

# Q&A

## CDI and denials management



As part of the ninth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Janie Brown, RN, CCDS, who is the director of clinical documentation accuracy at Community Health Network in Indianapolis, Indiana, a member of the Indiana ACDIS chapter, and of the 2019 CDI Week Committee, answered these questions. Contact her at [jbrown5@community.com](mailto:jbrown5@community.com).

For more information about denials management, read the [2019 CDI Week Industry Overview Survey Report](#) today.

### **Q** According to the 2019 CDI Week Industry Survey, 56.51% of respondents are currently involved in the denials management or appeals process. Is your CDI team involved in this process? When did they first get involved?

**A** Our team first became involved with denials management on an informal basis. The denials coordinator at that time reported up through health information management (HIM), and she would reach out to a CDI staff person if she needed clinical eyes on the record. Often, we could mine the record and come up with additional data points to support an appeal. Our physician advisor also helped in this effort and continues to be involved in writing appeals.

Over time, it made sense for denials pertaining strictly to coding errors to be routed to coding and clinical validation denials to be routed to CDI. The volume of denials varies widely from month to month, so it was difficult to predict what the workload was going to be. We now have a denials team that reports up through care management, and they handle the routing of the denials and the writing of the appeal letters. They continue to reach out to coding and CDI if they need an additional look

at the record. The denials team also attends our coding/CDI bimonthly meetings with updates on denials trends. This information is also provided in our monthly utilization review meeting. When trends are identified, we take a deeper dive into those records to identify strategies to avoid future denials.

### **Q** Who on the CDI team is involved with the denials management/appeals process? Do you have a dedicated team member?

**A** I was the designated team member who worked on clinical denials, and when I took on the director role, I continued to hang onto that until our denials team was able to take it on. Overall, I think managing denials is an area where there can be a lot of balls in the air. There can be denials coming in from multiple sources, and it's helpful to have someone serve in a coordinator role as the keeper of all knowledge as to where the denial came from, how it's routed, and most importantly closing the loop and making sure the denial is addressed and deadlines are met. As long as one person is responsible for those details, I think putting many heads together can be beneficial in fighting denials.

**Q How long have you been involved with the denials management/appeals process? How have you seen the denials landscape change over that time period?**

**A** I have been involved for about five or six years now. I think from a clinical perspective I've seen payers start to deny multiple CCs or MCCs on a record—anything to take the DRG down a level. I've also seen the advent at our institution of severity of illness (SOI)/risk of mortality (ROM) denials that are associated with repayment.

Another evolution is the extremely fluid nature of the criteria used to deny a diagnosis. If we met Sepsis-2 criteria, then the payer will deny it based on Sepsis-3. Acidosis used to be a no-brainer CC until payers started denying based on anion gap. We have learned to really do our homework before including a diagnosis on the record and make sure that clinical support is airtight. Clinical validity queries really help with this.

As we reviewed the inpatient prospective payment system (IPPS) proposed rule changes for this year, I'm wondering how we define homelessness, for instance. Though the additional codes for homelessness, etc. ultimately weren't implemented, it seems that payers focus on trends and will deny a diagnosis over and over again for a while and then move on to the next thing. I think we need to be cautious with the few opportunities for movement we may see in the future and be sure the support is there for those diagnoses.

**Q What types of diagnoses do you see most frequently denied? How have you worked to fight against those denials?**

**A** I think we see the same ones that seem typical at other facilities: sepsis, acute respiratory failure, severe malnutrition. We have worked with our physician advisor to develop internal guidelines around malnutrition (using ASPEN criteria) and acute respiratory failure. We included physicians, coding, CDI, dietitians, respiratory therapists on the appropriate committees to be sure we were covering all our bases. We use the clinical guidelines to help inform our query process as well as using them as tools for provider education.

Our CDI specialists and coders work together pre-bill to make sure that these high-denial diagnoses are supported. We also have a work queue for sepsis cases that have not been reviewed by a CDI specialist. If unspecified sepsis is going to be used as the primary diagnosis and there isn't a CDI review on the record, the case will come back into the work queue for review prior to coding and billing. This provides an opportunity for a retrospective clinical validity query if appropriate. As we're reviewing about 90% of inpatient records, the cases that typically wind up in this queue are shorter length of stays on which sepsis may not be supported—either that or they are mortality charts, in which case we verify that SOI/ROM levels.

**Q What other 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** The denials team loops us in as needed. We work with coding, as mentioned earlier, on individual cases and through bimonthly meetings which the denials team attends. We discuss denials with care management during monthly utilization review meetings. We inform providers of frequently denied diagnoses and educate on clinical indicators to support them.

We are embarking on a collaboration with quality also. Collaborating with nursing is going to be very important as we address the opportunities around skin and wound documentation after the October 1 changes take effect. We've also looped in respiratory and dietitians in formulating internal guidelines. I would be very remiss if I did not mention our internal audit team. They often point out areas that could turn into an issue denials-wise and help us to address them before they become a problem.

**Q According to the Industry Survey, 23.71% of respondents have been involved in the denials management process for less than a year. What would you recommend to them as they ramp up their involvement? Is there anything you wish you'd known when you started out?**

**A** I wish I would have known to take the emotion out of it. I can remember being outraged, often on behalf of the patient, when I would see a payer attempting to take a really critical diagnosis off a claim when it was clearly monitored, evaluated, and treated.

Now, I really view that anger as wasted energy. To paraphrase Jesus, “Denials will always be with us.” It’s not up to me to question payer ethics. Our CDI program expanded greatly 10 years ago, and during that time we’ve been diligent in our efforts to send out a record that accurately depicts the patient encounter. If we do receive a denial, we know that we acted in good faith and we placed that diagnosis on the record according to our understanding of that diagnosis at that time.

That’s another thing I would include in the evolution of denials: I have looked back at records from two years ago and thought that if we had reviewed that same record today, we would have gone after more clinical support. But hindsight’s 20/20, so you can’t beat yourself up about those types of misses.

**Q We’ve heard of CDI teams being involved in the payer contracting process to ensure they know all the requirements and clinical indicators set by the payer. Is this a practice you’ve been involved in? Why or why not?**

**A** We have just skirted around the edges of this, trying to look at different payers and making sure the documentation meets their requirements for a given diagnosis. First, the payers are not too eager to provide this information. Secondly, they can, and do, change their criteria at the drop of a hat so you can find yourself chasing your tail on these types of things pretty quickly. With a big diagnosis like sepsis, I think it’s worth looking at all the criteria available if you know a particular payer is looking for Sepsis-3. If you know the clinical criteria are there and you can get the physician to address Sequential Organ Failure Assessment scores, lactate levels, and procalcitonin, why not?

**Q How do you measure the success of CDI program involvement with this process? What metrics do you track, and how do you track them?**

**A** Several years ago, I did a provider education piece on the value of CDI and used that old credit

card ad campaign that mentioned the cost of various items and then summed up the total impact of your purchases as “priceless.” I equated our effect on denials as the “priceless” piece of our CDI efforts because it’s kind of difficult to prove a negative outcome.

Anecdotally, we’ve seen the volume of malnutrition denials drop since we implemented our malnutrition guidelines. It’s so hard to measure—did the payers move on to the next big thing or did we really effect change? Again, I must give a shout out to our internal audit team. They keep these things on their radar and revisit them after some time has gone by to see if we really have our hands around it. One metric that we did keep close track of was the volume of denials that we were reviewing and the diagnoses that were being denied. This helped to support additional full-time employees for the denials team.

**Q What effect has CDI had on the denials landscape at your organization?**

**A** I believe that our biggest effect has been raising awareness of denials overall. I think we’ve shouted from the rooftops that Medicare has a seven-year look-back period. I think we’ve educated the organization around the dangers of listening to vendors when they arrive on-site with a laundry list of MCCs that you can use to boost a surgical DRG to the highest level. I think we’ve advocated for the ethics of ensuring a complete and accurate record for the patient and raised the awareness that the data we generate is used for so many things beyond revenue.

**Q What would be your best piece of advice for writing an effective appeal letter?**

**A** Include as many data points as possible. I’ve heard speakers point out that including all the relevant points, not just one set of vital signs or labs, is helpful. I think that including length of stay information helps. If the patient’s stay lines up with the geometric mean length of stay information for the DRG that was billed, that supports that the DRG was correct. Including documentation from ancillary departments, not just providers, is also important.

**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** Just raising awareness is important, and since we are on-site with the providers, we have that opportunity to give informal education and open discussion in a more organic way.

**Q Can denials data be leveraged for physician education/engagement? If so, how?**

**A** Absolutely. Physicians may not always want to hear this info, and the way you approach them with that info is really important. The key is to avoid blaming them for the denials. I think helping them understand that the more they can share their thought process and concern for the patient, the more solid

the record becomes. We reference creating a “denial-proof” record. Presenting this as a team effort that involves all the services, CDI, coding, billing, and the denials team is helpful, too.

**Q For CDI teams looking to get involved in this process, what would you recommend to them as the best first step (e.g., reaching out to a particular person)?**

**A** Our involvement began by being open to assisting the denials coordinator when she needed help looking at a case from a clinical perspective. I would recommend just offering your assistance on an informal basis and see what develops out of that. Keep good records, though!

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### CDI program involvement

There's no doubt that CDI teams can dramatically influence denials prevention, particularly through documentation review at the point of care.

It's critical to address clinical validation concerns at the point of care in order to be on the preventive, proactive side of claim denials. CDI programs play an important role in identifying discrepancies up front and preventing downstream rework after a payer denies a claim. By that point, it's more difficult to clarify encounter details, particularly when the clinical indicators aren't syncing up with the provider's diagnosis.

We currently see CDI as having a seat at the denials management table in two ways. They're being invited to actively participate in denial roundtables and committees. We also see that many of our clients are starting to perform focused CDI reviews at the point of care for vulnerable diagnoses at risk for denial. This active involvement is much more effective at preventing denials than being called in on an ad-hoc basis.

In addition, CDI leadership should attempt to have a seat at the managed care contracts negotiation table. CDI leaders understand what clinical guidelines the payer is following. They can voice concerns when something doesn't support both national and organizational guidelines for certain clinical disease categories—before a contract is finalized. A CDI perspective is vital to ensure these critical concerns are appropriately addressed.

### Additional staffing and resources

It's difficult to take on greater involvement in these areas with fewer, or the same, resources. CDI teams are pushing the boundaries of their scope of practice with efforts to help reduce denials on the front end. It's challenging to expand the workload of a team already stretched to the limits.

Unfortunately, quantifying CDI productivity metrics isn't easy, and many organizations don't have concrete data available. Management needs to measure how long it takes for a traditional record review and determine how additional goals affect that productivity. They also need to identify how long it takes to create a solid case around a denial and gather data from the revenue cycle or HIM department on current denial volume. The CDI manager, in collaboration with these other department leaders, can determine how to help, and then make the argument for additional staff where needed.

### Leadership engagement and data analysis

To get actively involved in the denial prevention process, CDI leaders need to collaborate with their peers in revenue cycle and HIM to understand the current denial landscape. They can break down departmental silos when CDI and coding partner on denial prevention. CDI provides the initial picture of the complexity of the patient's illness, and coding finalizes the story. Both departments must work together toward the common goal of reducing denials and ensuring an accurate depiction of patient care.

Once CDI is engaged with denial discussions, it's time to start analyzing the data. Organizations may find that some cases are denied because the record didn't have a CDI review. They also may find cases where CDI was involved, but either didn't leave a query or stopped reviewing the record once it was DRG optimized.

Data may also show you are receiving denials due to lack of clinical validation support. For example, a doctor might state that a patient has sepsis, but the clinical indicators don't support that diagnosis. Frequently, CDI and coding professionals will hesitate to question the physician's medical opinion. In their eyes, this case contains coding that reflects the physician's diagnosis, but the clinical indicators were not there, and therefore, the case is at risk of denial. These types of concerns around clinical validation are really starting to change the game regarding what a CDI review should encompass.

Sometimes, concerns like these relate to organizational or programmatic policies. For example, some organizations worry that they're querying too

much and are self-limiting the number of queries. Let's face it; the physician burnout factor is huge, and CDI staff aren't the only ones bothering them.

### **Denials management and technology**

In our modern world, advanced technology is designed to address specific challenges. It can be leveraged to analyze documentation for clinical evidence or lack thereof and identify discrepancies or gaps for CDI review. Additionally, innovative technology offers ways to identify denial triggers early by using natural language processing (NLP) and artificial intelligence.

You're not going to be able to review all or most of your facility's record reviews without some help—and that's where advanced technology comes in. Using NLP-based technology to identify those cases at risk enables the CDI department to contribute significantly to front-end denial prevention. It focuses CDI reviews on the cases that can be improved and allows you to expand your program without increasing your staff.