The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 15th issue of the CA ACDIS journal!

September 2021 Index

Multidisciplinary Effort to Improve the Diagnosis of Malnutrition in Hospitalized Patients: An Interview with Authors Jennifer Quartarolo, MD and Byron Richard MS, RD, CDCES

Analyn Dolopo-Simon MPH, RN, ACM, CCDS

New guidelines published in the May 2012 Journal of the Academy of Nutrition and Dietetics represented a consensus statement of the American Academy of Nutrition and Dietetics (the Academy AND) and the American Society for Parental and Enteral Nutrition (ASPEN) provided characteristics recommended for the identification and documentation of adult malnutrition (undernutrition) [1].

The Academy and ASPEN state malnutrition should be diagnosed when providers identify at least two or more of the following six characteristics: insufficient energy intake, weight loss, loss of muscle mass, loss of subcutaneous fat, localized or generalized fluid accumulation that may sometimes mask weight loss and diminished functional status as measured by hand grip strength[1]. Laboratory data are not included in criteria for of 6 characteristics of malnutrition per AND/ASPEN.

This article will focus on interdepartmental collaboration, system wide efforts and achievements on new malnutrition guidelines, identification and documentation of malnutrition, as well as corresponding timelines and highlights from the paper by Dr. Quartarolo.

California acdis Official Local Chapter

Issue 15 September 2021

Administrative and coding data were used to obtain malnutrition diagnoses and the number of patients who had a test for serum prealbumin level ordered during the study period. The collaboration lead to increase of identification and diagnosis of malnutrition from 6% to 12% with sustained capture and serum prealbumin levels checked decreases from 13% to 8% over the study period resulting in cost savings[2]. As mentioned before, laboratory data is not included in AND/ASPEN Malnutrition Criteria. Laboratory studies, including serum prealbumin level, have been shown to have poor predictive value of malnutrition [2]. Prealbumin has been previously identified as one of the "Things we do for no reason" as part of the Society of Hospital Medicine's Choosing Wisely Campaign [3].

2013: A multidisciplinary collaboration between UCSD Physician Champions, Informational Technology, Registered Dietitians, Coding and Clinical Documentation was started to improve identification and diagnosis of malnutrition based on guidelines from AND/ASPEN on admitted patients at UCSD Health. UCSD Health is an 800 bed urban academic medical center. Before, UCSD Registered Dietitians (RD) used prioritization schedules and laboratory values[2].

CDI included new AND/ASPEN Criteria for Malnutrition in CDI Top Ten Tips Cards and included information into Medicine, Family Med and Surgery team inservices.

Creation of EMR Nutrition Malnutrition Patient Drop list was created with collaboration of Nutrition and CDI teams. Patients who were identified with Malnutrition by RD are dropped into list for concurrent queries to help decrease retrospective queries after patient was discharged. RD would notify treating teams of nutritional diagnosis. Coding and Clinical Documentation Specialists sent queries to the primary team when signs of malnutrition were noted but the diagnosis had not been documented in the medical record.

2015: The UCSD Nutrition Department, with institutional administrative support, joined the Malnutrition Quality Improvement Initiative (MQii) by Avalere and the AND Malnutrition Screening Tool (MST) was chosen to assist in screening criteria weight loss and oral intake questions that were embedded in the nursing screening form in the EMR, the question was asked in the first 24 hours of admission. Positive screens initiated "triggers" to staff via the electronic medical record (EMR) and these triggers were investigated by clinical staff, leading to a nutrition assessment and a malnutrition diagnosis in some cases [2].

The Nutrition Department adopted Nutrition-Focused Physical Exam/Assessment (NFPE/A) into its clinical practice and hands on education was provided to Registered Dietitians, Physician Champions, and CDI team. Coding, nursing and clinical teams were provided education by the Nutrition Department lead by Nutrition Manager Byron Richard in collaboration with CDI.

Video on NFPE created by UCSD Registered Dietitians was available to view:
https://vimeo.com/user16212450/review/221778734/8a51529764

2019: Collaboration with CMIO, IS, Dr. Quartarolo and Nutrition to create EMR Malnutrition Smartlink of RD Flowsheet to EMR DC summary. The collaborative efforts allowed a continued to improvement of capture of malnutrition conditions and per Vizient UCSD FY 18/19 capture was 13.4% improved from 8.6%. Malnutrition capture is now monitored on Tableau and current capture is 12.6%.

Outcomes

Per Dr. Quartarolo, a multidisciplinary approach to improving the diagnosis of malnutrition was effective and sustainable at UCSD. We noted a behavior change for providers in both the documentation of the condition and the decreased utilization of laboratory studies as part of their clinical diagnostic workup, thus avoiding unnecessary laboratory utilization and leading to potential cost savings [2].

The first step toward improving care for patients with malnutrition is recognizing this diagnosis. Inpatient providers are key to multidisciplinary efforts to improve the diagnosis of malnutrition. Now that a standardized methodology for the diagnosis of malnutrition has been accepted and widely disseminated, more research is needed to find what interventions have the greatest impact on patient outcomes both in inpatient and outpatient settings[2].

CDS Tips

- Understand the criteria of malnutrition by AND/ASPEN.
- Collaborate with your Nutrition Department and join a training workshop, if possible.
- Identify documentation improvement opportunities.
- Help disseminate information on Malnutrition to clinical teams.
- Many physicians and advanced practitioners are not aware of the Malnutrition criteria and look to the R.D. Professionals to provide resources and education

Enclosed is the ACDIS Podcast regarding this article with Brian Murphy Director, ACDIS

https://acdis.org/acdis-podcast/multidisciplinary-malnutrition-capture

Meet the Authors

Dr. Jennifer Quartarolo MD, SFHM
Clinical Professor, Division of Hospital Medicine
UCSD CDI Physician Advisor and CDI Program Director

Education: I attended medical school at Washington University in St. Louis and completed residency in Internal Medicine at Barnes-Jewish Hospital in St. Louis.

UCSD: I developed an interest in hospital-based medicine. I joined the faculty of UC San Diego Hospital Medicine in 2006.

I received additional quality improvement training through the Mini Advanced Training Program Course in Healthcare Delivery and Improvement at the Institute for Health Care Delivery and Research in Salt Lake City, Utah.

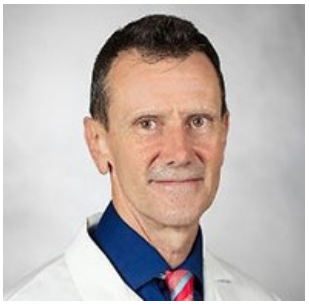
How did you become involved with CDI?

I have always been interested in working in multidisciplinary teams to improve the quality of care provided in the hospital. My work improving care transitions/the hospital discharge process gave me experience in some of the administrative and quality elements of hospital care. I enjoy CDI work, as I am able to collaborate with frontline providers, coders, clinical documentation staff, and hospital administrators to ensure that the excellent patient care being delivered in our hospital is accurately captured.

What inspired you to become involved in the malnutrition education, identification, and documentation and capture efforts at UCSD?

Malnutrition impacts many outcomes for patients- increasing their risk of infection, mortality, and readmission. It is therefore a highly weighted variable in risk-adjustment reimbursement models. Like any other disorder, the first step in treatment is making the diagnosis. I saw an opportunity to improve our rates of recognition, therefore eventually allowing us to intervene and improve outcomes for patients with malnutrition.

Over the past decade, The Choosing Wisely campaign initiative of the American Board of Internal Medicine (AIM) Foundation was created in order to promote discussions regarding unnecessary medical tests and procedures. The goal is to support quality, cost-conscious care. Prealbumin is a test that may be ordered unnecessarily, as it is not required to make a malnutrition diagnosis. So, our intervention allowed our organization to improve quality of care and save costs.



Meet the Authors

Byron Richard MS. RD. CDCES
UCSD Clinical Nutrition Manager

Education: Texas Tech University with MS Nutrition CNM

UCSD: I joined UCSD Health in 2014.

How you became involved in CDI? By default, and a wanting to keep up with our national organizations thinking.

What were the outcomes of the collaboration on malnutrition?

Establishing outpatient nutrition clinics for surgical oncology, cancer, colorectal surgery for new ostomy at Moore's Cancer Center. The Moore's Nutrition team have established many pathways and implemented screening measures for oncology areas, not necessarily ostomy alone or specifically. The nutrition screening process has taken on a life of its own and is an annual goal of oncology. The Nutrition team has seen more patients than ever and are working on multiple research projects.

In Early Recovery After Surgery (ERAS), along with the ERAS coordinator (Delee Glasser), the RDs has worked closely to deliver products to IP and OP providers and worked on education for patients.

UCSD NFPE Workshops, we are in our 6th year, this year and the last year the workshops were virtual. I think we had nearly 75 participants last year on the virtual platform.

What inspired you to become involved in the malnutrition education, identification, and documentation and capture efforts at UCSD?

This was the direction RDs needed to lead to become more involved in inpatient care.
We were looking for many metrics to show malnutrition diagnosis accuracy and other improvements. Cost savings was an aspect of improvement. For RDs, this is the direction to lead and persevere since it takes a village, to work with Hospitalists and coders as well as IT professionals to gain traction.

References:

1. New malnutrition criteria could help ensure consistent coding. Editor Andrea Kraynak, CPC . Just Coding News: Inpatient, July 18, 2012. http://www.hcpro.com/content.cfm?dp=HIM&content_id=282409#:~:text=The%20Academy%20and%20ASPEN%20state%20malnutrition%20should%20be,functional%20status%20as%20measured%20by%20hand%20grip%20strength

2. Multidisciplinary Effort to Improve the Diagnosis of Malnutrition in Hospitalized Patients. Jennifer Quartarolo MD, Analyn Dolopo, Byron Richard https://pubmed.ncbi.nlm.nih.gov/33821499/ Nutr Clin Pract. 2021 Apr 5. doi: 10.1002/ncp.10644. Online ahead of print

3. Things We Do for No Reason: Prealbumin Testing to Diagnosis Malnutrition in the Hospitalized Patient. Mary Lacy MD, Justin Roesch MD, Jens Langsjoen MD
J. Hosp. Med. 2019 April; 14(4):239-241. Published online first October 31, 2018 https://www.journalofhospitalmedicine.com/jhospmed/article/176616/hospital-medicine/things-we-do-no-reason-prealbumin-testing-diagnose

Change is Hard, but Collaboration is Better

California acdis Official Local Chapter

Thank you for your support!

Visit our Facebook and Instagram pages:

https://www.facebook.com/californiaacdis

https://www.instagram.com/california_acdis

Impact of Communication on Clinical Documentation Improvement

Ahmad Khan MS, MD, CDIP, CDS
UCSD Trauma/Burn Surgery CDS

Communication is the backbone of every business; it is not feasible to connect facets in a working process without communication needed for the work continuum. Communication can happen in different formats such as face-to-face, telephone, emails, letters, text messages, and voicemails. Sometimes, it depends on a job role which means of communication fit in a specific position. For example, the best way to talk to an operator then leave a phone message. On the other hand, a Clinical Documentation Specialist can interact with a provider through different formats such as emails, phone calls, and in-person regarding a query.

We can describe communication as a linear process to exchange or share ideas, thoughts, and emotions among two or more peoples' minds solving a problem or analyzing/scrutinizing new routes at work[1]. Communication is a primary task that people do at work and in their social lives in various formats, except when they are asleep.

Today, every business needs communication to function appropriately. Without communication, we will stagnate, and be unable to deliver information and perform other essential tasks in a working environment. Even the most advanced machinery-based business needs to communicate a program to another program to function [2].

In every business, effective communication is the glue that binds the staff within an organization together. Furthermore, effective communication can improve our performance and outcome at work [4]. For example, in aviation, effective communication can ensure the pilot lands the plane on the runway safely. On the other hand, poor communication in aviation can put the lives of hundreds of passengers at risk. In the healthcare industry, many studies have indicated that effective communication can enhance patient safety, decrease medical errors [6], and improve teamwork [7].

Clinical Documentation Improvement departments are not an exception. For the completeness and integrity of patients' medical charts, Clinical Documentation Specialists (CDS) need to communicate their queries with clinicians. Today, the traditional way to communicate with providers is to send electronic queries and follow-up emails. According to Liebler and McConnel [4], emails are the weaker tool for communication. Also, a report from 2014 showed that an academic physician received 2,035 mass distribution emails and studies have indicated that emails have caused physician burnout [8].

Strengths of Face-to-Face Communication

Conveying ideas and information in face-to-face interaction is the most effective and efficient tool of communication. The tone of voice, body language, and words are the three essential components of face-to-face communication. For effective interaction, the percentage of the three components are words (7%), body language (55%), and tone (38%) to convey the message [3]. Moreover, optimal and efficient body language can indicate empathy, caring, and support in face-to-face communication.

Appropriately used face-to-face communication has some critical characteristics in comparison to other formats of communication. In face-to-face communication, we convey the information in words, vocal tone and facial expressions, and other body language to support our ideas and transaction of a message. During face-to-face communication, the receiver and the person who conveys the message have the opportunity for immediate feedback, questions, and answers to be exchanged, and a better comprehension of the message can be achieved. Face-to-face interactions are the most beneficial tools for filling gaps during the workday [4] .

In my experience as a Trauma and Burn Surgery CDS, I found face-to-face communication regarding my queries one of the best approaches. Face-to-face communication has assisted me in making a team bond with the attending teams in the trauma and burn department. I can answer questions regarding the queries efficiently and quickly. At the same time, I can receive the query response more quickly.

A CDS can interact with the attending teams through phone calls, email paging, and face-to-face communication to assist in the completeness, accuracy, and consistency of clinical documentation in the medical chart to bolster coding and reporting of high-quality healthcare data [5].

References

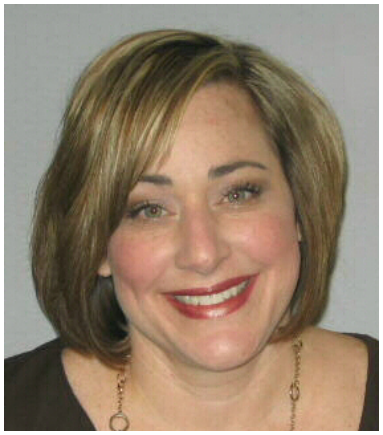
1. Ogwu, S., Sice, P., Keogh, S., & Goodlet, C. (2020). An exploratory study of the application of mindsight in email communication. Heliyon, 6(7), e04305.
2. Malmelin, N. (2007). Communication capital. Corporate communications: an international journal.
3. Mehrabian A. (2016). Silent messages: A wealth of information about nonverbal communication (body language). http://www.kaaj.com/psych/smorder.html.
4. Liebler, J. G., & McConnell, C. R. (2020). Management principles for health professionals. Jones & Bartlett Learning.
5. Association of Clinical Documentation Integrity Specialists. (2020). ACDIS code of ethics.
6. Squires, M. A. E., Tourangeau, A. N. N., Spence Lashhinger, H. K., & Doran, D. (2010). The link between leadership and safety outcomes in hospitals. Journal of Nursing Management, 18(8), 914-925.
7. Laschinger, H. K. S., & Finegan, J. (2005). Empowering nurses for work engagement and health in hospital settings. JONA: The Journal of Nursing Administration, 35(10), 439-449.
8. Paul, I. M., & Levi, B. H. (2014). Metastasis of e-mail at an academic medical center. JAMA pediatrics, 168(3), 290-291.

Vaccinate ALL 58
Together we can end the pandemic.

https://www.vaccinateall58.com/

California acdis Official Local Chapter

CDI Professionals Key to the Clinical Validation Denials Process



UC-Davis CDI Leadership Team:
Shirlivia Parker, MHA, RHIA, CDIP, BS-HIM, UCSD CDI Manager and Tami McMasters Gomez, BS, CCS-P, CCDS, CDIP, (MHL)
Director, Coding and CDI Services at UC Davis Medical Center in Sacramento, California, and a members of the ACDIS CDI Leadership Council.

Article by Shirlivia M. Parker, MHA, RHIA, CDIP, BS-HIM

There have been a multitude of discussions in the CDI profession about denials, specifically clinical validations for the past several years. The question that one may ponder is why CDI isn't leading the way of clinical validation denials. The answer to that may be understanding how we can fit in, who we should talk to, why we aren't invited to participate. I think the answer to that question is understanding how clinical validation denials, work, and understanding that not everyone in the revenue cycle may know that these types of denials exist. This article will help you identify:

1. Why the revenue cycle, specifically, the patient financial services (PFS) team may not know about these types of denials.
2. How to establish yourself, as a CDI professional or unit in the process, lead the way to process improvement, and become that extension with PFS to win the race on clinical validation denials.
3. Establish a tracking system to involve contracting and fight against strategies of the payers to take back money received, and your organization deserves.
4. Understand the type of denials to help understand the overall process of establishing a denial program. We all need to be on the same page in understanding different types of denials.

Why the Revenue Cycle: PFS May Not Know Clinical Validation Denials Exist

The PFS teams may not know these clinical validation denials exist initially because the denial is a closed claim 90% of the time versus an open claim.

An open claim is the claim that has not been billed or payment has not been received by the payer. Open claims of discharged patients are tracked on the discharged not final billed (DFNB) reports, and everyone a part of the revenue cycle knows about these claims.

A closed claim is a claim that has been billed, and payment has been received. Closed claims are no longer reflected on any billing reports since the claim is closed, and there is no denial on the billing remit. When a denial is not on a billing remit, and on a closed claim, it's hard to track the denial from start to finish. When a written letter is received for recoupment on monies on a closed claim, the closed claim is not reopened, and payment is paid, and not linked to the closed claim at all. Therefore, it is extremely important to establish a tracking process internally to know your volume and eliminate these types of denials in becoming a part of pre-bill audit process and being a forgotten issue.

Payers take a special interest in organizations that have no idea about these denials, and recoupment of monies paid is easy. They become easy targets. Typically, by the time CDI gets involved, their organization has become an easy target, and the denials have been occurring for some time.

My advice to CDI professionals is to get involved by speaking the language of PFS. Initially, they may say they have a robust process for all denials—and they do for open claim denials that are denied on remits. When it comes to closed claim denials, however, they may not. When PFS tells you they have a robust denials process you should ask whether their process includes closed claims and denials not captured on remits. Clinical validation denials are typically on closed claims that do not generate on remit. The denials are received through paper mailings and can go to PFS, HIM, or a multitude of other departments. In partnership with all the stakeholders, however, you can streamline the process, fight back, and win.

How CDI can establish themselves as a key stakeholder

CDI should establish themselves as a key stakeholder and work with PFS and others to establish a denials management process across departments. It's a team effort. CDI must establish themselves as a subject matter expert for clinical validation denials.

One key issue to conquer is to a establish a single point of entry with payers on all denials. We all are aware that for any denial on a remit, the single point of entry is PFS; however, when it comes to clinical validation denials, these letters tend to be received by a multitude of departments across the hospital system. I have seen these letters go to the radiology department, case management, HIM, and specific clinics associated with the hospital—just to name a few.

> The bottom line is until you call each payer or third-party entity that sends these letters and request that they send all denials to the specific point of entry, they will continue to go everywhere and delay the appeals process. My recommendation would be to establish PFS as your single point of entry.
>
> While that approach makes sense on paper, you may wonder if it's practical in reality.

Each organization will handle things differently, but if you're a CDI leader, you can start by reaching out to your manager or the director of revenue cycle/PFS and present any data you have to start the conversation. You can even use this article as your starting point if you want to. The goal is to start the conversation and begin to understand what the opportunities are for your organization. Add in your Medicare and Medicare Advantage biller(s) to this conversation; they are typically aware of the paper close claim recoupment process taking place now in your organization. Clinical validation denials come from many payers; however, the volume of these type of denials are typically greater for Medicare and Medicare Advantage payers.

Identify any current challenges you are aware of during your conversations with the revenue cycle/PFS leadership, and billers. In my experience, payers may use various tactics to take advantage of the denial follow-up process and take back money quickly, without fulfilling the full denials process. You'll need to know your current overturn rate and whether the clinical validation denials are being tracked at all.

> Identifying the top denied diagnosis is also important. Knowing the MS-DRG is fine, but the diagnosis is key to identifying tends, especially with sepsis denials and Sepsis-2 versus Sepsis-3 clinical definitions. This will assist in incorporating contracting into the overall process of success, as well. Knowing the top denied diagnosis is helpful for any process improvement and education with the CDI team and physicians. The goal is never to change the clinical definitions your organization agreed too, but to ensure the clinical definitions used by your organization are solid in the chart without question.

Finally, check if medical records are being sent with the appeal letter to validate its contents and who's responsible for sending that information.

After you meet with revenue cycle, PFS, and your billers, your next move should be to consider what other stakeholders will ensure your continued success in establishing a standard denials process for your organization. Again, CDI is your subject matter expert on clinical validation denials; however, there are many different denials for which a process is currently in place.

> Think about these other stakeholders and discuss how they benefit your program as a whole. Some examples may include the coding department, HIM/release of information (ROL), and your physician advisor. In some cases, the HIM/ROL department may help by sending out the appeal letters and accompanying medical records; in others, PFS leads this process. Your physician advisor can likely assist in some appeal levels, such as peer-to-peer discussions.

Contracting, Tracking, and Trending

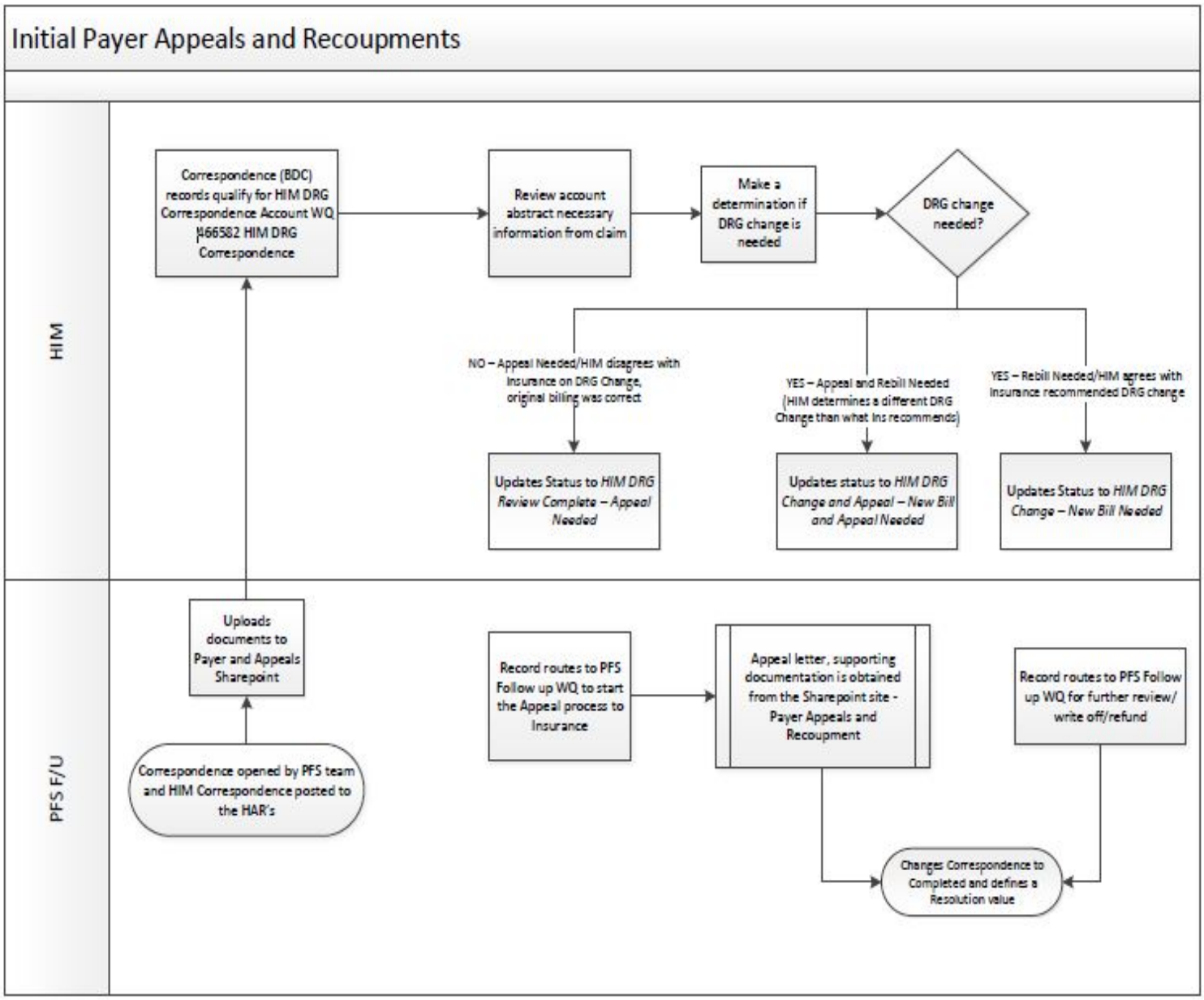
Tracking and tending is the key to your success, not only for provider education and CDI process improvement, but also for connecting with your contracting team. Your contracting team has a payer representative that they work with consistently. This means they can bring up concerns with the payer representative to fight back on inappropriate processes, such as forcing the health system to use Sepsis-3 clinical definition, for example.

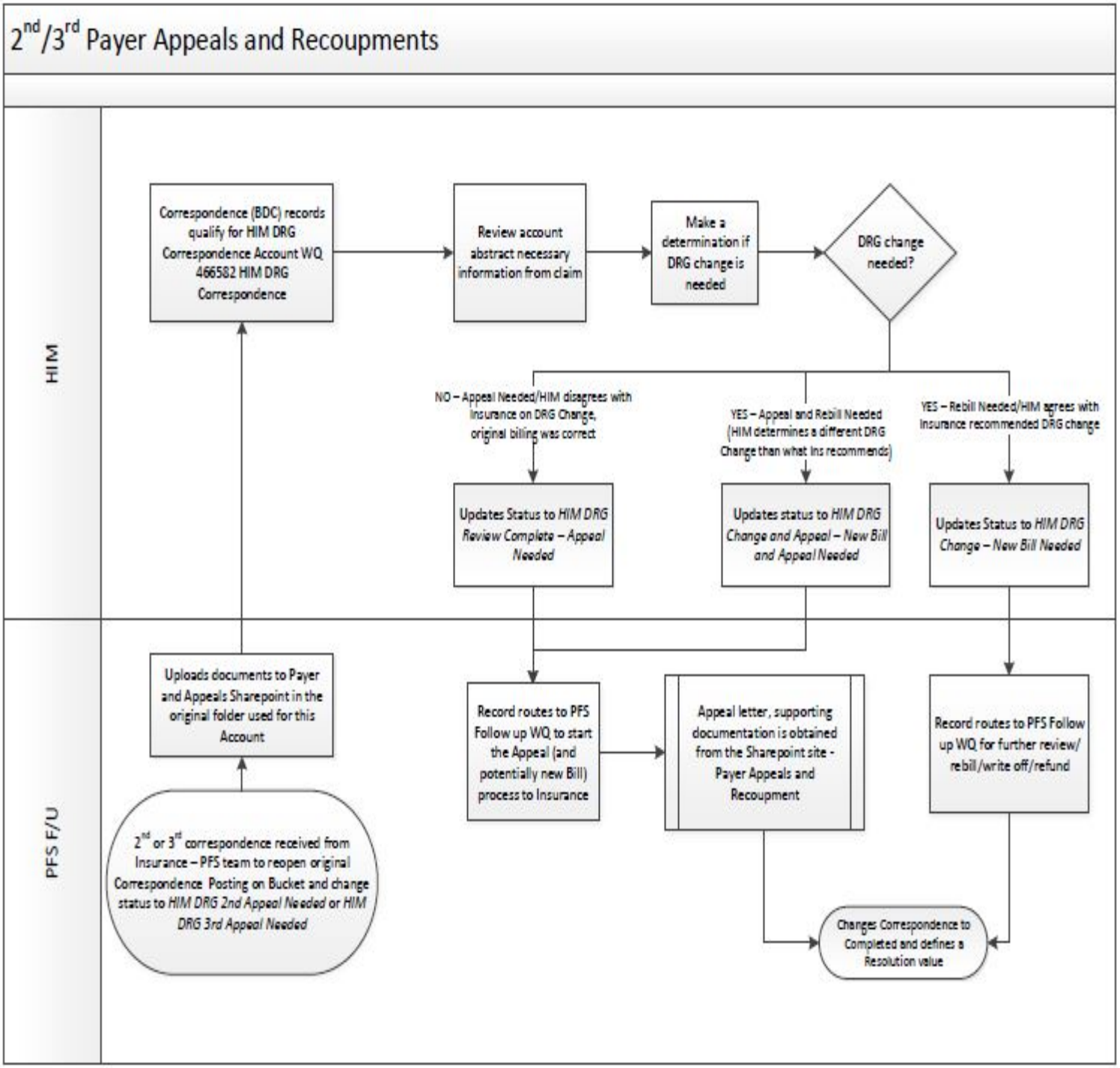
Contracting knows strategies they can take to fight back ethically. For example, they could partner with your state hospital association to fight back on unfair payer practices, such as demanding recoupment of clinical validation denials when the appeals process is not complete.

Use your contracting teams to your advantage to fight back. It is a payer's right to audit your charts and ensure you are providing quality care and doing the right thing. It is not their job to tell physicians how to treat their patients and dictate what evidence-based definition they should use.

As you consider your tracking and tending process, consider adding the following data elements:

- Denied diagnoses
- Levels of appeal (first, second, and third)
    - Most payers will have three levels of appeal, some four.
    - When you receive a denial, your goal should always be to identify what levels are appeal is required. Here are two examples:
    - United Healthcare (reviewed by a third-party auditor)
        - Level one: Written letter of appeal is required to entity denying the claim.
        - Level two: Peer-to-peer (physician to physician) can be requested in writing and must be scheduled.
            - Peer-to-peer is physician to physician conversation, but the organization can invite anyone they want to attend, as it is typically a conference call.
        - Level three: The payer medical director.
    - Aetna (Medi-Cal/Medicaid)
        - Level one: Written letter.
        - Level two: Second written letter back to entity denying the claim. If you wish to request a peer-to-peer, this must be stated in this written letter.
        - Level three: Peer-to-peer requested in level 2 written appeal.
        - Level four: Back to medical director of Aetna, if reviewed by third party entity.
- Letter receipt
- Type of denial
- Payer
- Third party entity reviewing the claim
- Financial impact
- Comments


Initial Payer Appeals and Recoupments
HIM
PFS F/U
Correspondence (BDC) records qualify for HIM DRG Correspondence Account WQ 466582 HIM DRG Correspondence
Review account abstract necessary information from claim
Make a determination if DRG change is needed
DRG change needed?
NO – Appeal Needed/HIM disagrees with Insurance on DRG Change, original billing was correct
YES – Appeal and Rebill Needed (HIM determines a different DRG Change than what Ins recommends)
YES – Rebill Needed/HIM agrees with Insurance recommended DRG change
Updates Status to HIM DRG Review Complete – Appeal Needed
Updates status to HIM DRG Change and Appeal – New Bill and Appeal Needed
Updates Status to HIM DRG Change – New Bill Needed
Uploads documents to Payer and Appeals Sharepoint
Correspondence opened by PFS team and HIM Correspondence posted to the HAR's
Record routes to PFS Follow up WQ to start the Appeal process to Insurance
Appeal letter, supporting documentation is obtained from the Sharepoint site - Payer Appeals and Recoupment
Record routes to PFS Follow up WQ for further review/ write off/refund
Changes Correspondence to Completed and defines a Resolution value


2nd/3rd Payer Appeals and Recoupments
HIM
PFS F/U
Correspondence (BDC) records qualify for HIM DRG Correspondence Account WQ 466582 HIM DRG Correspondence
Review account abstract necessary information from claim
Make a determination if DRG change is needed
DRG change needed?
NO – Appeal Needed/HIM disagrees with Insurance on DRG Change, original billing was correct
YES – Appeal and Rebill Needed (HIM determines a different DRG Change than what Ins recommends)
YES – Rebill Needed/HIM agrees with Insurance recommended DRG change
Updates Status to HIM DRG Review Complete – Appeal Needed
Updates status to HIM DRG Change and Appeal – New Bill and Appeal Needed
Updates Status to HIM DRG Change – New Bill Needed
Uploads documents to Payer and Appeals Sharepoint in the original folder used for this Account
2nd or 3rd correspondence received from Insurance – PFS team to reopen original Correspondence Posting on Bucket and change status to HIM DRG 2nd Appeal Needed or HIM DRG 3rd Appeal Needed
Record routes to PFS Follow up WQ to start the Appeal (and potentially new Bill) process to Insurance
Appeal letter, supporting documentation is obtained from the Sharepoint site - Payer Appeals and Recoupment
Record routes to PFS Follow up WQ for further review/ rebill/write off/refund
Changes Correspondence to Completed and defines a Resolution value

Types of Denials

As I close this article, I think it is important to discuss the type of denials and provide definitions. I believe when discussing denials, we must provide definitions to ensure we are always on the same page. In my experience, setting definitions facilitates the conversation, and may bring certain things to light that you otherwise may have missed.

- **Medical necessity:** The diagnosis reported for the procedure performed is not valid. Or for utilization review departments, medical necessity can mean denial of a specific day for an inpatient encounter.

- **MS-DRG coding denial:** The entity believes they have identified a coding error that impacts the DRG assignment, either through the Official Guidelines for Coding and Reporting or Coding Clinic guidance typically. It is important to note that a denial can start out as a MS-DRG coding denial and can shift to clinical validation denial, after the initial appeal is written or vice-versa.

- **Technical denial:** The claim has been rejected for technical non-medical reasons, such as medical records requested weren't submitted or pre-authorization was required and not obtained in a timely manner.

- **Outpatient claims denial:** This type of denial can occur for a multitude of reasons, such as incorrect usage or missing modifier. Medically unlikely edits (MUE), non-covered services are used by the Medicare Administrative Contractors (MAC).

- **Clinical validation denial:** Denial of a diagnosis due to lack of clinical evidence in the chart in line with an evidence-based clinical definition.

I hope you find this article insightful and helpful to establish your CDI department in the denials process. It is truly a hidden treasure, and when we crack the code, success awaits us.

This article was originally published in the July 12, 2021, edition of the CDI Leadership Insider, a publication of the ACDIS Leadership Council."

Read more: If you are starting your denials program, try reading more. ACDIS has additional resources on their website:

- CDI Week Q&A on denials management with Parker
  - This Q&A was originally published on the ACDIS Blog as part of the 2019 CDI Week celebration."
- Q&A: After the third level appeal
  - This Q&A was originally published on the ACDIS blog as part of the forum talks, July 2019
- Q&A: Sepsis appeals
  - This Q&A was originally published on the CDIS blog as part of the forum talks May 6, 2021

Issue
15
September
2021

Visit our Facebook page:

https://www.facebook.com/californiaacdis

To support our chapter, please send your donations via PayPal using this link:Paypal.me/CAACDIS

Thank you for your support!

So, What is Your CDI Program Doing for CDI Week 2021. Email photos and Descriptions to Analyn for the Next Newsletter in December email: adolopo@health.ucsd.edu

UCSD CDI Program is Celebrating CDI Week 2021 with a UCSD CDI Charcuterie Board Contest

CA-ACDIS Newsletter Team voted on top #3: Decadent Deserts -Angela Maxfield, Hearty Snacks-Alma Yap and Charcuterie Kiddie Ala Mode-Kristine Fernando

CDS Spotlight: Ahmad Khan MS, MD, CDIP, CDS
UCSD Trauma/Burn Surgery CDS

Analyn Dolopo-Simon MPH, RN, ACM, CCDS

My background
I am originally from Afghanistan, and I came to the United States in 2014. Now I live in Riverside County, California. I am a foreign medical doctor. I did my three years of residency in Adult Internal Medicine and a one-year internship in a Level 1 military trauma hospital. After coming to the United States, I completed my master's degree in Healthcare Quality at George Washington University.

What I like about this Job
I started working as a Clinical Documentation Specialist in 2016. I found this job very interesting. I like this job because it keeps my medical knowledge fresh as I review patients' charts and discuss queries with providers. I also enjoy working in collaboration with other departments, such as coding and quality team. This collaboration is an excellent platform for learning from one another.

I try to approach my Trauma members at the most convenient times, being sensitive to the Trauma calls and keeping conversations short. It's been pleasant and collaborative experience and I am treated as part of Trauma team as their CDS.

Recommendation to a new CDI
My recommendation for the new Clinical Documentation Improvement Specialist is to evolve clear communication skills in written and verbal queries compliant with ACDIS and AHIMA query practice guidelines.

Places to visit and eat in San Diego.
One of the best places to visit in San Diego is the San Diego Zoo and Safari Park. It is great to see all of the different animals. My favorite restaurant in San Diego is The Melting Pot.

Calling on all Californian CDSs!!!!

Showcase your Hospital and CDI Program contact Analyn. Send your stories and pictures

Now is your chance to satisfy that urge to write—CA CDIS is looking for new writers to step up to the plate and write that article you've always wanted to do!

Don't be shy. We'll give you editing tips and even article suggestions if you're unsure of where to start.

Contact: Analyn Dolopo at adolopo@health.ucsd.edu

Call for Speakers!

Do you have new ideas that you would like to share?

Is your CDI Program on the cutting edge of a new endeavor or initiative?

Do you want to share your experience in the field of CDI?

Apply to be a Speaker at the 6th Annual CA ACDIS Conference rescheduled to February 4, 2022! Applications due 11/5/2021. Send applications to

Pamela Stence, CA ACDIS Co-Chair at Pamela.Stence@sharp.com

or

Caryn Nowak, Conference Coordinator at Cnowak@rchsd.org

Proposal should include the topic, summary of the presentation, including learning objectives, and PowerPoint presentation (if available). Also include a biographical sketch and speaker photo.

We look forward to hearing from you.

And thank you to our sponsors:

CALLING ALL CA-ACDIS MEMBERS!!!
REPRESENTING CALIFORNIA

PLEASE SHARE YOUR PHOTOS AND MEMORIES OF THE ACDIS NATIONAL CONFERENCE, OCTOBER 24-28, 2021 AND SEND TO

California acdis Official Local Chapter

Visit our Facebook and Instagram pages:
https://www.facebook.com/californiaacdis
https://www.instagram.com/california_acdis