



The

# ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

## OB Information for CDI and Coding

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This is a quick and easy reference to assist with obstetrical cases.

### Stages of Labor

**First stage-** starts when labor begins and ends with full cervical dilation and effacement.

Early labor

Active labor

Transition to 2<sup>nd</sup> stage of labor

**Second stage-** commences with complete cervical dilation and ends with the delivery of the baby. (((pushing)))

Regarding 2<sup>nd</sup> stage, which is 10 cm to delivery of the baby. The average pushing takes 1-2 hours. Prolonged 2<sup>nd</sup> stage is pushing for longer than 2 hours with provider documentation.

**Third stage-** initiates after the fetus is delivered and ends when the placenta is delivered.

### Pertinent Codes:

O63.0	Prolonged first stage (of labor)
O63.1	Prolonged second stage (of labor)
O63.2	Delayed delivery of second twin, triplet, etc.

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## **Incompetent Cervix:**

**AKA, short Cervix, Incompetent Cervix, Cervical insufficiency.**

Cervical insufficiency is the inability of the cervix to retain fetus, in the absence of uterine contractions or labor (painless cervical dilatation), owing to a functional or structural defect. It is cervical ripening that occurs far from the term. Cervical insufficiency usually occurs during the middle of the second or early third trimester resulting in a premature birth or the loss of a healthy pregnancy. Before pregnancy, it's usually closed and firm.

### **Causes:**

- Cervical Lacerations during Childbirth
- Leep (Loop Electrosurgical Excision Procedure) done for abnormal PAP
- Vaginal & Cervical infections
- D&C (Dilation & Curettage)
  - ⇒ TAB (therapeutic Abortion) with D&C
  - ⇒ D&C's for Retained Products of Conception post-delivery or status post miscarriage
  - ⇒ Diagnostic

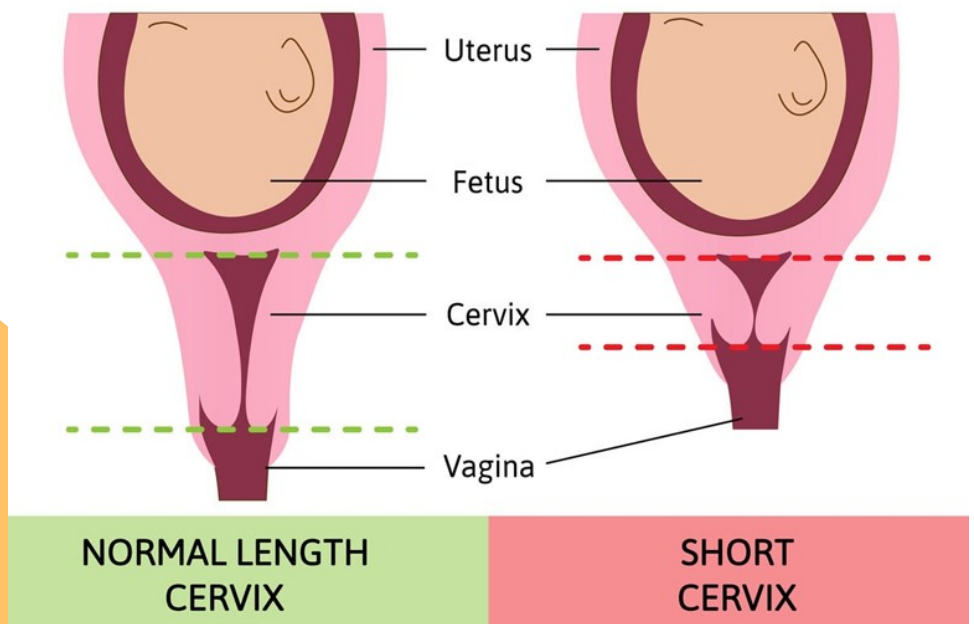
A cervix with a tight band or a Cervix that won't dilate is not an Incompetent Cervix. An incompetent Cervix results in loss of a pregnancy.

### **Pertinent Codes**

- O34.30 Maternal care for cervical incompetence, unspecified trimester
- O34.31 Maternal care for cervical incompetence, first trimester
- O34.32 Maternal care for cervical incompetence, 2<sup>nd</sup> trimester
- O34.33 Maternal care for cervical incompetence, 3<sup>rd</sup> trimester

### **Treatment:**

- Cerclage
- Progesterone injection during pregnancy
- Bedrest
- Ultrasounds for Cervical length



## Fetal Heart Rate aka FHR

The average fetal heart rate is between 110 and 160 beats per minute. It can vary by 5 to 25 beats per minute. The FHR may change as the baby responds to conditions in the uterus. An abnormal fetal heart rate may mean that the baby is not getting enough oxygen or that there are other problems.

- **Accelerations**-they are present when the babies FHR rises. They are a normal part of the FHR and reassuring that the Intrauterine environment is still “friendly” for the baby.
- **Variable Decelerations**- can occur when there is decreased amniotic fluid, meconium, cord around the neck. They are a “semi-normal” part of the FHR in labor. There are always variations (rise/fall of the FHR) hence variable decels during labor.
- **Early Decelerations**- Almost always insignificant. Usually due to head compression as the baby enters the pelvis or further dilation occurs resulting in said head compression.
- **Late Deceleration**- Decrease in FHR following a contraction. They are caused by decreased blood flow to the placenta and can signify an impending fetal acidemia. Often leads to C-Section if continuous
- **Fetal Bradycardia- Fetal arrhythmia**- FHR less than 110 bpm. Like some adults, some babies run a lower HR. Must be watched & can require an emergency C-Section.
- **Fetal Tachycardia**- FHR >160 bp. It is also an abnormal FHR, but not ominous. It’s usually 2/2 an infection of the mother, Uterine or otherwise. If present, 9 times out of 10, mother is Febrile. Treat the infection and the FHR will often return to normal.

### **Treatment:**

Most of the treatment for any of the above abnormalities of the FHR is repositioning, IV hydration, Stopping Pitocin if they are on it, applying oxygen to the mom, giving Terbutaline for tachysystole/to frequent uterine contractions to slow/stop uterine contractions.

### **Coding aspects:**

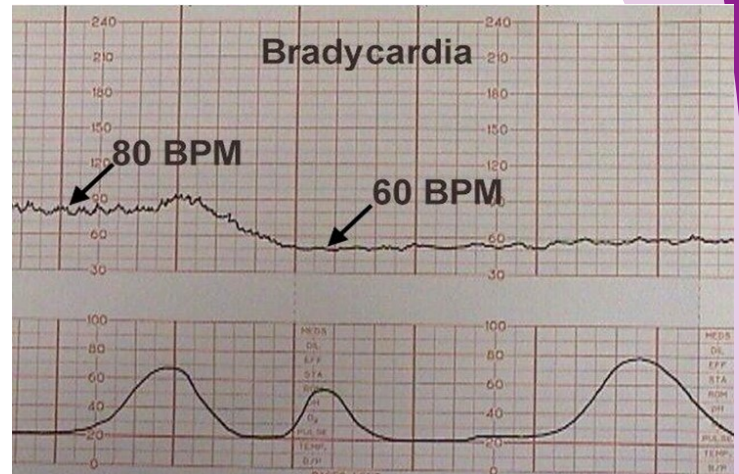
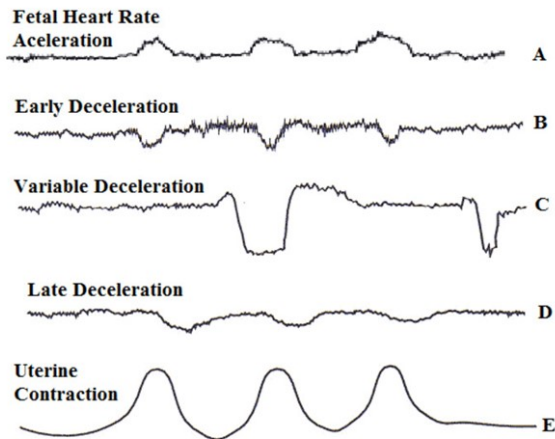
It is extremely important that the physician document well the Abnormal FHR to code it. A couple of variable decels or rare late decel is not enough to code it. Think about the diagnosis, did they treat it? What was the outcome? Did they do an emergency C/S for Fetal distress or non-reassuring FHR. These terms, if treated, do equal an Abnormal FHR. If CDI/Coder thinks it’s an abnormal FHR and not well documented, reach out to the physician for clarification.

### Pertinent codes – Mother’s Chart:

- O36. 831 Maternal care for abnormalities of the fetal heart rate or rhythm, first trimester
- O36. 832 Maternal care for abnormalities of the fetal heart rate or rhythm, second trimester
- O36. 833 Maternal care for abnormalities of the fetal heart rate or rhythm, third trimester
- O36.8390 Maternal care for abnormalities of the fetal heart rate or rhythm, unspecified trimester, not applicable or unspecified
- O76 Abnormality in fetal heart rate and rhythm complicating labor and delivery

## Pertinent Codes for Baby's chart:

- P03. 810: Newborn affected by abnormality in fetal (intrauterine) heart rate or rhythm, before the onset of labor
- P03. 811: Newborn affected by abnormality in fetal (intrauterine) heart rate or rhythm, during labor
- P03. 819: Newborn affected by abnormality in fetal (intrauterine) heart rate or rhythm, unspecified as to time of onset



## Electronic Fetal Monitoring AKA EFM

Electronic fetal monitoring is a procedure in which transducer, held against your abdomen, are used to continuously record the heartbeat of the fetus and the contractions of the woman's uterus during labor.

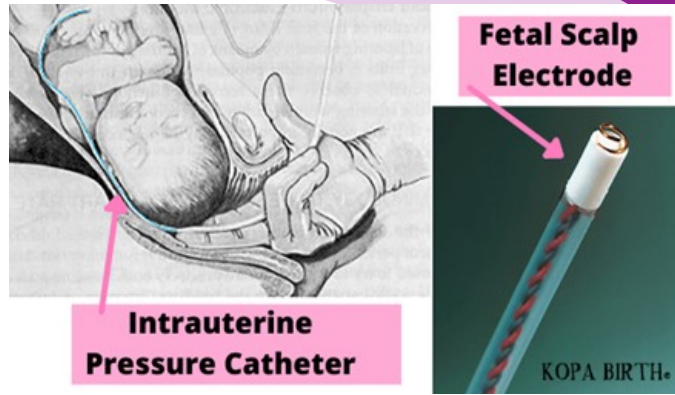
Types:

1. External Fetal monitoring- Monitors are applied to the patient's abdomen to record the Heart Rate of the baby and the Contractions of the Uterus.
2. Internal Fetal Monitoring-
  - A. FSE (fetal scalp electrode) is inserted by RN or MD to the fetal scalp and record the Heart rate of the baby. It's invasive, has risk of infection and not the preferred method.
  - B. IUPC (intrauterine pressure catheter) is inserted by MD for more accurate recording of Uterine Contractions, especially when high dose Pitocin is in use & if the patient is morbidly obese.

None of these are used to record "Neurological" activity in regards to Coding.



Fetal Heart Rate Monitor



## **Induction vs. Augmentation**

### **Induction**

There are several ways to induce labor contractions.

- Medicine may be used to soften the cervix and help it thin (efface).
- Medicine may be used to cause the uterus to contract.
- A balloon catheter (such as a Foley catheter) may be used to help the cervix open.
- If the cervix is soft and slightly open, sweeping the membranes or rupturing the amniotic sac (amniotomy) may start or increase contractions (AROM = artificial rupture of membranes)

Medicines used to ripen the cervix and induce labor:

- Misoprostol (Cytotec) is a pill taken by mouth or placed in the vagina (using a smaller dose). It is a medicine currently approved for treating ulcers. Using it for cervical ripening is a widely accepted but unlabeled use of this medicine.
- Oxytocin (Pitocin) can be given through a vein (intravenously) in small amounts to ripen the cervix. But it usually is given after the cervix softens, to cause the uterus to contract. Labor that is induced by oxytocin usually progresses faster than labor that starts on its own, especially in first-time mothers. If oxytocin does not progress labor or if the baby's heart rate indicates distress, a cesarean delivery (C-section) may be needed.
- Dinoprostone (such as Cervidil® or Prepidil® Gel) can be inserted as a suppository into the vagina (intravaginally). It can also be given as a gel that is gently squirted into the opening of the cervix (intracervically). When the cervix is ripe, labor may start on its own. This not as widely used currently.

Cervical Ripening (Labor Induction) using cervical inserts or tablets with prostaglandins (e.g. Cervidil®, Prepidil®, misoprostol or similar) should be coded as: 3E0P7GC--Introduction of other therapeutic substance into female reproductive, via natural or artificial opening.

- O61.0-O61.9 is the code set range for failed induction of labor



## **Augmentation**

If active labor has started on its own but contractions have slowed down or completely stopped, steps need to be taken to help labor progress: this is called augmentation.

Augmentation will be done when:

- Active labor has started, but contractions are weak or irregular or have stopped entirely.
- The patient is in active labor, but the amniotic sac has not ruptured on its own. In this case, the doctor may rupture the amniotic sac (amniotomy) to augment labor. If labor still does not progress, oxytocin (Pitocin) may be given to make the uterus contract.
- Active labor has started and the amniotic sac has ruptured on its own, but labor still is not progressing. Oxytocin (Pitocin) may be given to make the uterus contract.

The CDIS and coder has to be careful as providers sometimes will use the terms incorrectly. If patient is in early labor, or has premature rupture of membranes, the labor is augmented and not induced despite the terminology a physician uses

Only induction of labor is coded, not augmentation.

## **Prolonged Labor Definition**

Latent phase

On the basis of the 95<sup>th</sup> percentile threshold, historically, the latent phase has been defined as prolonged when it exceeds 20 hours in nulliparous women and 14 hours in multiparous women. ... prolonged latent phase (e.g. greater than 20 hours in nulliparous women and greater than 14 hours in multiparous women)

- Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery. No 1 March 2014 Reaffirmed 2016. ACOG

Active Phase

The active phase of labor has been defined as the point at which the rate of change of cervical dilation significantly increases. Active phase labor abnormalities can be categorized as protraction disorders (slower progress than normal) or arrest disorders (complete cessation of progress) - Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery. No 1 March 2014 Reaffirmed 2016. ACOG

Updated definition from 4cm dilation to 4-6 cm dilation as long as maternal and fetal status are reassuring. —ACOG Committee Opinion: Approaches to Limit Intervention During labor and Birth. No 766. Vol 133, No 2, Feb 2019, ACOG

## **Obstructed Labor**

Obstructed Labor occurs when the passage of the fetus through the pelvis is mechanically obstructed.

Category O64, Obstructed labor due to malposition and malpresentation of fetus, is used to describe situ-

ations in which labor “may be” obstructed due to position of fetus. Example:

- Incomplete rotation of fetal head (O64.0),
- Breech presentation (O64.1),
- Face presentation (O64.2),
- Brow presentation (O64.3),
- Shoulder presentation (O64.4),

Other Example include- Cephalopelvic Disproportion (CPD), Shoulder Dystocia.

### **Chorioamnionitis (Intraamniotic infection)**

**Chorioamnionitis (AKA Chorio)** or intraamniotic infection is an acute Inflammation & Infection of the membranes and chorion of the placenta. It is the most common cause of Sepsis in the pregnant patient. It can be the cause of Chronic lung disease in infants. It can lead to Morbidity & Mortality for the mother and baby.

Causes:

- Prolonged rupture of membranes
- Prolonged labor
- Multiple vaginal exams s/p rupture of membranes
- First time pregnancies/moms
- Meconium stained fluid
- Preterm labor

Bacteria: Most common is Group B Strep, E Coli, Mycoplasma pneumoniae, Urea plasma, Gardnerella.

Treatment: Ampicillin, Gentamycin, Clindamycin, Ancef, Vancomycin.

Biggest take away, if Chorioamnionitis is suspected, OB’s will treat the patient as though she had Chorio & send the placenta to Pathology. There can also be a documented “infection of Amniotic sac/membranes” when they aren’t sure if it’s Chorioamnionitis. We **must** remember, we need the Physicians documentation to code Chorioamnionitis. We cannot code it off of a pathology report. If the Pathology report reflects Chorio & the MD has not documented this, it needs a query.

- O41.1030- Infection of Amniotic sac/membranes 3<sup>rd</sup> trimester
- O41.1230- Chorioamnionitis 3<sup>rd</sup> trimester

\*\*\*\*\* Both of these codes/code sets are MCCs & have to be documented properly to code them.

## **Disease of the Digestive System Complicating Pregnancy:**

Pregnant delivered with Crohn's Disease:

- O99.16 with a secondary code: K50.90

Cesarean Delivery: If a Cesarean delivery is necessary-if the admission is for a condition that resulted in the need for Cesarean, this condition would be sequenced as the Principal Diagnosis.

Example: Secondary Uterine Inertia O62.1

## **Covid 19 and Pregnancy:**

During Pregnancy, childbirth or the puerperium, when a patient admitted because of COVID 19, the Principal Diagnosis should be O98.5 Other viral diseases complicating pregnancy, childbirth and the puerperium plus U07.1 COVID 19

Clinical Indicators: T: >101.0, Tachycardia, Tachypnea, loss of taste/smell, body aches, cough, Positive Covid Test, Chest X-ray w/ground glass opacities, SOB, Fatigue

## **Current Admission Delivery "In Childbirth" Option**

Wherever delivery occurs during the current admission, there is an "in childbirth" option for the obstetric complication being coded, the in childbirth code should be assigned for coding.

For example: Hypothyroidism delivered

- O99.284 Endocrine, nutritional and metabolic diseases complicating childbirth,
- E03.9 Hypothyroidism unspecified

## **Postpartum Complications**

It is acceptable to report puerperium codes with complication of pregnancy and childbirth if a condition arises postpartum during delivery encounter.

Example: Following delivery immediately the mother complains of headache. Patient diagnosed with severe postpartum preeclampsia administered IV magnesium sulfate.

- O14.15 Severe pre-eclampsia complicating the puerperium.

Clinical Indicators for Pre-Eclampsia-Defined as HTN w/Proteinuria or Thrombocytopenia.

- Pre-Eclampsia with severe features includes: Systolic BP of 160 mmHg or Diastolic BP of 110 mmHg, liver function tests 2 times the upper limit of normal, serum creatinine >1.1. Elevated DDimer, PT, PTT, Uric acid.
- Severe headaches, severe right upper gastric pain, blurry vision, spots before the eyes, edema/sudden



weight gain.

Pre-Eclampsia can occur after pregnancy as well requiring readmission to the hospital for Magnesium Sulfate therapy.

### **Pre-Existing Diabetes Mellitus**

Pre-Existing Diabetes Mellitus should be coded as Diabetes Mellitus in Childbirth if the patient delivers during the current admission.

- O24.12 Pre-existing diabetes mellitus type 2 in Childbirth.
- O24.02 Pre-existing Type 1 DM in childbirth.

### **Alcohol and tobacco use during Pregnancy, Childbirth and Puerperium**

The ICD-10 CM Coding guideline for alcohol use states that codes from alcohol use states codes from subcategory O99.313 Alcohol use complicating pregnancy, childbirth, and the puerperium, should be assigned for pregnancy case when a mother uses alcohol during the pregnancy or puerperium. A secondary code from Category F10, Alcohol related disorders, is also assigned to identify manifestations of the alcohol use.

Example: Delivered at 39 weeks of gestation, alcohol abuse.

- O99.314 Alcohol use complicating childbirth plus F10.10 alcohol abuse uncomplicated.

Example: Delivered at 39 weeks with tobacco dependence, complicating childbirth, patient smokes two packs of cigarettes daily.

O99.334 Smoking tobacco complicating childbirth plus F17.210 Nicotine dependence

### **Postpartum Hemorrhage**

Postpartum Hemorrhage (O72) includes hemorrhage after delivery of fetus/infant & placenta. There are two categories:

A. O72.1 Postpartum hemorrhage Immediate within 24 hours after birth

B. O72.2 Delayed after 24 hours postpartum

Normal Blood Loss Values:

- Vaginal Delivery- 500 ml
- Cesarean Section- 800-1000 ml

Reminder: Normal Blood Volume in a non-pregnant women is 4,500 ml-5,700 ml. In pregnancy, their vol-

ume can increase to 30%-50% more blood volume. Pregnant women have a great capacity to compensate for blood loss. Be sure there is documentation & treatment to support the Diagnoses of Postpartum Hemorrhage or Acute Blood Loss Anemia before Coding.

Uterotonics: Meds often given during a hemorrhage or heavy bleeding with delivery: Pitocin, Methergine, Cytotec (orally, vaginally or rectally). Hemabate. These meds usually are used for treatment during the occurrence and if heavy vaginal bleeding occurs during postpartum. If there is a heavy blood loss or hemorrhage, w/low H&H, often treatment of Iron, PNV w/extra iron or iron infusion/Venofer will be given. Obstetricians use blood transfusion as the last resort. They try everything to not to give blood.

## **Resources:**

AWHONN Association, PIH/Pre-Eclampsia Guidelines.

Chapter 15: Pregnancy, Childbirth and the Puerperium, ICD-10-CM/PCS Coding Clinic, Fourth Quarter ICD-10 2019

CMS ICD 10 Codes [https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode\\_cms/P1168.html](https://www.cms.gov/icd10m/version37-fullcode-cms/fullcode_cms/P1168.html)

Coding Tip: Pregnancy, Childbirth, and the Puerperium Tidbits (Chapter 15 in ICD-10-CM by Kim Carrier, RHIT, CCS, CCS-P, Director of Coding Quality Assurance, AHIMA-Approved ICD-10-CM/PCS Trainer

<https://www.acog.org/womens-health/faqs/fetal-heart-rate-monitoring-during-labor#:~:text=Electronic%20fetal%20monitoring%20is%20a,the%20woman's%20uterus%20during%20labor>.

<https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/fetal-heart-monitoring>

<https://www.kopabirth.com/fetal-monitors-in-labor-pros-and-cons/>

<https://www.mayoclinic.org/diseases-conditions/incompetent-cervix/symptoms-causes/syc-20373836#:~:text=An%20incompetent%20cervix%20happens%20when,it's%20usually%20closed%20and%20firm>.

<https://www.ncbi.nlm.nih.gov/books/NBK525954/#:~:text=The%20most%20common%20acquired%20cause,or%20second%20trimester%20of%20pregnancy>.

<https://www.ncbi.nlm.nih.gov/books/NBK557393/figure/article-20845.image.f1/>

<https://www.ncbi.nlm.nih.gov/books/NBK532251/#:~:text=Most%20commonly%2C%20chorioamnionitis%20is%20associated,known%20bacterial%20or%20viral%20infections>.

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ICD-10-CM and ICD-10-PCS, Coding Handbook 2016 by Nelly-Leon-Chisen, RHIA

New ICD-10 Code and Reporting Guidelines Effective April 2022

# Overview of Comorbidity in Health System

Ahmad Khan MS, MD, LSSGB, CDIP, CDS

UCSD Trauma Burn CDS



Reducing quality of  
life



Impairing function



worsening physical  
and mental health



Increasing the risk  
death

In the world, healthcare facilities are increasingly encountering the need to address the management of patient populations with multiple diseases, and this pattern is not specific to one country but rather a norm in every country. For example, in the United States, approximately 80% of the Medicare budget is allocated to patients with four or more chronic conditions. As the number of chronic conditions increases, the cost of care is exponentially increasing at the same time. This is one of the reasons that in the healthcare system, practitioners and researchers are keen to learn and evaluate the burden of comorbid conditions such as mortality, quality of life, and healthcare services (1).

Several researchers have found it challenging to study the burden and impact of comorbid conditions due to a need for more consensus on defining and measuring the concept. In mainstream health literature, comorbid conditions indicate the presence of more than one disease in an individual, and at the patient level, other distinctions are the significance of the second condition and the chronological order of conditions by time. Comorbidity in the health system entails conditions that coexist with another disease, which can increase hospital stays, resource use, mortality, and morbidity, and may cause delays in diagnosis of other states of interest, or we can say comorbidity is a health issue that can happen at the same time as another disease's occurrence. These conditions may have the same cause or not. Also, they can be attributed to the complications of illness, medication, or inappropriate treatment, and there is a higher chance of increasing the number of comorbid conditions as people get old (2).

Health care facilities use various methodology to score comorbid conditions, and comorbidity scores are derived from administrative data to measure premorbid status in the patient population, and comorbidity scores are critical to describing the complexity of care. Different countries use different scales to provide risk adjustment for outcome indicators for hospital mortality. For example, in Australia, the National Core Hospital-based Outcome Indicators and the Health Round Table are used for risk adjustment, such as hospital mortality.

The two other commonly used methodologies for comorbid scores are the Charlson Comorbidity Index and the Elixhauser Index, derived from hospital administrative data. Mary Charlson and colleagues created the Charlson Comorbidity Index, which was incepted around four decades ago using 559 cancer patients' data, and it entailed 19 comorbidities to predict the survival of patients or risk of death within one year of hospitalization for a patient population with certain comorbid conditions (2). Later, Deyo and colleagues modified the Charlson comorbid condition to 17. In 1992, the Elixhauser Index was created from 1.8 million patients' data. **The Elixhauser Comorbidity Index** is a methodology where we can categorize the comorbidities of the patient population based on the International Classification of Disease diagnosis codes in healthcare settings. The index is used to allocate hospital resources and mortality during hospital stays (3).

The health system comorbidity score, the Charlson comorbidity index, and the Elixhauser comorbidity indicators are developed to predict prognosis in the patient population. Also, they are used in observational studies to provide an efficacious way to describe comorbidity and control confounding. Initially, the set of Elixhauser comorbid indicators was created; back then, it had 30 indicators based on the ICD-9-CM algorithm(4). When the International Classification of Disease, 10th Revision, Clinical Modification coding system emerged, the Agency for Healthcare Research and Quality healthcare researcher modified the Elixhauser to use ICD-10-CM and expanded it to 38 comorbidities (4).

### **Role of Coding and Clinical Documentation Specialist**

Coding team and clinical documentation specialists can be essential in identifying the comorbid conditions in the patient's chart and when further clarification is required. They can communicate with attending teams via verbal and written queries to accurately report the data on the comorbid in the health system.

### **Conclusion**

Healthcare professionals and stakeholders are interested in having accurate data on comorbid conditions for various purposes, and coding teams and clinical documentation are the key players in reporting and coding them accurately. Accurate data on the comorbid condition can convince health policymakers and other relevant stakeholders to orient the healthcare services to meet the patient's needs.

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Metcalfe D, Masters J, Delmestri A, et al. Coding algorithms for defining Charlson and Elixhauser comorbidities in read-coded databases. *BMC Med Res Methodol.* 2019;19(1):115.

Moore BJ, White S, Washington R, Coenen N, Elixhauser A. Identifying increased risk of readmission and in-hospital mortality using hospital administrative data. *Med Care.* 2017;55(7):698–705.



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# How CDI programs can help with Denial prevention and appeals

Miriam Gallahue, RN, CCDS.

Miriam is currently on break from work and classes

Clinical Documentation Improvement (CDI) plays a critical role in addressing denials in healthcare organizations by focusing on prevention and appeals strategies. Denials management is essential for safeguarding the financial health of healthcare institutions, ensuring they have the resources to serve their patient population effectively.

## Why CDI Matters for Denial Management:

The threat of denials in healthcare is ever-present and can have significant consequences:

1. **Costly:** Dealing with denials can be financially burdensome, requiring resources for appeals and reprocessing claims.
2. **Time-Consuming:** The appeals process can be lengthy, with third-level appeals taking up to 3 to 4 years to resolve.
3. **Quality and Mortality Impact:** DRG downgrades where diagnoses are removed by payors can negatively affect the quality and mortality profiles of healthcare facilities.
4. **Increasing in Number:** Denials are on the rise, making it crucial to proactively address them.

**Frustrating:** The process of appealing denials can be frustrating for healthcare professionals. To effectively address denials, it is important to identify diagnoses that are at high risk of denial. Some diagnoses face vulnerability due to a lack of consensus diagnosis criteria within the medical community or ambiguity in health records.

## Types of Denials:

Payors have moved from more straightforward coding rules denials to the more grey area of clinical validation denials. It is estimated that 40% of denials are concentrated in five diagnoses, with sepsis, respiratory failure, severe malnutrition, encephalopathy, and kidney injury topping the list. Furthermore, specific Diagnosis-Related Groups (DRGs) represent a sizable portion of denials.

Challenges in denials management include the seemingly arbitrary nature of denial and appeal decisions, which often lack clear payer rules and criteria. Physician advisors have identified concerns such as high denial volumes, confusing payer rules, and auditor behavior as emerging challenges.

## Denial Prevention and Appeal Strategies by CDI:

1. **Clinical Validation:** CDI professionals play a crucial role in identifying diagnoses at risk of denial. They must possess a strong understanding of clinical indicators to perform clinical validation reviews effectively. Clinical validation on high-risk diagnoses prior to billing is critical in preventing denials. (See link to AHIMA's Practice Brief on Clinical Validation)



2. **There are no sources in the current document.**
3. **Understanding Prior Denials:** Analyzing past denials can strengthen audit defense programs and uncover opportunities for documentation and coding education.
4. **Establishing Facility Definitions:** In collaboration with physicians, Coding, Clinical Documentation Specialists, Registered Dieticians, and other SME's establishing Evidence – based definitions supported by professional society position papers and respected medical references limit an auditor's ability to deny documented diagnoses and strengthens the appeal if denied.
5. **Payor Contracts:** Getting facility consensus definitions added to contracts and agreement that coding rules as set out by CMS will be honored.
6. **Physician Education:** CDI specialists can work with physicians to improve documentation, reducing the risk of denials.

**Identifying Outliers:** Utilizing data from Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help identify cases that require closer scrutiny.

#### **Why CDI is Well-Suited for Denial Prevention:**

CDI specialists are well-equipped for denial prevention and appeals teams because they possess clinical knowledge and a deep understanding of coding rules and guidelines.

#### **The Bottom Line:**

Addressing denials is crucial for healthcare organizations to protect their financial health and provide quality care to patients. CDI teams play a pivotal role in preventing denials, and research suggests that a significant portion of denials is both preventable and recoverable. By implementing effective denial prevention and appeal strategies, healthcare institutions can mitigate the financial and operational challenges associated with denials.

Strong denials prevention program with improved overall documentation and coding accuracy increases the number of records auditors must review to find one potential denial or DRG downgrade. Auditors tend to target facilities with a three-to-one ratio as opposed to five or six-to-one for denial opportunities.

The financial, time investment and emotional cost of fighting denials is very significant. In a recent ACDIS podcast, Vaughn Matacale, MD director of the physician advisors at ECU Health in Greenville, North Carolina, discussed Vidant Health *seven year battle with OIG about malnutrition denials* and presented at ACDIS 2023.

#### **Resources and References:**

CDI Field Guide to Denial Prevention and Audit Defense, by Trey La Charité, MD, FACP, SFHM, CCS, CCDS. (There is an updated second edition now, but I have original one)

[What is PEPPER and uses](#)

[AHIMA Clinical Validation Practice Brief](#)

[ACDIS How-Strong-Physician-Leaders-Are-Making-a-Difference Denials](#)

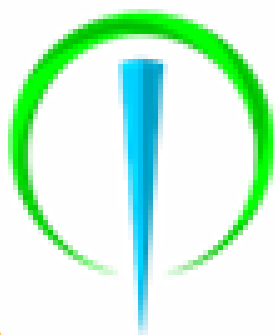
[ACDIS-3M-2023 LCM report hot topic Denials](#)

[ACDIS Optimized CDI Programs](#)

<https://www.advisory.com/topics/health-policy/2019/02/the-state-of-denials>

Podcast: <https://acdis.org/acdis-podcast/vidant-health%E2%80%99s-seven-year-battle-oig-over-malnutrition>

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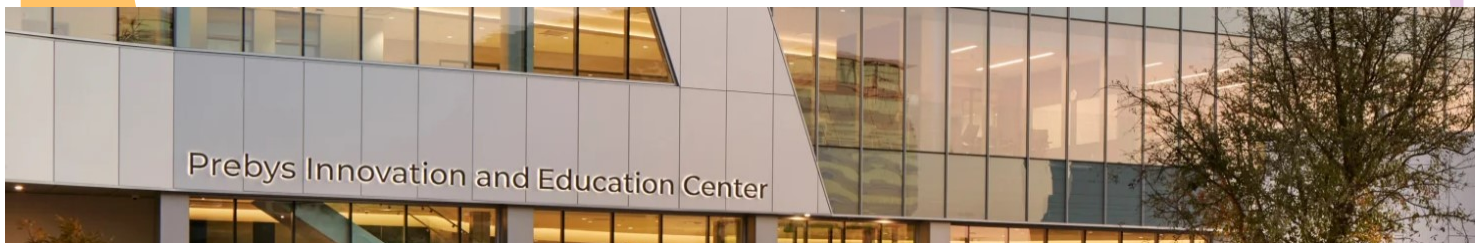
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