Denials Management

As part of the fifteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Kimberly Forslund, RN, CCDS, a CDI specialist at MaineHealth, answered these questions. Forslund is a member of the ACDIS Furthering Education Committee. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

Q: According to the 2025 CDI Week Industry Survey results, about 55% of CDI programs are involved with some sort of denials management. Of those whose CDI departments are not involved in denials management at their organization, 19% of respondents said they are planning to get involved in the near future. How is your CDI team involved with denials, and for how long has it been involved? What successes and/or challenges have you experienced in that time?

A: Artificial intelligence (AI) software used by payers to generate denials has been a challenge based on the sheer number. Our involvement in the denials management process has evolved in recent years. Our leadership team works closely with DRG validators, physician advisors, and our physician liaison to write denial appeals letters. In the past, this group was tasked with hours of combing through the medical records to support our position to appeal. Our CDI team has taken a newer approach to hopefully make our reviews more denial-resistant. We are clinically validating all diagnoses, with special attention given to those at high risk for denial. This facilitates the appeals process by consolidating the evidence needed to support our claim in one document, with sections for Framingham criteria, supporting labs for acute kidney injury, nutrition consult notes with RD diagnoses, SIRS and SOFA criteria, etc.

Q: When asked who in the CDI department is involved with the denials management/appeals process, almost 36% of respondents said that their CDI department had a designated denials or appeals specialist, which is a notable increase from 2024 industry survey data (29.17%). Have you noticed this type of role becoming more common in the CDI industry? Who on your team is involved with denials management and/or appeals, and what is their role like?

A: Several years ago, our manager and director worked alongside a physician advisor to address denials. The original CDI specialist who reviewed could view the process retrospectively, but now each CDI specialist is taking a more proactive approach by clinically validating all diagnoses on the initial review. This change has improved our daily work clinically regardless of denials. It also facilitates the denials appeal process by consolidating pertinent information/clinical data into one document for reference

Q: When asked about the most common type of denials that their CDI program is involved in, 87.73% of respondents chose clinical validation. The runner-up was DRG validation, chosen by 64.11%, which was an increase of nearly 10

percentage points compared to 2024 (54.66%). Why do you think CDI involvement in DRG validation denials may be becoming more common? What types of denials does your CDI team help with, and how was that decision made? What advice do you have for CDI programs in choosing which types to focus on?

A: Clinical validation queries can be challenging when a provider is given clinical criteria and verbiage that coding will need. They are the clinicians on the front lines, and their word is final for coding. When we see a "ruled in" for a diagnosis that clearly does not meet criteria, however, we send an informative/educational "90-second update" that includes best practices with clinical indicators needed. Our team focus is not specific to a query or denial type. If we feel the diagnosis is valid and can be objectively supported, we pursue the appeal.

It made sense for us to not only perform a solid review (including clinical validation of unclear diagnoses that may not meet criteria), but to try and make our work more streamlined/standard when another CDI or appeals writer needs to get involved.

Q: Respondents continue to report that the majority of their denials originate from private payers (35.67%). Those whose denials originate most from Medicare Administrative Contractors did see a small increase this year, however, from 15.93% in 2024 to 20.55% in 2025. Do you think Medicare may be making a comeback as the biggest group denying claims in the future? What group has your organization seen the most denials from in the past year, and have you had any success mitigating these denials?

A: According to our director, Robin Matthews, Medicare Advantage (MA) plans have consistently been the largest source of denials over the past year in our organization, followed by commercial payers. These plans tend to have more aggressive utilization review processes and stricter documentation requirements, which contributes to the higher denial volume. An Office of Inspector General report published in April 2022 found that MA organizations denied 13% of prior authorization requests that would have been approved under traditional Medicare.

MA plans frequently require prior authorizations, apply narrower coverage criteria, and use third-party vendors to conduct automated or manual reviews that can lead to denials—even when services meet CMS coverage guidelines. These practices are not inherently illegal but are often used to control cost, sometimes inappropriately.

We've had some success mitigating denials through clinical validation, tracking denial trends by diagnosis and payer, and ensuring CDI staff are educated on the most denied conditions. Proactive documentation and close collaboration with appeal teams have also helped improve overturn rates and reduce recurring denials.

Q: About 85% of respondents reported that sepsis is one of their top five denied diagnoses, consistent with past years. Respiratory failure saw another small jump, from 74.02% who said respiratory failure was in their top list in 2024, to 77.61% in 2025. Encephalopathy saw a notable increase as well, chosen by 57.36% of respondents in comparison to 48.77% in 2024. Have you noted an increase of certain denials in recent years, such as those related to encephalopathy or respiratory failure? What are the top five denied diagnoses at your organization, and what about these diagnoses do you think makes them more prone to receiving a denial?

A: Our system has experienced similar types of denials (sepsis, acute kidney injury, malnutrition, encephalopathy, respiratory failure). Perhaps the relative weight for reimbursement is driving the payer to challenge these, along with the move toward using Sepsis-3 vs. Sepsis-2 criteria.

Q: About 18% of respondents said their program uses some form of technology to identify charts that may be vulnerable to denials, and in the free response section, many wrote that they are looking into this kind of solution. Does your program use any technology to help identify charts at risk of denial or to assist in any other part of your denials management process? If so, what advice would you give to CDI programs seeking to integrate technology into denials management?

A: According to our director, our current CDI software does not include preemptive prompts or predictive

analytics to flag cases at risk for denial. However, we do utilize a manual tracking process: When a denial is identified, we apply a "denial" code to the case in our system, allowing us to retrospectively monitor patterns and trends.

While our approach is primarily manual, our team is proactively educated on the top 10 most common denial-prone diagnoses. They are trained to clinically validate these diagnoses during their reviews and to document their validation on the CDI worksheet. This practice helps strengthen documentation from the outset and provides support if an appeal becomes necessary.

For programs looking to integrate technology into their denials management strategy, I would recommend starting with strong data governance and clearly defined workflows. Identify which diagnoses or DRG categories are most frequently denied and build your technology strategy around those targets. Technology should augment—not replace—clinical expertise. Ensure that any solution adopted allows for CDI input and supports workflow integration, not disruption.

Q: Compared to 2024 data, there was a drop of nine percentage points among respondents reporting that their CDI program is involved in some form of denials management. Do you have any ideas about why that might be? Do you think that CDI involvement in denials is usually worth the investment for organizations, and why or why not?

A: According to our director, the observed drop in CDI involvement in denials management may reflect a few key shifts in the industry. One possibility is the growing use of third-party vendors to manage the denials and appeals process, particularly as organizations look to streamline operations or reduce internal workload. Outsourcing can reduce the need for direct CDI involvement, especially in smaller departments that may already be stretched thin.

Additionally, the increased use of AI by payers could be contributing to a higher volume of automated denials. This could overwhelm smaller CDI teams, leading some organizations to prioritize their CDI resources elsewhere—particularly if the return on investment for CDI-led appeals is perceived as low.

Despite these challenges, I do believe that CDI involvement in denials management is often worth the investment—especially for clinical DRG denials. CDI professionals have the clinical expertise to interpret documentation accurately and know exactly where to locate supporting evidence within the record. Their involvement enhances the quality and credibility of appeals, which can result in higher overturn rates and ultimately stronger financial performance. In cases where appealable denials are frequent and complex, CDI-led efforts can absolutely justify the cost.

Q: Almost 15% of respondents said that they collaborate cross-departmentally on denial defense, a small increase from 2024 (10.87%). What other departments or groups have you collaborated with on the denials management/appeals process? In what capacity do they collaborate (e.g., through monthly meetings, during the appeal writing process, etc.)? Is collaboration an effective denials mitigation tactic in your experience, and why or why not?

A: According to our director, collaboration is a critical part of our denials management and appeals process. CDI nurses who are actively involved in writing appeals regularly collaborate with DRG validators to ensure clinical accuracy and consistency. These collaborations typically occur through scheduled meetings and case reviews, where both teams can align on DRG assignment logic, clinical documentation, and supporting evidence needed for successful appeal submission. Cross-departmental collaboration is a highly effective denials mitigation tactic, as it fosters shared ownership of the process, ensures consistency in clinical and coding interpretations, and improves the quality of appeals. More importantly, it closes communication gaps and builds a culture of accountability, which has a direct impact on reducing preventable denials and improving financial outcome. ■

Sponsor Insight

CDI Week

CorroHealth

Precision Over Volume: Rethinking the Role of Tech in CDI

CDI has come a long way in the last decade. Hospitals now face more automation options than ever—many promising to solve long-standing challenges using artificial intelligence (AI), large language models, and predictive analytics.

But for CDI leaders facing real-world pressures—denials, quality metrics, capacity constraints—not every innovation translates to impact. In fact, some of the most popular technologies create new burdens under the guise of help.

CDI doesn't need more technology. It needs the right kind of technology.

The Pitfall of "Review Everything"

Some CDI platforms advertise their ability to review 100% of patient charts, touting more findings, more alerts, and more revenue. But reviewing everything doesn't mean capturing what matters most. It often results in:

- Reviewer overload from low impact cases
- Alert fatigue that causes physicians to disengage
- Lost trust from a high volume of non-actionable queries
- Ballooning administrative burden that strains already-stretched teams

More isn't always better, especially when precision is what's required. In today's margin-pressured environment, hospitals can't afford to treat every documentation gap equally. Accuracy—not just activity—is the new currency of CDI.

Prioritization Is the Real Superpower

CorroHealth developed VISION™ Clinical Validation Technology to shift the focus from automation alone to clinical precision and defensibility. Unlike platforms that cast a wide net, VISION™ uses a blend of generative AI (GenAI), machine learning, and clinician-trained logic to evaluate each case for:

- DRG vulnerability
- Reimbursement potential
- Documentation complexity
- Clinical defensibility and compliance risk

Only those encounters that present meaningful opportunity—financial, clinical, or regulatory—are surfaced for review. And VISION™ doesn't just flag charts. It explains why the case matters using natural language tuned to healthcare workflows.

That means CDI reviewers get clinical clarity—not just coded alerts—before they even consider a query.

Built by Clinicians, Not Just Engineers

Some platforms rely on automation trained solely on billing data. VISION™ was built with input from more than 300 clinicians—physicians, nurses, and CDI specialists—who understand how documentation impacts care, compliance, and reimbursement.

Their expertise is embedded in the logic, workflows, and GenAI that power VISION™. The result? A platform that helps reviewers prioritize and act, rather than react.

It's not just about finding more. It's about finding what's right.

What Value Looks Like in Practice

Across hospitals of all sizes—academic centers, regional systems, and independent providers—VISION™ has helped:

- Double DRG findings
- Uncover up to 80% more revenue per reviewed case
- Deliver up to six times the ROI, often within a single quarter

And the value isn't just financial. Clients report stronger physician engagement, fewer compliance concerns, and higher query response rates. That's because VISION™ equips CDI teams to focus only on defensible, impactful documentation gaps—not just scan for anything that looks off.

From CDI Noise to CDI Strategy

Documentation quality isn't just a reimbursement issue—it directly impacts:

- Patient Safety Indicators
- Hospital-acquired conditions
- CMS quality metrics and ratings

When you prioritize cases with real clinical weight, CDI becomes a tool not just for financial health—but for care quality and compliance performance.

This is where "review everything" platforms fall short. They generate noise. VISION™ generates clarity.

The Next Era of CDI

The future of CDI won't be won by who reviews the most charts. It will be defined by three things: precision, trust, and confidence.

Precision in identifying what's truly worth reviewing. Trust in the recommendations surfaced. And confidence that your team's time is being spent where it matters most.

If your CDI program is already stretched—or stuck in reactive mode—it's not because your team isn't skilled. It's because they're being asked to do too much, too manually, with too little focus.

VISION™ was built to change that. To work smarter. To move from volume to value. And to deliver the clinical, financial, and operational ROI hospitals need in today's environment.

Because CDI doesn't start with a query. It starts with clarity. ■