Denial trends and CDI involvement

As part of the fourteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. **Debbie Breton, BSN, RN, CCDS**, ACDIS-approved CDI educator at Providence Health & Services in the Oregon region, answered these questions. Breton is a member of the ACDIS Furthering Education Committee and the ACDIS Florida local chapter. For questions about the committee or the Q&A, contact ACDIS Editor Jess Fluegel (*jess.fluegel@hcpro.com*).

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Q: About 64% of CDI programs are involved with some sort of denials management, according to CDI Week industry survey data. How is your CDI team involved with denials, and what successes and/or challenges have you experienced?

A: Our organization collaborates with an external vendor to manage denials. When the vendor identifies a case as eligible for appeal, they draft and dispatch the response accordingly. Conversely, if they believe an appeal is not justified, they forward the case to our team for a secondary review, primarily conducted by our CDI coder liaison (CDL). Should this second-level assessment support an appeal, we provide the vendor with the rationale to proceed. If the review concurs with the vendor's initial assessment against an appeal, the case is reverted to the assigned CDI specialist for further evaluation and educational feedback.

One of our successes has been improving the accuracy of clinical documentation by way of CDI specialist educational feedback when the decision not to appeal is upheld. When the second-level review finds that an appeal is supported, the CDL's rationale is provided to the outside vendor, increasing the likelihood of a successful appeal. A significant challenge for our organization is the variation in payer requirements and the evolving criteria for denials (e.g., payer contract mandates adherence to Sepsis-3 criteria while the hospital organization utilizes Sepsis-2).

Q: When asked who in the CDI department is involved with the denials management/appeals process, 41.67% of respondents said the team leads/managers, followed by 29.17% who said a designated denials or appeals specialist in the CDI department. Who on your team is involved with denials management and/or appeals, and what is their role like?

A: Our CDL is primarily responsible for conducting the second-level reviews, ensuring each case is thoroughly evaluated before final decisions are made. The CDI manager will occasionally perform second-level reviews as needed.

Q: Clinical validation was the most common type of denial that CDI programs are involved in, chosen by 85.54% of respondents. The runner-up was DRG validation, chosen by 54.66% of respondents. What types of denials does your CDI team help with, and what advice do you have for CDI programs looking to get involved in these types?

A: In my experience, clinical validation denials are the most common, particularly for diagnoses like sepsis and

respiratory failure. DRG validation denials also occur, especially when there is a discrepancy between clinical documentation and coding. The key in addressing these is to focus on ensuring that documentation is as precise and thorough as possible to provide clear clinical evidence that will support the diagnoses.

Q: Respondents continue to report the majority of their denials originate from private payers (35.05%). Does this mirror your experience? Do you have thoughts on why private payers seem to have surpassed Medicare as the biggest group denying claims in recent years, and has your organization had any success mitigating these denials?

A: The industry trend showing that private payers issue denials more often than Medicare has been true in my experience. This might be due to the more stringent and varied criteria used by private payers, who may focus on reducing their own costs. The shift might also reflect a more aggressive stance taken by private payers as opposed to Medicare in scrutinizing hospital claims.

Q: More than 85% of respondents reported that sepsis is one of their top five denied diagnoses, followed by 74.02% who said respiratory failure was in their top list (a significant jump from 2023, when 64.56% said respiratory failure). Have you noted an increase in respiratory failure–related denials in the past few years? Why do you think these two diagnoses pose such a denial risk? What types of diagnoses do you see most frequently denied, and how have you worked to fight against those denials?

A: I have observed notable increases in denials related to respiratory failure, mirroring the trend reported in the survey results. Sepsis and respiratory failure are both complex diagnoses that often involve subjective clinical judgment, making them prime targets for denial. These diagnoses require thorough and precise documentation to support their clinical validity, which can sometimes be challenging given that both diagnoses are complex and can be subject to clinical interpretation. This makes them frequent targets for denial. To mitigate this, I recommend focusing on providing clear, detailed documentation that aligns with clinical guidelines.

In addition to sepsis and respiratory failure, conditions like acute kidney injury, severe malnutrition, acute encephalopathy, and heart failure are also frequently denied at my organization. We work to prevent denials by educating our team members on the specific documentation requirements that clinically validate the provider's diagnosis, thus reducing the likelihood of denial.

Q: 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.)?

A: In my experience, collaboration happens primarily with the coding team. This collaboration occurs through email, phone, and meetings, where we work closely with CDI and coding professionals to review denial trends and develop strategies to enhance documentation and coding accuracy.

Q: The most common denial mitigation tactic was clinically validating high-risk diagnoses concurrently (42.55%), followed by reviewing denials on a case-by-case basis upon request (41.61%). What methods do you think are most effective and the best use of CDI time? If a CDI team does not have access to denial volumes, how can they effectively choose a focus area?

A: The most effective denial mitigation strategy our CDI team has found is concurrent clinical validation of high-risk diagnoses. By addressing potential issues in real time, we can prevent denials before they occur. Reviewing denials on a case-by-case basis is also valuable, particularly for identifying patterns or recurring issues that can be addressed through targeted education or process improvement.

For CDI teams without access to denial volumes, focusing on high-risk or frequently denied diagnoses such as sepsis and respiratory failure can be a good starting point. They can also collaborate with other departments, like coding or compliance, to identify areas where documentation improvements could make the most impact.

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

A: In my experience, the success of a CDI team's involvement in the denials management process can be measured through a variety of metrics. Key indicators include the percentage of successful appeal outcomes, the overall reduction in denial rates for targeted diagnoses, and the financial recovery resulting from overturned denials. Additionally, the accuracy and thoroughness of clinical documentation should be assessed as it directly impacts the CDI program's ability to prevent and address denials.

These metrics are tracked using a combination of methods, including detailed reports from our external vendor, internal audits, and regular analysis of denial trends. These data points are reviewed regularly to identify areas for improvement and to ensure that our CDI efforts are effectively contributing to the reduction of denials and the success of appeals.

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Proactive denials management: New opportunities with AI

CDI professionals work tirelessly to ensure clinical documentation contains accurate diagnoses and patient acuity. It requires experience, expertise, and intuition to scour patient records for inaccuracies, investigate discrepancies, and ensure appropriate reimbursement.

After all this effort, payer denials can be frustrating—for CDI practitioners, who must spend time finding evidence for an appeal, and for physicians, who feel their professional judgment is in question. Despite the work of CDI teams, denials remain common, especially for conditions such as sepsis or acute respiratory failure, where hospitals and payers may use different diagnosis criteria.

However, recent technological advances, particularly in artificial intelligence (AI), are transforming CDI programs by supporting clinical documentation specialists to proactively manage denials and preserve revenue.

The proactivity opportunity

AI creates many opportunities for CDI teams to handle increasing workloads more easily. This is especially important at a time of CDI staff shortages, often driven by retirement and nurses in CDI roles returning to bedside duties. As this invaluable experience is lost, those new to the role will need support to make their work more effective—and more rewarding.

For example, in the days of manual workflows, a CDI specialist with 100 cases on their worklist needed to carefully examine each case to find which ones required a clinical validation query. Today, AI can quickly pinpoint cases at high risk of denial and create a prioritized worklist that allows CDI professionals to focus their efforts and expertise where they'll have the biggest impact.

This AI-powered prioritization enables CDI teams to review more cases and focus their expertise in the right areas. Rapid advances in generative AI have the potential to streamline CDI workflows even further by providing instant access to all relevant patient information and clinical evidence in one place. So, instead of spending an hour flipping back and forth between chart areas and different documents to review a case, CDI professionals can instantly see all the information they need to establish their working DRG.

As well as helping CDI teams make better use of their time, AI can have a major impact on physician education, fostering continuous improvement in documentation quality to prevent denials before they happen. By analyzing trends in clinical validation queries, AI can provide insights for highly targeted education initiatives based on individual physicians' most frequent diagnoses.

AI can also help CDI teams preserve revenue by alerting them to cases where patients may be receiving an inappropriate level of care. For example, by monitoring severity of illness and risk of mortality measures, AI can indicate where an intensive care patient could be moved to a more suitable care setting. CDI can then communicate this to the resource utilization management team, helping the hospital reduce care costs.

A bright future for CDI teams

It's important to remember that AI won't replace CDI specialists; its role is to augment their expertise by surfacing information, unlocking valuable insights, and automating repetitive tasks. As we enter the age of AI, the experience, ingenuity, and human empathy of dedicated professionals are still vital for successful CDI programs.

So, this CDI Week, let's look forward to a future where AI supports clinical documentation specialists to help patients get the most appropriate care, empower physicians to continuously improve documentation quality—and proactively prevent denials to protect hospitals' revenue. ■