Denials mitigation and CDI involvement

As part of the sixteenth annual Clinical Documentation Integrity Week, ACDIS conducted a series of interviews with CDI professionals on a variety of emerging industry topics. Rebekah May, MSN, MBA, RN, CDI director at The University of Kansas Health System and a member of the Kansas City, Missouri ACDIS local chapter, answered these questions. For questions about the Q&A, contact ACDIS Editor Jess Fluegel (jess.fluegel@hcpro.com).

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Q: According to the 2026 CDI Week Industry Survey results, about 59% of CDI programs are involved in some sort of denials mitigation/appeals process, a small increase from 2025 (54.72%). This is most likely due to an increase in those who report implementing a process, from 11.95% in 2025 to 15.87% in 2026. How has your CDI team been involved with denials, and for how long? What successes and/or challenges have you experienced in that time? Have you noticed an increase in denials involvement across the industry?

A: The CDI team at the University of Kansas Health System (UKHS) has worked closely with the inpatient coding team on all appeal letters for over 10 years. The coding team will review all letters and then hand off clinical validation and DRG downgrade denials to the CDI denials team. Due to no tracking process within our EMR, a manual spreadsheet has been maintained by both the coding and CDI teams for monitoring and tracking purposes, which poses as a time restraint.

We have noticed a significant increase in denials among several of our payers. One of the largest denials is for sepsis, with many attempting to use Sepsis-3 criteria. Other behaviors of payers have included the use of AI resources for pulling medical accounts with targeted diagnoses. This behavior has resulted in large denial dumps, causing great stress to our teams who write appeals letters.

Q: When asked who in the CDI department is involved with the denials management/appeals process, 45.19% of respondents named a designated denials or appeals specialist, which continues the year-over-year increase from previous industry survey data (29.17% in 2024, 35.89% in 2025). 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: The UKHS CDI team members have been the experts when it comes to denials management of the appeal process. We have designated CDI specialists who were trained and now focus only on tracking, reviewing, then writing our appeal letters. Some CDI specialists are PRN and work 10 hours a week, while a CDI lead at another hospital manages the denial process. Our CDI specialist team spends anywhere from 20 to 35 hours per week at two of our five hospitals. We have three other smaller community hospitals who write appeals ad hoc.

Q: Clinical validation was the most common type of denials that CDI programs are involved with,

chosen by 87.7% of respondents. The runner-up was DRG validation, chosen by 66.04% of respondents, in line with last year's results. What types of denials does your CDI team help with, and how was that decision made? What advice do you have for CDI professionals who are just getting started in reviewing denials?

A: I agree with the statistics based on our most recent poll. We do see clinical and DRG validation as our top two reasons for denials, and appeal most of the cases we receive from payers. We work diligently to ensure we provide strong clinical evidence supporting the diagnosis the payer is challenging.

For anyone just getting started, we recommend having a template for your CDI specialist to use for their first denial with as much clinical detail and coding guidance as possible. Many times, payers don't overturn their denial on the first appeal. We found that CDI reviewers were spending lots of time writing lengthy letters with their clinical evidence only to have it overturned, so the second denial letter is a summary of key points included from the first letter. The third letter is a statement upholding our clinical findings that support our appeal.

Q: Sepsis remains the most commonly denied diagnosis reported by respondents, seeing a small increase from about 85% to 89% year-over-year. Respiratory failure also saw an increase for the second year in a row, from 77.61% to 80.21%. In line with 2025, encephalopathy was chosen by almost 57% of respondents, indicating last year's nine-percentage-point increase was not an outlier. 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 methods have you noticed help move the needle for any of them?

A: Sepsis continues to be our top denial again this year. Many times, we see denials due to the use of Sepsis-3 and SOFA criteria not being captured according to their guidelines of "life-threatening organ dysfunction caused by a dysregulated host response to infection." CDI partners with inpatient coding to query for the organ dysfunction linking to sepsis and not rely on a diagnosis of only sepsis or severe sepsis.

The second highest is acute respiratory failure, followed by malnutrition, encephalopathy, and acute kidney injury. We work on reducing denials by obtaining clinical specificity or clinical validation to ensure we have clinical indicators linked to the documentation using MEAT criteria (monitor, evaluate, assess, treat).

Q: About 25% of respondents said their program uses some form of technology to identify charts that may be vulnerable to denials, a significant increase from last year (18.4%). 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: Currently, we do not have any additional technology assistance supporting the denial process. We are investigating a third-party vendor to assist with writing denial letters for certain payers, evaluating whether a different approach could increase our overturn rate.

The advice I would give to CDI programs is to understand the process of how the technology would be implemented. If you plan to implement the same process, consider what data would support your key performance indicators as well as the cost with its return on investment.

Q: Of those with access to denials data at their organization, 14.02% of respondents reported that their inpatient claims result in a denial of any kind about 6%–10% of the time, followed by almost 11% that said it happens 1%–5% of the time, and 7.32% who said 11%–20% are denied. What does the rate of denials look like at your organization? Has your organization seen an increase in recent years? How has CDI involvement affected your denials and appeals data in general?

A: Due to recent revenue cycle department restructuring, I do not have exact data on the increase in denials. However, based on the growing use of third-party auditing companies by payers and the rising volume of denial letters requiring review, we have had to increase budgeted hours to support denial appeal writing. As noted earlier, vendors' use of AI software has also added to the appeal writing workload.

We are beginning to have conversations with department chairs and physician informatics about the back-end work being done by the CDI team. The awareness has been greatly appreciated as providers have no idea how much time, resources, and denial management is being done on patient charts that they think have great documentation.

Q: When asked what methods their CDI team employs for denial mitigation, about 49% of respondents said they clinically validate high-risk diagnoses concurrently, and another 38.67% review denials on a case-by-case basis upon request. In third place was conducting mortality reviews for denial defense (34.79%), a small increase from 2025 (31.03%). What tactics does your CDI team employ (through query drafting, collaboration, data analysis, etc.) to mitigate denials?

A: Clinical validation has been a large focus this past year. We have spent time sharing examples of areas that could be increased with supportive documentation using clinical validation queries. We ensured our clinical validation query templates were simple and easy to use for both the CDI specialist and the provider receiving the queries.

Another focus has been strategic DRG reviews, with a retrospective final bill workflow ensuring strong clinical criteria. These case-by-case reviews safeguard for our patients and providers that we have strong documentation for denials and focus on ensuring an accurate and concise electronic health record (EHR).

Q: Denial mitigation and CDI involvement has been an important industry topic for a while, but how have you seen the conversation evolve in recent years? What external factors do you anticipate influencing how denials are changing and/or how CDI teams will be involved in the future? Any other thoughts you have on the future of the industry in this area are welcome!

A: CDI experts at the table of denial mitigation have been key. CDI involvement during payer contract discussions would be a future win for any hospital and health system strategy. I do believe AI software usage will continue to increase in the denial industry and thus require AI-generated assistance for CDI workflows on the back end for the appeal process.

It may also be a matter of incorporating AI scoring to provider notes within the EHR to measure denial vulnerability. We must keep working with key stakeholders on getting ahead of the denial game instead of being on the defense. Keeping the dollars in-house to cover the cost of patient care instead of lining the payer's pockets will require executive focus and collaboration to identify how to work smarter instead of harder.

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The Denials Crisis and the Evolution of Documentation: A New Era

CDI has changed dramatically in the last decade.

For centuries, medical records focused on continuity of care and communication among clinicians. What began as straightforward documentation to support care is now the backbone of reimbursement, denials prevention, audit defense, and quality reporting.

The result is a documentation system doing far more than it was ever designed to do, and a level of burden many hospitals are struggling to absorb. At the same time, coverage requirements, clinical criteria, and review processes have grown more complex and dynamic, increasing the level of rigor expected in the medical record.

How Documentation Became Overloaded

The balance began to tip as healthcare systems modernized. The transition from paper to electronic health records brought undeniable benefits: legibility, portability, durability, and access to longitudinal patient histories. Documentation became easier to store, retrieve, and analyze, but at the same time new expectations accumulated.

Documentation was increasingly relied upon to validate billing, satisfy audits, meet regulatory standards, and support performance reporting. Each new requirement added complexity, asking the same clinical note to serve multiple, and often competing, purposes. Over time, documentation drifted away from clinical storytelling and toward administrative validation.

To manage this complexity, organizations layered on reviews, audits, and queries. Though these interventions were meant to correct gaps retroactively, they introduced friction into clinical workflows and didn't prevent those gaps from occurring in the first place. Notes evolved from narratives of care into checkpoints for compliance and clinicians spent more time documenting and responding to queries, while downstream teams struggled with records that were technically complete but clinically fragmented.

Retrospective reviews and audits aimed to fix documentation issues but often failed because they addressed symptoms rather than root causes. Rules-based processes scaled existing problems instead of resolving them, multiplying documentation burden rather than simplifying it. Meanwhile, denials, particularly around DRG downgrades, readmissions, and authorizations, continued to rise in volume and complexity, demanding more sophisticated documentation and review to resolve.

The system didn't fail because documentation was inaccurate. It failed because it was no longer designed around context.

The Turning Point: Moving CDI Earlier

A fundamental shift is now underway: moving CDI earlier in the process, before coding and billing are finalized. Instead of relying on retrospective correction, organizations are focusing on the window between post-discharge and bill release, when documentation can still be clarified without disrupting patient care or delaying reimbursement.

Effective solutions now exist that integrate full-chart context, AI-driven prioritization, and structured review workflows. As an example, VISION Clinical Validation Technology® by CorroHealth supports pre-bill review to resolve documentation issues before

they impact downstream processes. VISION transforms CDI by uniting advanced machine learning with generative AI and clinical expertise, driving a 102% increase in DRG findings and up to six times the ROI, while cutting denials and reclaiming lost revenue.

Importantly, technology alone is not enough. Many documentation workflows were designed for manual review and retrospective correction. Simply digitizing those processes preserves inefficiency. Real progress requires redesigning workflows to remove unnecessary steps and allow intelligent systems to operate where they add the most value, behind the scenes, rather than in front of clinicians. It also depends on closer alignment between CDI, coding, and denials teams so that what is learned from reviews, audits, and denials consistently informs upstream documentation.

The opportunity today is not to document more, but to document better. When systems understand context, they can help ensure that records accurately reflect the patient's condition and the care delivered. Ambiguity decreases, chart reviews accelerate, and documentation becomes more defensible, all without increasing clinician workload. Modern solutions can transform CDI from an administrative requirement into a strategic asset that serves clinicians, patients, and healthcare organizations alike.