for staff and providers, I personally measure the collective

success of the CDI department by the query reports I run for provider education. That is an educational gold mine for me! It shows me diagnoses that our team sent clinical validation queries on, if there is an uptick in certain diagnosis queries (e.g., COVID-related queries during surges), as well as how providers are responding and agreeing to our clarification requests. When I'm reviewing denials, out of habit I check to see if a CDI specialist reviewed the account. I reach out to the CDI specialist to get feedback on the account or to give kudos on sending a clinical validation query, even if the provider disagreed with their query.