CDI’s role in preventing downstream denials
Improve CDI performance and demonstrate impact
3M™ Performance Advisory Services with Performance Data Monitoring 2.0

Performance Advisor
- Analysis and custom reports
  Uncover key findings in your data from custom reports built by performance advisors.
- Improvement strategies
  Make data-based decisions on education, prioritization rules, staffing changes or workflow.
- Coaching
  Receive ongoing coaching from performance advisors to discover opportunities.

Performance Data Monitoring Software
- Metrics and benchmark reports
  Assess financial impact and opportunity, operational metrics and variance against national benchmarks.
- Drill-down capability
  Review reports by site, time period, payer, service line, physician, DRG and case/patient.

Physician dashboard
- Show actual versus expected performance against peer groups to improve physician documentation.

Click to learn more or visit go.3M.com/pdm
FEATURES

6  Interdepartmental collaboration for denials management
When it comes to denials management, interdepartmental collaboration is imperative for both preventing and appealing denials.

14  CDI leaders’ perspective on denials management
During a recent ACDIS Leadership Council meeting, members of the Council discussed their CDI departments’ involvement in denials management and shared lessons learned.

22  Sepsis and malnutrition denials
It’s no secret that certain diagnoses seem to be frequent denial targets. Each year, respondents to the CDI Week Industry Survey say that both sepsis and malnutrition remain top denied diagnoses with little sign of those denial rates slowing.

34  Physician advisors and denials management
As with CDI’s involvement in any new project or venture, there are a number of avenues for involvement in the denials management and appeals process, and organizations may leverage their physician advisor differently.

OPINIONS & INSIGHTS

9  Strategies for clinical validation
Sydni Johnson and Denice Piwowar offer advice for dealing with the most common clinical validation targets.

18  Denial volumes as KPIs
Anneleah Williams-Bridges discusses the need for denial volume trending as a CDI key performance indicator.

27  CDI tips for top denied diagnoses
Brian Simpson shares his lessons learned from fighting sepsis, pneumonia, respiratory failure, malnutrition, encephalopathy, and acute kidney injury denials.

CONTINUING EDUCATION CREDITS

BONUS: Obtain one (1) CEU for reading this Journal
ACDIS members are entitled to one continuing education credit for reading the CDI Journal and taking this 20-question quiz.

For permission to reproduce part or all of this newsletter for external distribution or use in educational packets, please contact the Copyright Clearance Center at www.copyright.com or 978-750-8400.

CDI Journal (ISSN: 1098-0571) is published bimonthly by HCPro, 35 Village Road, Suite 200, Middleton, MA 01949. Subscription rate: $165/year for membership to the Association of Clinical Documentation Improvement Specialists. © 2020 HCPro, a SimplifyCompliance Healthcare brand. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro or the Copyright Clearance Center at 978-750-8400. Please notify us immediately if you have received an unauthorized copy.

For editorial comments or questions, call 781-639-1872 or fax 781-639-7857. For renewal or subscription information, call customer service at 800-650-6787, fax 800-639-8511, or email customerservice@hcpro.com. Visit our website at www.acdis.org. Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. Opinions expressed are not necessarily those of CDI Journal. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions.
Credit where credit is due

by Linnea Archibald

When people talk about CDI’s effect on an organization’s health, often they are referring to the traditional CC/MCC capture and DRG changes for financial improvement and accuracy associated with CDI reviews. Of course, we know that CDI professionals do so much more than that for the health of an organization—from appropriate reimbursement, to improved quality scores that reflect a patient’s true severity of illness, all the way to better patient care through the continuity and precision of the medical record. CDI’s reach is long, and their fingerprints can be found all over an organization.

Traditionally, CDI’s work happened before the bill dropped, while the patient was in the hospital or immediately following discharge before final coding. Even with the most stringent CDI processes and an exceptionally engaged physician group, we know that that final bill will never be entirely safe from auditor scrutiny or secure from the risk of denial.

According to the 2020 CDI Week Industry Survey respondents, payer denial tactics are getting more and more aggressive with each passing year, putting organizations at great financial risk. This risk perhaps feels even greater this year in light of slashed organizational budgets and revenue shortages associated with COVID-19. According to ACDIS’ May 2020 survey regarding COVID-19’s impact on CDI departments, more than 60% of respondents said their department has been impacted by organizational cost-saving measures such as staff furloughs, education budget cuts, unpaid time off, pay reductions, and even layoffs.

Because of this landscape and the tenuous nature of organizational bottom lines, an increasing number of CDI departments find themselves tasked with helping to avoid downstream denials or push back the wave of existing denials through the appeals process. That’s why we’ve devoted this entire edition to CDI’s role in denials management.

Within this edition’s pages, you’ll find insight into current denial targets from the Office of Inspector General in our Podcast Recap on p. 20, tactics for particularly problematic diagnoses compiled by ACDIS Associate Editor Carolyn Riel on p. 23 and from Brian Simpson, MS, RRT, CCDS, CDIP, CCS, CRC, on p. 27, as well as a variety of articles surrounding CDI’s everyday involvement with this process.

We know that any new project comes with a slew of challenges and decisions based on staffing, resource allocation, productivity
expectations, and the like. While some CDI teams may have the bandwidth to step into a more involved role with appeal writing, others may focus primarily on incorporating clinical validation reviews and education into their existing reviews on the front end, or help out on an as-needed basis when asked for input.

No matter your organization’s level of involvement, this issue seeks to highlight ways CDI professionals can aid in denials prevention and the appeals process and get credit for the value they bring by doing so.

For those who are just starting the conversation about CDI’s involvement, read the article from Riel on p. 6 about collaboration opportunities in this arena. Leaders can also turn to p. 14 and read the article I wrote with the ACDIS CDI Leadership Council members about managing your new priorities and data.

For those involved in front-end denials prevention work, take a look at the articles by Sydni Johnson, RN, BSN, CCDS, Denice Piwowar, BSN, RN, CCDS, and Trey La Charité, MD, FACP, SFHM, CCS, CCDS, on p. 9 and 38 related to clinical validation processes.

If your department has a physician advisor at its disposal, there’s an article on p. 34 from Riel that outlines how you can leverage their expertise for this process as well. La Charité’s article will be informative here too.

As with any new venture, CDI leaders need to know how to track and trend the department’s success in order to make decisions about ongoing involvement, resource allocation needs, and any tweaks to improve the process. My article on p. 14 deals with this topic, but we also have an excellent guest column from Anne-leah Williams-Bridges, MS, MBCA, RHIA, CCS, CCS-P, CCDS, RH-CBS, LIA, on p. 18 all about denial volumes as a key performance indicator.

This edition also includes articles focused on mortality review and its impact on observed to expected mortality ratios from Howard Rodenberg, MD, MPH, CCDS, on p. 32, a recap of this most unprecedented year from Associate Editorial Director Melissa Varnavas on p. 12, and an interview with one of our ACDIS members in the Meet a Member column on p. 41.

Whatever your involvement is with the denials management and appeals process, the value you’re bringing to your organization should not be underestimated. Especially this year, ensuring your organization gets the proper credit and reimbursement from payers for the care it’s provided is paramount.

We hope this edition will help you navigate this landscape and stem the denials tide.

We hope this edition will be a help to you navigate this landscape and stop the stream of downstream denials.
CDI teams have to work with other departments nearly daily in their line of work, be it the coding department, the clinical team, the quality department, or others. When it comes to denials management, this interdepartmental collaboration becomes even more imperative for both preventing and appealing denials.

“You’ve got to have interdepartmental collaboration,” says Rani Stoddard, MBA, RN, CPHQ, RHIA, CCDS, CCS, CDIP, CDI and health information management (HIM) supervisor at Henry Mayo Newhall Hospital in Valencia, California. “Breaking down silos is so essential. CDI can’t function without the other departments.”

Not only can the other departments widen CDI’s view and help them understand the scope of the denials management and appeals process, but CDI’s involvement also helps other departments and individuals understand the documentation requirements and the risk of denials.

Getting involved

Knowing that a CDI team needs to work with other departments on denials management is one thing, but implementing that collaboration is a whole other monster to tackle. “We started involving CDI in denials very slowly,” says Stoddard. “It’s funny, because originally the coding supervisor was writing appeals but would work with me for clinical input.”

Stoddard says that with writing more and more appeal letters, over time she took over this portion of the denials process.

“As the CDI supervisor, I now have full-time responsibility of writing denials letters,” she says. “I lean heavily on my staff, especially our CDI educator for the really tough ones. She has a background in insurance denials, so she really
helps to give me the extra information that I need.”

When stepping into the denials arena, Stoddard says it’s helpful to take an in-depth look at your facility’s existing denials and see where the trouble spots are. “It was amazing to me that there was such a huge percentage that are single CC or MCC,” she says. “You can really see what the insurance companies are targeting, which allows us to pass that information back to our CDI staff as education.”

For education, Stoddard says their organization has a denials coordinator who creates financial presentations for the business office. “I do the action plan for what we can do to make it better, and we bring this together in a structured PowerPoint® for presenting the data,” she says.

Stoddard goes over everything she covers in the financial presentation with her CDI team in their weekly meetings. “We have full disclosure, so anything I share with the denials team I share with all of the CDI team as well,” she says. “They need to know what’s going on.”

Finding collaboration avenues

CDI teams will need to work with different departments and groups throughout the denials management and appeals process depending on the case, but the business department will likely become a constant ally, Stoddard says.

“We work hand-and-glove with the business department,” she says. “We have a denials management meeting every month with the business office.”

In addition to formal and concerted collaboration efforts, the CDI department’s reporting structure may also provide a natural opportunity for collaboration.

“We, as the CDI department, report up through the director of HIM, and that person reports directly to the CFO [chief financial officer],” says Stoddard. “Even if we reported to quality, we would still be working with the business office, though.”

On a more personal level, CDI specialists may need to work independently with individual clinical departments on their documentation or as a case-by-case effort for education.

“I’m working with the orthopedic manager to help her understand CC/MCCs because it’s really not something they’re taught,” Stoddard says.

It might take more than one try, but never give up and always remember the patient is the bottom line. That’s what keeps me going. You might look at denials and think it’s just all about the money. But the truth of the matter is that if we don’t have the money to keep the hospital afloat, we can’t care for the patient.

Rani Stoddard, MBA, RN, CPHQ, RHIA, CCDS, CCS, CDIP

On the back end, there may be numerous collaboration opportunities during the appeals process for collaboration. CDI specialists may work closely with the physician advisor and dietitian for administrative law judge (ALJ) cases with malnutrition, or with doctors from other specialties.

When you’re assembling your team to fight a denial—whether that means being on a call with an ALJ or writing a compelling appeal letter—make sure to involve the people who can speak to the clinical nuances of the case at hand. For example, if there is a pressure ulcer denial, the CDI specialist working on this denial should reach out and work with the wound care team.

Gaining buy-in

While gaining physician and other departments’ buy-in can feel like an uphill battle, Stoddard says she has been successful with finding support for CDI’s involvement with the denials management process.

“There’s been an overall spirit of comradery and teamwork,” says Stoddard. “I think part of it might be because we are all working so hard and closely in the COVID-19 environment. We’ve had some layoffs like a lot of organizations have, so now we’re really focused on all pulling together, not worrying about competition between departments, and just having the attitude of asking ‘how can I help?’ ”

That willingness to help one another also comes from every individual and department understanding the role they play in the denials
management process, and when needed everyone involved can be reminded how they fit into the larger picture. It may also be helpful to have one point-person who is part of the denials process that everyone else involved can report to and count on; this helps gain buy-in for the idea of teamwork.

If you are having trouble gaining buy-in or even getting CDI’s foot in the denials door, don’t give up—keep reaching out to find the right person who will see the value.

“It might take more than one try, but never give up and always remember the patient is the bottom line. That’s what keeps me going,” Stoddard says. “You might look at denials and think it’s just all about money. But the truth of the matter is that if we don’t have the money to keep the hospital afloat, we can’t care for the patient.”

BOOK EXCERPT: BASIC APPEAL CONSTRUCTION

by Trey La Charité, MD, FACP, SFHM, CCS, CCDS

If you are convinced the denial is unfounded, it is time to craft the actual appeal. At this time, all supporting documents previously collected should be immediately available. This ensures that all potential counterarguments are considered and increases the efficiency of the creative process. Trip after trip to the bookshelf, to the computer, to the copier, to the printer, or to a collaborator’s desk serves only to slow down and distract from accomplishing the stated task.

Additionally, set aside sufficient time to construct the appeal letter before getting started. Interruptions to the creative process are damaging if not frustrating and can lead to lower-quality work. In other words, if 20 minutes remain before the start of an hour-long hospital committee meeting, wait until that meeting is over before becoming engrossed in all the reasons the Recovery Audit Contractor (RAC) is incorrect.

For the actual letter structure itself, develop a general appeal letter format or template and stick with it. Appeals will occur with a large enough frequency to warrant this approach. Having to expend effort only on constructing the individual counterarguments in any given letter will save both time and energy. The more aspects of an appeal letter that can be systematized or transcribed into other appeal letters, the more time is available to ensure the appeal is won and that the RAC cannot exploit that crack in the hospital’s defenses again in the future.

When constructing an argument in the body of the appeal letter, be sure to cite from exactly what source or sources that argument is drawn. The physical copies of those sources that will be faxed or mailed with the appeal letter must then be conspicuously highlighted or underlined at the specific sections of text that corroborate that argument. (Remember that highlighting does not transmit through faxes, as facsimile machines almost universally print in black and white only.) This highlighting or underlining must be done, as the RAC cannot be trusted to find those portions of the text on his or her own.

Not surprisingly, numerous sources have speculated that evidentiary citations received by auditors that do not have the critical elements highlighted or underlined frequently end up in the recycle bin without any review or consideration. For every counterargument made in an appeal letter as to why the RAC is wrong, these steps must be repeated. Occasionally, it may seem as if the entire medical record must be sent again. However, if that is what it takes to win an appeal, that is what should be done.

Editor’s note: This sidebar is an excerpt from the book, *CDI Field Guide to Denial Prevention and Audit Defense* by Trey La Charité. To find out more about this book (and ACDIS’ entire library), click here.
GUEST COLUMN

Essential strategies for clinical validation

By Sydni Johnson RN, BSN, CCDS, and Denice Piwowar, BSN, RN, CCDS

Clinical professionals generally consider clinical validation queries to be the most challenging queries to generate and format. As CDI managers and educators, we’re often asked how to request supporting indicators of a documented diagnosis without questioning the provider’s judgment or coming across as leading, which is what we’d like to address in this column along with some basics of clinical validation.

First, know that the clinical validation process generally requires cooperation between CDI professionals, HIM professionals, quality professionals, and providers. Qualified professionals with evident clinical knowledge generate clinical validation queries when they identify a gap between the documented diagnoses and clinical indicators. The treating provider, however, remains the ultimate authority for the diagnostic decision.

According to the American Hospital Association’s advice and the ICD-10-CM Official Guidelines for Coding and Reporting, “Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.” This guideline can pose a conundrum for anyone sending a query, and they may wonder whether clinical validation queries are necessary (or ethical) if code assignment is based on documentation and not clinical criteria. One answer to this question is that documentation of robust clinical indicators supporting the diagnoses and procedures helps secure the accuracy of both reimbursement and quality reporting.

CMS introduced clinical validation as part of the Recovery Audit Contractor (RAC) program. The RAC program was established to identify improper payments on healthcare claims paid by Medicare Part A and B. RACs and other external auditors have excluded principal and/or secondary diagnoses that affect MS-DRG assignment due to lack of clinical validity. In other words, clinical validation denials can result in a DRG and/or reimbursement change. Clinical validation queries help ensure the integrity of documented diagnoses and can assist in preventing these denials.

A successful clinical validation process starts with educating not only the CDI and coding teams, but also providers. A query is simply one of many tools that can be used in this process. If the providers do not understand the “why” behind the question, though, it will be difficult to get them to respond appropriately.

Lack of provider engagement with the clinical validation process can also reinforce the CDI professionals’ reluctance to send these types of queries. The providers need reassurance that the query process is not intended to question their clinical judgment or medical decision-making, but rather to support their work and appropriately capture resource utilization.

Defining troublesome diagnoses

One way to assist providers and CDI professionals in understanding and supporting clinical validation is by obtaining consensus within the organization on standardized definitions of diagnoses and procedures that are “at risk” for denials.

For example, in 2018, the Banner Health Critical Care Consortium adopted the Surviving Sepsis Guidelines third edition criteria to define sepsis. After careful study of recommendations from leading medical societies and published sepsis mortality data, Derek Braun, MD, medical director for care coordination, met with the internal medicine and Critical Care Consortium groups as well as the sepsis advisory group to discuss industry standards and review the varied sepsis indicators being documented within the organization.

The group also considered, debated, and ultimately rejected other commonly used criteria, such as Sepsis-3, primarily due to the lack of support in identifying early sepsis. After consensus was achieved, the Critical
Care Consortium issued a position statement that was distributed to all providers within our organization.

Additionally, we executed a grassroots education plan to ensure all providers, CDI professionals, and coders were aware of the guidelines. In the following months, CDI professionals at 18 Banner inpatient facilities met with various provider groups to bolster the recommendations set forth by the clinical leadership.

We have also adopted the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria to identify and diagnose severe protein-calorie malnutrition. These criteria are the primary tool used by all registered dietitians to evaluate for protein-calorie malnutrition in the adult patient population. The ASPEN malnutrition severity scale has been integrated into the EHR and is a standard part of nutrition consults. Additionally, the EHR alerts the attending provider when a nutrition consult has been completed. The intent of the alert is to facilitate timely review of the assessment, expedite implementation of treatment, and promote improved accuracy in documentation of malnutrition severity.

Establishing uniform criteria for the diagnoses of sepsis and severe protein-calorie malnutrition has helped CDI professionals consistently identify scenarios where documentation lacks sufficient clinical evidence, prompting the generation of a clinical validation query.

**Querying without consensus definitions**

A lack of consensus need not dissuade the CDI program from developing its own standards that outline medically accepted, evidence-based definitions that include supporting clinical indicators for commonly queried diagnoses. These standards can be used to develop query templates that promote a consistent query process and elicit provider engagement.

At Banner Health, we have developed a robust library of query templates. We are fortunate to have physician advisors available to review the templates and offer feedback. The query templates also include diagnosis-specific reference materials with examples of clinical indicators and coding guidelines to assist CDI professionals in developing a clinically credible and compliant query. (To read about other ways physician advisors are involved in the denials management process, see the article on p. 34.)

Although it can be helpful for a CDI program to establish standardized definitions and clinical criteria for query construction, it’s important to recognize that not all patients will display the same indicators and providers have the autonomy to establish a diagnosis based on criteria of their choosing. In other words, providers can use their own clinical judgment to determine a diagnosis.

According to the 2019 update of the ACDIS/AHIMA “Guidelines for Achieving Compliant Query Practice,” “While organizations, payers, and other entities may establish guidelines for clinical indicators for a diagnosis, providers make the final determination as to what clinical indicators define a diagnosis.”

To defend that diagnosis against a denial, though, providers need to document their clinical decision-making and the indicators used to establish the diagnosis. Per ACDIS guidance, a clinical validation review process is intended to confirm that the provider’s clinical criteria can be easily linked to the corresponding diagnosis. Clinical validation is a regulatory requirement under the False Claims Act, as diagnoses that are billed to Medicare or Medicaid for payment “must be clinically valid.”

**Knowing when to query**

The clinical validation query process should be initiated when a diagnosis appears to be unsubstantiated and/or there is conflicting or contradictory clinical evidence in the record. Clinical validation queries can be challenging to compose and are not intended to question the provider’s clinical judgment.

A clinical validation query is simply an opportunity for a provider to document supporting clinical indicators or rule out the diagnosis. According to an ACDIS white paper, “An alternate response to the query would be to negate the diagnosis as erroneous or ruled out.”

Clinical validation queries can have various formats, including open-ended questions, multiple choice, yes/no, or rule in/rule out formats. CDI professionals can also deliver the query verbally, which allows for real-time
discussion about the “why” and may prevent providers from feeling their diagnosis is being challenged.

Regardless of the format used, the query must contain a request for documentation of the substantiating clinical indicators. The CDI professional must be mindful of verbiage to ensure the query is not leading, is not perceived as questioning the provider’s clinical judgment, and conforms to compliant query practices. The query should clearly state the risk factors, clinical indicators, and treatments that were present in the record even if they do not support the diagnosis.

CDI professionals at Banner Health can choose from several clinical validation query templates depending on the circumstances. The open-ended template may be the best option for a verbal query, whereas a rule in/rule out format may be clearer to the provider if the query is a written one.

If the clinical indicators in the health record support an alternate diagnosis, then a multiple choice query format should be considered with an option for the alternate diagnosis along with an option requesting the clinical indicators for the diagnosis being documented. (See samples of our query templates below.)

Ultimately, providers hold the final responsibility for documenting diagnoses with the clinical criteria supporting their medical decision-making. Nevertheless, CDI professionals can use their clinical and coding knowledge to help ensure the integrity of documentation through education and clinical validation queries.

You can think of the medical record like a movie that tells the story of the patient’s hospitalization: The diagnoses are the main characters, and the clinical indicators are supporting actors that make the stars shine.

Editor’s note: Johnson is a CDI educator, and Piwowar is the associate director of CDI, both at Banner Health in Phoenix, Arizona. Contact them at sydni.johnson@bannerhealth.com and denice.piwowar@bannerhealth.com. Opinions expressed are those of the authors and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.

### CLINICAL VALIDATION QUERY TEMPLATE EXAMPLES

Banner Health queries include risk factors, clinical indicators, and treatment. Clinical validation queries will include risk factors, clinical indicators, and treatment that were present even if they do not support the diagnosis, and they will also include lack of supporting symptoms and lack of appropriate treatments.

**Open-ended query template**

Based on your professional judgment, please document the clinical indicators which support the documented diagnosis of *(insert diagnosis here).*

**Multiple choice query template**

Based on your professional judgment, please document the condition being treated:

- *(Insert alternate diagnosis that is supported by current clinical indicators)*
- *(Insert documented diagnosis here).* Please provide supporting clinical indicators.

- Other explanation of clinical findings, please specify
- Clinically Undetermined, please explain

**Rule in/rule out query template**

*(Specify diagnosis)* was documented *(Specify where, when, and who documented)*, but has not been addressed by the attending. Based on your professional judgment please indicate if *(diagnosis)* was:

- Ruled in (please document clinical indicators and if present on admission)
- Ruled out
- Other explanation of clinical findings, please specify
- Clinically undetermined, please explain
ASSOCIATE EDITORIAL DIRECTOR’S NOTE
Wade in the waters of record defense

by Melissa Varnavas

When I was a kid, my siblings would tease me. They’d tell me I was wrong, that I didn’t know what I was talking about. They’d say, “You’re in denial, and it ain’t just a river in Egypt.” Imagine a kid in pigtails sticking out her tongue and wagging her fingers in the air.

Fun facts about the Nile River:
- It’s the longest river in the world
- It’s home to more than 100 animal species, including hippos
- It cuts a swath of fertile land across an otherwise desert landscape

I think about that silly old play on words whenever we discuss a CDI program’s role in denials management.

Fun facts about denials:
- In 2015, Recovery Auditors Contractors (RAC) returned nearly $4 million to Medicare, according to the Council for Medicare Integrity
- Healthcare plans under the Affordable Care Act marketplace denied an average of 1 in 5 in-network claims in 2017; denial rates ranged from 1% to more than 40% across insurers, according to the Kaiser Family Foundation
- More than 240,000 RAC-related appeals remain pending in the in the Office of Medicare Hearings and Appeals (OMHA), by the end of the second quarter of 2020, according to a court memo released by the American Hospital Association (AHA), this past June

Denials management represents as important a piece of the healthcare revenue cycle ecosystem as accurate medical record documentation, code assignment, and billing practices—even if Nile River facts are way more fun than facts about denials.

No one wants to pay for services they never received. Certainly, no one wants the government using taxpayer dollars to fund care that the patient never received. This core concept represents the impetus behind much of the federal government’s efforts in recouping dollars billed for diagnoses unsupported in the medical record.

Another fun fact: The United States spent $3 trillion on healthcare in 2014, roughly $9,523 per person and more than 17.5% of the gross domestic product, according to CMS’ 2015 National Health Expenditures Highlights report. Almost half (45%) of healthcare costs are currently paid for through some form of local, state, or federal government sponsorship, according to Trey La Charité, MD, FACP, SFHM, CCS, CCDS, in the book CDI Field Guide to Denials Prevention and Audit Defense. (For more denial tips from La Charité, make sure to read the article on p. 38.)

Many call the government’s audit and denial intentions into question due to recoupment methods such as incentivizing RACs to identify errors by paying them a share of the money recovered. Yet the government’s efforts in identifying fraud, waste, and abuse are fairly transparent. In fact, several federal agencies offer information about their payment-error targets; the Office of Inspector General publishes its Work Plan, and CMS issues the Program for Evaluating Payment Patterns Electronic Report (better known as PEPPER) and the Medicare Quarterly Provider Compliance newsletter. Even RACs are required to announce their review targets ahead of time.

Currently, CMS’ record review, claims denial, and auditing efforts remain in flux. Back in March, CMS suspended most Medicare fee-for-service medical reviews—conducted by Medicare Administrative Contractors, RACs, and others for both pre- and post-payment—in order to allow providers to focus their time and resources on fighting the COVID-19 pandemic. By August, however, CMS said it was resuming its audit efforts, according to the AHA.
These are just a few reasons CDI professionals need to stay informed about denials and audit activities. Here’s another: While Medicare represents the largest healthcare payer, most commercial insurers follow CMS’ lead. While the federal government wants to make the most of its meager healthcare dollars, private insurers want to hold onto every dollar possible to make a profit for their shareholders. And while CMS pays for roughly half of Americans’ healthcare coverage, 55.8%—or about 178 million people—have private insurance, according to the Kaiser Family Foundation.

Perhaps it’s why many respondents to this year’s CDI Week Industry Survey “feel that the denials landscape is becoming more aggressive with time.” According to the Industry Survey, nearly 60% of respondents said that their CDI department is currently involved in the denials management process. More than 35% assist in writing appeal letters, more than 25% review specific diagnoses for denials prevention, and slightly more than 20% send post-discharge queries and/or conduct mortality reviews to defend against denials.

CDI professionals need to know about the ebb and flow of this aspect of the healthcare payment system. This edition of the CDI Journal focuses on all the ways that programs have waded into these denials management waters in an attempt to prevent audits and ensure not only the integrity of the medical record, but the continued flow of the entire healthcare revenue river.

You know the history—CDI programs for the most part originated in 2007 after CMS instituted the MS-DRG system. The new system allowed for the capture of greater granularity and better specificity regarding patients’ level of sickness. With this came increased reimbursement based on the care needs of those patients. CDI professionals help ensure that all the right documentation leads coding professionals to capture that severity. But between the final coded, final billed, and final payments comes intense scrutiny of the medical record, especially for high-dollar, high-volume diagnoses.

While it may not be a zero-sum game per se, there are definitely drought and flood seasons related to our healthcare economy. Understanding the role of CDI in denials can help your program and your facility stay afloat—and not just on that river in Egypt.

**Editor’s note:** Varnavas is the associate editorial director for ACDIS. Contact her at mvarnavas@acdis.org.
Managing priorities, monster spreadsheets: CDI leaders’ perspective on denials management

by Linnea Archibald

As the CDI profession has matured and expanded over the years, many CDI departments find themselves pulled down new avenues outside of the traditional chart review process. While not traditionally a role of CDI work, many have begun branching out into denials management and appeals because of CDI professionals’ unique perspective and chart review prowess.

According to previous CDI Week Industry Survey results, the percentage of CDI departments involved in denials management has grown from roughly 56% in 2019 to 60% in 2020, showing a slow but steady overall industry expansion. During a recent ACDIS Leadership Council meeting, members of the Council discussed their CDI departments’ involvement in the denials management process, shared lessons learned along the way, and offered takeaways for those interested in expanding to this area themselves.

Choosing a starting point

Given their unique roles and view of the entire patient chart, it’s not surprising that CDI professionals are increasingly called upon to help with the denials management and appeals process.

“CDI specialists […] are uniquely prepared to do an appeal against a clinical validation denial,” says Dee Banet, RN, BSN, CCDS, CDIP, regional director, CDI Central Florida Division—Northern region, at AdventHealth in Daytona Beach, Florida. “They have a very unique skill set, having that clinical expertise and that understanding of the coding process. They’re just going to be more successful in appealing the denials.”

Even if their team has an apparent aptitude for this type of work, CDI leaders need to define a clear focus to determine the team’s scope of involvement, staffing needs, and resource allocation. According to Banet, a natural starting place may present itself based on the types of questions and diagnoses coding colleagues challenge. It’s likely that
the coding team has a good grasp of which diagnoses get denied frequently, and some may even be hesitant to code certain things knowing they will likely be denied.

This practice is difficult to justify based on the *Official Guidelines for Coding and Reporting* guideline 19, which stipulates that code assignment is based on the provider’s judgment and statement that a diagnosis exists. Therefore, clearing up those documentation trouble spots on the front end with good documentation will make the coders’ jobs easier and help prevent denials on the back end.

“We were initially getting a lot of pushback from coding and they were saying we couldn’t code certain things because it’ll get denied,” says Jo Brautigam, BSN, RN, CCDS, CDI manager at Roper St. Francis Healthcare in Charleston, South Carolina. “We’ve tried to become very proactive and work with coding to see what the denials are on so that we can build queries, educate the doctors, and preempt the denial by having it already in the documentation.”

Even if your coding department hasn’t brought any issues to your attention, leaning on their expertise will help you determine where to start and how the CDI team can help. According to Angela Edwards, BSN, RN, CCDS, CCS, system manager of CDI at Hospital Sisters Health System in Decatur, Illinois, many CDI teams find themselves thrown into the denials conversation with an increase in clinical validation denials, which offers a natural entry point for collaboration with the coding team.

“The coding staff are wonderful at what they do. I don’t know everything about coding, so having someone with that unique skill set has been invaluable when we’re doing the clinical validation denials,” she says. “As that number has increased, it’s really driven the need and the financial impact for how having CDI involved can really help offset those setbacks.”

“Addressing staffing, scope

Once CDI leaders have determined an entry point into the denials conversation, they must face the implications for their staff and the scope of their involvement. While some teams choose to rotate the responsibility from staff member to staff member, the majority lean on their CDI leaders to avoid overtaxing the already-busy CDI staff members.

“You really want to think about productivity. We do appeal or denials management on a case-by-case basis,” Brautigam says.

“Right now, it’s mostly myself, the manager, and my senior CDI staff member who is the second-level reviewer. We’ll look at the cases, sometimes we’ll pull in a CDI reviewer who has seen the case so that they can understand what’s coming through,” she says.

“It’s a balancing act right now,” Banet adds. “I would love to have more involvement from my frontline staff, but we do not have enough resources to support taking staff away from their productivity. So, there’s myself and our educator currently doing the work for our team. I do think that feedback to the team with the purpose of helping them understand trends that we’re see-

The CDI lead not only has multiple years of CDI experience, but they’re often more exposed to the business side of things. There’s a mindset needed for denials. That said, I think anybody—a CDI specialist or lead—can do it, it’s just determining who has the time to really dig in.

Angela Edwards, BSN, RN, CCDS, CCS
Not only does a CDI leader bring a certain business knowledge to the table, but according to Brautigam, they also have a level of distance from the chart that may be helpful when writing the appeal. On one hand, a CDI specialist’s intimate knowledge of the chart provides them with the level of detail to write a compelling appeal. But on the other, that same knowledge can be a stumbling block and prevent them from zeroing in on the issue under scrutiny.

“The CDI staff are very, very attached to the chart, so any denials on my team are almost a personal affront to them,” Brautigam says. “I haven’t been in the chart, haven’t read it day by day and lived with it, so I can get in there and look at it point by point, dig through the chart. I’m looking at it from a different view. I’m not trying to see if we’re missing documentation, I’m looking for one specific topic and making sure it is solid in the chart.”

Of course, given the depth and time-consuming nature of the denials management work, some CDI leaders may find that the cost-benefit analysis for their team comes up short and it’s best to leave this work to another department. That doesn’t mean, however, that the CDI team should be left completely out of the denials loop. Denial information and data can help drive their reviews and shape their focuses, which will in turn help with denial prevention, even if the team isn’t directly involved with appeals.

“When you only have one or two CDI staff members, it may not be worth the effort,” Edwards says. “It may be better to have the denials housed somewhere else. For us, being directly involved is just the best way that we can support the organization, support the coders, and support our CDI staff by providing education and the ongoing trends of where our documentation is weak.”

**Analyzing denial trends**

Even after you’ve chosen a starting point for your foray into denials management and appeals, ongoing monitoring and analysis of denial trends is essential. While diagnoses such as sepsis, malnutrition, and respiratory failure may sit atop denial lists across organizations, getting to know your payers’ tactics and monitoring what’s happening at your particular organization will help you focus on the most impactful opportunities. (To read more about specific tactics for combating sepsis, malnutrition, and respiratory failure denials, see the articles on p. 23 and 27.)

It seems there are often two primary payer tactics across organizations: increase denial volume, and use conflicting/outdated/incorrect criteria in the denial letter. According to Brautigam, the denials for particular diagnoses seem to come in waves.

“Recently, one of the private payers went ahead and dumped 10 denials for sepsis on us,” she says. “I don’t know if there’s some kind of an automated system that picks up a code. […] We’ve had multiple denials on one chart so that it’s almost like we have no codes left, so I guess in that case we just wouldn’t get paid.”

When this type of trend emerges, it may be time to reach out to the payer higher-ups, Brautigam says. In one instance, when they had exhausted all levels of appeal and were trying to get a peer-to-peer review, she says their appeals manager actually took her complaint straight to the payer’s CEO to express their frustrations.

“It’s frustrating and it’s time-consuming and it just doesn’t seem fair,” she says. “We’ve worked very hard, no one is trying to do anything shady, and I just don’t understand how we have to work so hard just to be paid for what we’ve done.”

Any denial trends may also help CDI leaders develop stopgaps to ensure the documentation on those charts gets thoroughly reviewed before the chart is final coded and the bill is dropped, adds Edwards. This also offers another avenue for CDI and coding collaboration.

“Right now, we’ve seen a lot of denials of ATN [acute tubular necrosis] and so that’s the one right now that the coders send back to the CDI staff if there hasn’t been a CDI review on the chart,” she says.

In addition to denial volumes, pay attention to the criteria payers cite in their denial letters. On some occasions, payers will use outdated, misquoted, or differing criteria compared to what the organization uses.
to diagnose a condition (e.g., Septis-2 versus Sepsis-3 criteria).

Edwards has even seen payers use the same resources the CDI team uses, but with slight wording changes. For example, a criteria set for respiratory failure may originally say that “any of these indicators” can be used to diagnose the condition, but the payer will say that “all of these indicators” must be met to diagnose the condition. In those instances, the person writing the appeal has to be prepared to do some digging and legwork to craft the appeal.

“You really have to be nitpicky and watch for those things, then call them on it,” she says. “It’s getting very detailed.”

**Proving an ROI**

As with any new CDI venture, proving a return on investment (ROI) looms large in the minds of CDI leaders. A successful ROI can be used as rationale for additional staffing, resources, and budget for the CDI department, so leaders need to carefully track and trend that information. Not only that, but knowing where the greatest opportunities lie will help CDI leaders allocate their existing staff and resources effectively.

One way to track the potential impact is to look at the number of denials per month, and multiply the result by 12 to estimate the total amount for the year.

“For our six facilities, we’re averaging about 30 of the clinical validations per month, and they average $5,000 of the proposed overpayment. So, if you annualize that, that’s $1.8 million that’s at risk,” Banet says. “There’s definitely a business case to be built. But it really is a full-time job and it takes a lot of work.”

After the CDI team has been involved for a longer period of time, you can then analyze the successfully overturned denials and calculate the avoided reimbursement recoupment as well.

“At the end of the year I can actually report out the potential revenue loss prevention,” Brautigam says. “It can be quite significant.”

It’s likely you won’t have enough data to calculate the actual revenue saved until a year into CDI’s involvement, however, because often the appeals process (especially if it extends to multiple levels) takes months to complete, Banet says. Even if your early overturn rate is moderate, keep pushing because the story isn’t over till it’s over.

“Since we started in January, we’ve only received about 10%–15% of the responses and we’re maybe at 10%–15% overturn,” she says. “But we also haven’t given up on any that we’ve gotten back as upheld. We’ve continued to take it to the next level, to just really let them know we’re not in agreement with the denial.”

Of course, CDI leaders will also need to determine a place and method for storing the data. At the beginning of your involvement, a home-grown spreadsheet is the most cost-effective approach and will help you understand which data points need to be tracked if and when you seek a vendor-provided tracking solution. Given the scale of the data, however, it may be intimidating. Be prepared for a big spreadsheet if you go that route, says Brautigam.

“It’s really hard to track all that data. That’s how you end up with the monster spreadsheet,” Brautigam says. Once you have the data behind you, though, and can prove an ROI, you’ll be able to make the case for more sophisticated solutions, she says, which will allow you to track with greater detail and hopefully less manual work. “We use a vendor, so they track all the letters, the overturns, and the financial impact,” she says.

Once that data is compiled in your tracking system and you’ve had some time to analyze the trends, you’ll be able to not only set a direction for CDI’s involvement in the future, but help the payer-contracting team negotiate with third-party payers on contract language to include certain diagnosis criteria sets and hopefully eliminate some of the most troublesome denials.

“Once we have the data in one place,” Edwards says, “I can’t wait to take it to some of the managed care team who would do the contracting for the entire system.” 🥰
Using denial volumes as KPIs

by Anneleah Williams-Bridges, MS, MBCA, RHIA, CCS, CCS-P, CCDS, RH-CBS, LIA

Until recently, many organizations have solely used their CDI resources to strengthen the capture of CCs/MCCs, Hierarchical Condition Categories, severity of illness/risk of mortality, and DRG validation. As shown in the 2020 CDI Week Industry Survey, however, 60% of respondents are now involved in the denials management or appeals process. Many organizations are using CDI professionals to review medical records for clinical validation query opportunities and assist in crafting appeals. In addition to back-end denials management, organizations can set initiatives based upon the denials data they already have, launching a more proactive approach to prevention.

Facilities that are not leveraging CDI efforts for denials management and tracking denials as a key performance indicator (KPI) should consider doing so. Denials are the framework for identifying gaps in provider documentation and are a surefire approach to tailoring physician education that is meaningful. Most providers prefer education through key points that help them improve their individual documentation deficiencies, rather than “blanket” education that’s less specific. To start leveraging denials data, however, we need to recenter the purpose of CDI.

First, we must remember that CDI’s purpose is first and foremost to improve the quality of patient care. Our goal is to improve the quality of documentation in order to support continuity of care, which supports our purpose. To do this, there must be an educational transaction between the CDI team and the clinicians, and within the CDI team itself.

In my opinion, CDI’s involvement in denials management is a necessity for quality of documentation, continuity of care, and a healthy revenue cycle. To get started, track your organization’s denial rates for unbundling, medical necessity, and clinical validation, adding other categories as you get more comfortable. The denial rates will tell a story about your organization’s CDI program and provider education gaps. Leverage the denials data to educate both the CDI department and the providers.

For example, share all clinical validation denials with the CDI team and identify where each denial could have been avoided or if there’s an opportunity to appeal the denial and overturn it. If there is an educational opportunity from a clinical validation standpoint, share it with your CDI team to intensify their efforts for similar future cases. The provider should also be made aware of clinical validation denials, receiving education on the elements needed to support clinical validation and fill any documentation gaps that need closing. Regardless of the status of the denial, conceded or appealed, there’s always an opportunity for the CDI team and the providers to grow and improve.

Your CDI team could also take a more proactive approach to denials management and review cases on the front end for both medical necessity and clinical validation, rather than waiting to educate or appeal retrospectively. This could entail concurrent reviews for specific diagnoses and mortality reviews to strengthen the organization’s denial defense. If an organization is not involving their CDI program in denials management, they are significantly vulnerable and are overlooking an untapped opportunity to prevent denials and preserve revenue.

At the beginning of CDI’s involvement, record the organization’s baseline for clinical validation and medical necessity denials. From here, monitor denials for trends to determine the success of the CDI program initiatives. A downward trend in volume indicates successful CDI intervention on the front end, while a downward trend in provider queries for clinical validation and medical necessity indicates successful CDI efforts to educate providers. The KPI trends for denial rates will indicate where providers and CDI specialists need the most education.
According to the CDI Week Industry Survey, 33% of respondents stated that they do not track denial rates as a KPI. Industry leaders are urging organizations to begin leveraging denials data to support an effective CDI program. Clinical validation and medical necessity denials give us a heartbeat of the quality of provider documentation. If an organization is experiencing a high volume of specific denial types, it indicates that there is an issue with documentation quality.

CDI specialists should be in tune with the denial rates for their organization so that they can take a proactive approach to achieving the organization’s goal in reducing denials for high-risk areas. CDI specialists have a unique skill set and real power to proactively impact denial rates.

Denial volume is a useful KPI for CDI teams because CDI specialists are on watch for any records that do not accurately represent the patient’s clinical story. As gatekeepers of truth, CDI professionals should intercept the medical records that demonstrate vague or obscure clinical pictures and use their findings as educational points to engage the providers and improve documentation.

Leveraging denials data as a KPI could help build a stronger CDI team and develop a robust denials prevention machine. Tracking denial volume could uncover gaps within your CDI department as well as unaddressed vulnerabilities that could use CDI’s attention. It will help your organization identify where your CDI program is healthy, as well as which areas need more educational engagement or greater CDI efforts. Finally, it will help bolster physician engagement, utilizing denials data in a meaningful way to achieve documentation excellence.

Editor’s note: Williams-Bridges is the HIM/coding director at a 500+bed facility in Chicago, Illinois. Contact her at ljbridges1986@live.com. Opinions expressed are those of the author and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.
PODCAST RECAP

A conversation with the OIG on severe malnutrition

The following Q&A is an abbreviated transcript of the September 9, 2020 ACDIS Podcast. Note that the transcript has been lightly edited for clarity and grammar. This episode featured special guest Joseph Girardi, CGFM, CFE, assistant regional inspector general for audit services with the Office of Inspector General (OIG) in Philadelphia, Pennsylvania. The subject of the show was the July 13, 2020, OIG audit report, Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims. (You can find another article about malnutrition audits and denials on p. 23.)

Girardi has more than 30 years of internal auditing experience. He is currently responsible for overseeing and conducting Medicare Part A and Part B billing audits, and he has assisted the Department of Health and Human Services (DHHS) Office of Investigations and Department of Justice on several projects that led to criminal convictions and significant civil recoveries. Prior to arriving at the DHHS in 1996, Girardi worked for the Department of Defense, OIG for six years.

ACDIS: What is your role in the OIG and as manager of this audit?

Girardi: I’m responsible for supervising a team of 10 auditors, and since 2018 I’ve mostly been managing and coordinating Medicare Part A and Part B audits of providers in our regional jurisdiction, which is Pennsylvania, Maryland, Delaware, Virginia, West Virginia, and Washington, D.C. My role in this particular audit changed a few times over the course of the audit, but as manager, my role is mainly to supervise the staff and ensure that the work is relevant and impactful and meets our auditing standards.

ACDIS: Can you provide some insight into how and why this audit was conducted? Was it a result of the three prior audits for severe malnutrition of individual organizations, or general national patterns of an increased incidence of this diagnosis being reported? Were the claims taken from a wide range of hospitals or just a few?

Girardi: This nationwide malnutrition audit was conducted after we identified high error rates in the three previous audits of the hospitals that the OIG conducted from 2015 to 2017. During those three audits, we took a random sample of 100 claims and had a medical review contractor review each of those claims. As a result, we had error rates ranging from 85%–90%.

After we completed the third audit, we decided to conduct a nationwide audit basically using the same methodology. Instead of taking just the 100 claims, we decided to expand the statistical sampling design and select a random sample of 200 claims. Utilizing this methodology allowed us to efficiently assess the extent of the issue, and to bring the results to CMS in a timelier manner, and thereby allowing them the opportunity to take action.

The severe malnutrition audits we did of the three providers were an offshoot of 25 audits that we conducted from 2013 to 2016 that related to the kwashiorkor ICD-9 code. After we completed about 20 of these kwashiorkor audits, we analyzed the usage of the kwashiorkor...
diagnosis code to see if providers were still using that code at the same rate that they were using it in 2012.

What we found there was the usage of the kwashiorkor diagnosis code was actually going down dramatically, but the usage of the severe malnutrition diagnosis codes was increasing at the same time. That led us to look at a few of the providers’ use of the severe malnutrition diagnosis codes. The claims that were in our sampling frame for the nation included all hospitals nationwide, except for the three hospitals that we previously audited. And we excluded hospitals in the state of Maryland since they have the waiver covering their alternative payer model.

ACDIS: Can you give any insight into who performed the audit and what credentials they held? What criteria did they use for their determination that a lesser type of malnutrition or no malnutrition at all should have been reported?

Girardi: After we compiled the medical records for all 200 claims, we forwarded them to our medical review contractor. Each of the 200 claims was reviewed by a Certified Coding Specialist and a Registered Health Information Technician, as well as a licensed physician who is familiar and knowledgeable with the treatment of the patient’s medical condition. They provided us with a three- or four-page report for each claim.

The criteria they used was the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria that I believe came out in May 2012.

ACDIS: What is next with this audit, the OIG, and CMS? Are the hospitals with the 164 claims being contacted for recoupment of the $914,000 by CMS, and is CMS planning to open up the other 224,000 claims? Or is that an OIG recommendation that CMS can choose to follow up on?

Girardi: We are a recommending agency, so we make recommendations to CMS and it is ultimately up to CMS as to whether they decide to implement those recommendations. CMS has requested the detailed claims information for the 164 claims that the contractor denied, as well as the remaining claims from our sampling frame.

In its response to our recommendation, CMS said it will instruct the Medicare Administrative Contractors (MAC) to recover the $914,000 overpayment amount for the claims that were in our sample.

In our finding, we strongly suggested that they review the remaining 224,000 claims that were in our sampling frame. As far as I know, they are working with their MACs to have them at least review a sample of those claims, to determine if they were billed correctly. But again, as I said earlier, we are a recommending agency, and it really is up to CMS. But we will track these recommendations for the next six months to a year to ensure that CMS is at least recovering the $914,000 in overpayment amounts.

ACDIS: Do you have any recommendations for hospitals because of this audit? For example, ways that they can better educate themselves on compliant Medicare claims submission, work with their MAC, and not run afoul or raise their risk of OIG audits? Or conversely, any advice for hospitals who believe they are doing everything correctly with regards to severe malnutrition and are prepared to defend their claims?

Girardi: Yes, I think hospitals should be proactive and instruct their internal compliance staff to select a sample of claims where the severe malnutrition code was the only diagnosis code that was a major complication or comorbidity (MCC) on the claim, to ensure that the code was adequately supported in the medical record.

I would also encourage hospitals to send to their MAC examples of medical record documentation that they feel adequately supports the use of the severe malnutrition diagnosis code, and have the MAC review the claim to see if it agrees with the provider. This will help the provider to know that they’re on the right track as far as their documentation.
Payers deny claims on a wide variety of grounds, but it’s no secret that certain diagnoses seem to be frequent denial targets. Each year, respondents to the CDI Week Industry Survey say that both sepsis and malnutrition remain top denied diagnoses, and there is little sign of those denial rates slowing.

“The criteria for diagnosing sepsis wasn’t always an issue,” says Krysten Brooks, RN, BSN, MBA, senior healthcare performance advisor with 3M Health Information Systems, headquartered in Salt Lake City, Utah. “For years, there was general consensus on the definition of sepsis and everyone followed the standard CMS guidelines using systemic inflammatory response syndrome [SIRS] criteria.”

That accepted definition of sepsis remained largely unchanged for over two decades until the year 2014. “The European Society of Intensive Care Medicine and the Society of Critical Care Medicine convened a task force to review the sepsis definition with members representing critical care, infectious disease, surgical, and pulmonary specialists. The task force then published the Third International Consensus Definitions for Sepsis and Septic Shock, which created the sepsis-3 criteria,” Brooks says.

At this point, CMS recognizes the Sepsis-3 guidelines, but has yet to endorse that criteria set. “CMS is taking time to evaluate real-world issues with using Sepsis-3 criteria, so as yet, they haven’t formally adopted it,” Brooks says. “Although some organizations are starting to use Sepsis-3 criteria, many people are in the dark as to which criteria to follow—CMS SIRS criteria or Sepsis-3. And now fiscal year (FY) 2021 official coding guidelines have changed, including criteria for assessing neurologic mentation using the Glasgow comma scale score. This is now limited to traumatic brain injuries, which means that this scoring system can no longer be used as criteria with Sepsis-3.”

Along with sepsis, CDI professionals continually see denials for severe protein-calorie malnutrition, especially given that it remains a frequent audit target for the Office of Inspector General (OIG).

“It used to be that denial rates for malnutrition from the Recovery Audit Contractor [RAC] weren’t very high, and we didn’t have a major issue with clinical validation denials until more recently,” says Vaughn
Matacale, MD, CCDS, director of the CDI advisor program at Vidant Health in Greenville, North Carolina. “But then there was an issue where an OIG subcontractor had an extremely high error rate, which was out of sync with our experience with other external auditors. [...] Do we get denials out of that?

A few years ago, the OIG began doing a series of audits for kwashiorkor diagnoses, and malnutrition was on their radar after that. Even after the implementation of ICD-10, which resolved many issues from ICD-9 and kwashiorkor, the increase of denials for malnutrition persisted.

Sure. We still get some malnutrition denials, and sometimes we agree with their point, but most of the time we appeal.”

Malnutrition criteria challenges

When it comes to malnutrition audits and denials, many stem from the use of severe protein-calorie malnutrition diagnoses, according to Matacale, specifically in relation to kwashiorkor.

“A few years ago, the OIG began doing a series of audits for kwashiorkor diagnoses, and malnutrition was on their radar after that,” he says. “Even after the implementation of ICD-10, which resolved many issues from ICD-9 and kwashiorkor, the increase of denials for malnutrition persisted.”

In ICD-9-CM, there was a coding classification discrepancy between the Tabular List and the Alphabetic Index on the use of diagnosis code 260. In the Index, four other malnutrition diagnoses corresponded to code 260, but in the Tabular List, the code was only for kwashiorkor. Cases of kwashiorkor are highly rare in the United States and are often only seen in children during periods of famine.

Because kwashiorkor is so rarely seen in the United States, its coding raised level of awareness within the external auditor community and within the broader industry. “It’s been on the radar,” says Matacale.

In addition to kwashiorkor, “protein-calorie malnutrition is a major complication or comorbidity (MCC), so it’s a high target like some other MCC diagnoses,” Matacale adds.

The treatment and diagnosis criteria for malnutrition, according to Brooks, are also quite specific and stringent. Her education with facilities that contract with 3M focuses on both American Society for Parenteral and Enteral Nutrition (ASPEN) criteria as well as Global Leadership Initiative on Malnutrition (GLIM) scores, with GLIM being the newer and more intense of the two criteria sets, yet still not the universally recognized guidelines.

“For ASPEN guidelines, you need at least two criteria to even query about malnutrition,” says Matacale.

“You have to heavily rely on the dietitian to give that criteria within consultations in order to form queries for malnutrition.”

Sepsis criteria challenges

Because of the industry’s confusion over sepsis criteria sets, organizations find it difficult to decide which guidelines to follow for their sepsis documentation.

“Many third-party payers have adopted Sepsis-3 criteria, which is not in line with what CMS is doing,” says Brooks. “It’s important to remember that the first level of sepsis as defined in the SIRs criteria is not reflected in Sepsis-3. In SIRS, we evaluate for sepsis, severe sepsis, and septic shock, while in Sepsis-3 we’re looking for only the two severe types of sepsis.”

In her role as a 3M performance advisor, Brooks says she tries to provide detailed education on this topic and what it means to use CMS criteria versus Sepsis-3.

“We remind [organizations] that CMS introduced their core measures back in 2016, and although it’s a voluntary program, sepsis-related elements can affect quality reporting and value-based purchasing,” she says. CMS wants organizations to recognize and treat sepsis early while documenting it appropriately.

“Brooks explains that if a facility is following Sepsis-3 criteria but not following CMS SIRS criteria, they may be under-reporting regular sepsis. This will impact their quality metrics and their success under value-based purchasing. A hospital’s severity scores and likely its...
observed-versus-expected mortality scores may suffer in comparison with peer hospitals, suggesting the hospital is providing poor care to not-very-sick patients.

In contrast, Brooks says that, crucially, organizations often forget that with Sepsis-3, they’re not being graded on regular sepsis, but are being scored on the bundle of severe sepsis and septic shock.

“While you still want to be reporting sepsis, remember that you’re being scored from a quality perspective on severe sepsis and septic shock,” says Brooks. “That takes the sting out of which criteria to follow.”

While CMS has not fully adopted Sepsis-3 criteria, William Haik, MD, FCCP, CDIP, director of DRG Review Inc. in Fort Walton Beach, Florida, recommends hospitals start using Sepsis-3 criteria and introducing it into their regular record reviews.

“RACs have started to really move towards Sepsis-3, where many hospitals are still using Sepsis-2 or unsure of which criteria to use, but the move is headed towards Sepsis-3,” he says. “I think it’s more reflective of what sepsis actually is: organ dysfunction due to infection.”

Haik says he often sees hospitals that are using different criteria within their own walls and from physician to physician, so even if they do choose to stick with Sepsis-2 criteria, organizations need to make a concerted and formalized effort to get everyone on the same page.

“The problem with this is a lack of consistency, and physicians will agree to what they believe sepsis is, but unfortunately it’s not consistent with the literature,” he says.

Organizational criteria for malnutrition

An important step toward preventing denials on the front end is developing organizational policies and diagnostic criteria. This process should involve multiple departments, and the end product should represent the organization’s consensus statement on the condition’s diagnostic criteria, which can be used to appeal denials and anchor clinical validation queries.

For tackling malnutrition, Matacale suggests a facility adopt ASPEN and Academy of Nutrition and Dietetics (AND) guidelines for their diagnostic criteria. “The guidelines set forth by those entities are really the authorities in the industry as far as malnutrition documentation goes,” he says.

While it may be tempting to write your own guidelines, Matacale strongly suggests against it. Because there is already an industry standard available that’s been peer-reviewed and accepted by the broader medical community, this should be the standard facilities use. “These tools are already available to you,” he says. “The majority of hospitals that have been surveyed by AND and ASPEN have said these are the predominant criteria being used, so that shows you what the industry standard is.”

The criteria for malnutrition, however, is somewhat in a state of flux because of the newly created GLIM guidelines, Haik adds.

“I’d adhere to the ASPEN criteria for now, but at least peer over the counter at GLIM too as it’s very possible that will become the more relevant criteria at some point,” he says. Additionally, at least one of the RACs is using GLIM even though the AND has not fully field tested those criteria. “GLIM uses international standards for criteria, and the problem with that is we’re very different in the United States than other countries. We are more likely to have people who are obese but also malnourished, something not as common in other countries.”

Organizational criteria for sepsis

As with malnutrition, Brooks says it’s important to have a formal organizationwide clinical criteria set for sepsis.

“I’ve seen many organizations rely on an unspoken policy but not set criteria that they’re going to follow,” she says. “When they’re faced with multiple denials, for example, because they used SIRS criteria instead of Sepsis-3 criteria, they need to ensure their contract with payers specifies that they’re using SIRS criteria.” That way, when they do receive a denial based on Sepsis-3, they can refer back to the contract in their appeal letter and reiterate that they use SIRS criteria and shouldn’t be held to Sepsis-3.

When writing the sepsis criteria for the organization, make sure to
include a multidisciplinary group of medical professionals in the discussion. This helps to ensure they’re all on the same page and feel they’ve had their voices heard.

“Physicians aren’t bound to one set of criteria for sepsis; their diagnosis is based on medical judgment and their clinical experience,” says Brooks. “According to Coding Clinic, physicians can determine a finding of sepsis based on their preferred definition or guidelines, but the diagnosis has to be supported in their documentation. Additionally, CDI specialists should also look at labs, nursing notes, vital signs, and overall clinical presentation to support the diagnosis.”

Krysten Brooks, RN, BSN, MBA

Physicians can determine a finding of sepsis based on their preferred definition or guidelines, but the diagnosis has to be supported in their documentation. Additionally, CDI specialists should also look at labs, nursing notes, vital signs, and overall clinical presentation to support the diagnosis.

Matacale says. “Make sure it’s all uniform. That’s very important when dealing with malnutrition.”

While the dietitian’s documentation is crucial for capturing malnutrition, the dietitian isn’t the only one who needs education, because the treating physician still has to make the diagnosis in order for it to be coded. “When I say document, I don’t mean they just sign the nutritionist’s paper,” says Haik. “If they just sign it and say that they agree, that can be challenged.”

Even though it’s easier for the physician to simply sign and agree with an assessment, Haik says that asking the physician to document the diagnosis and treatment plan, and then sign it, will ensure the documentation is bullet (or audit) proof.

Don’t be shy about clinically validating malnutrition either, Matacale says. At Vidant, anyone examining the record or working in it is entitled to ask for clinical validation. “We believe everyone working on this has a valid perspective,” he says. When a malnutrition case goes into the clinical validation pathway, Matacale says it is reviewed by the coding auditor or CDI manager who may try to resolve the issue, then it might go to the physician advisor, who will have a dialogue with the attending physician to clarify or query.

Like any clinical validation question, make sure to look for the relevant treatments for malnutrition in the record as well, Matacale says, which may be outlined in the dietitian’s assessment and can be brought forward during the query process.

“For malnutrition, it starts with the least invasive [treatments] and moves to the most,” he says. “When you’re looking at reportability, don’t dismiss your assessments and treatments because they’re ‘not enough.’ When you’re appealing, report all things that can be reported and that have been met and how they’ve been met.”

Sepsis clinical validation, denial prevention

As sepsis denials continue to grow, Brooks says it’s becoming apparent that many of the issues revolve around clinical validation.

“may determine a patient has met criteria for sepsis because the patient had one heart rate above 90, or an infection with a white blood cell count that meets criteria. But auditors are looking for more,” she says. “Third party payers and CMS want to see trends. If a patient comes into the emergency department with a high white blood cell count, is it sepsis or something else? After the patient receives a fluid bolus and labs, and vital signs return to normal, it’s likely the patient did not have sepsis, but rather another condition such as dehydration causing abnormal

© 2020 HCPro, a Simplify Compliance brand
values.” Brooks also says that in addition to trends, CDI specialists should also look for contradictory notes from the emergency department and attending physician.

According to Brooks, CDI professionals should query the physician to determine whether that one SIRS element was linked to a sepsis diagnosis or caused by some other condition. Additionally, pay attention to the treatment provided to the patient: Does it support the diagnosis of sepsis?

“If sepsis is documented based only on the criteria of heart rate and white blood cell count, it’s going to be denied. If a patient is diagnosed with sepsis but isn’t being treated with antibiotics or for an infection, ask ‘is it really sepsis?’” she says.

“It’s important to establish multiple criteria when it comes to sepsis.”

When posing a sepsis clinical validation query, Brooks notes that the physician doesn’t want to read a drawn-out story. “They already know the patient; they just want to know what the question is,” she says.

Instead of writing out the patient’s entire chart in the query, just include the relevant clinical indicators and ask the physician whether the diagnosis of sepsis is appropriate.

If a CDI specialist sends a clinical validation query and the physician still says that the patient has sepsis, then there isn’t much more that can be done on the CDI side of things. “Have a plan for what to do when that happens,” Brooks says. “It’s up to the CDI team to ask the questions and escalate the issue if necessary. The best approach is to engage your physician champion to work with the physician. Ultimately, physicians want their patient’s story to be accurate.”

Even going off Sepsis-2 criteria, CMS can be strict about denying sepsis, so cases have to be strong and consistent throughout. “Organizations are frequently in the position of having to fight denials and go through the lengthy process of appealing,” she says. “You can’t just stop at the first denial letter and say ‘Okay, we lost.’ You have to follow all the way through to the end.” Brooks says that auditors will often cite just one or two element in the record to justify a denial. Take the time to go back and review the medical record as they may have missed something significant. Be prepared to defend the claim to get the reimbursement to which you’re entitled, she adds.

If your front-end tactics fail you and you’re left with only the appeal process as recourse, make sure you provide and cite the resources you’re using to fight the denial, such as official coding guidelines or medical journals, and include where you found that information. Physician involvement is also essential. Your physician champion or the attending physician can talk directly to auditors and explain the rationale for sepsis, which may lead the auditor to recommend the claim be resubmitted.

“Rely on official coding guidelines, the medical literature, and support your physicians when fighting a tricky denial,” Brooks says. “Fight the fight, and fight until the very end.”
Despite not having a formal denials management team at Penn Highlands Healthcare, I am fortunate enough to assist our coding department when we receive a clinical validation denial. Since I am a respiratory therapist by background, acute respiratory failure has always been near to my heart out of all the targeted denials that I am asked to review.

Along with acute respiratory failure, however, I frequently review denials involving sepsis, Gram-negative pneumonia, severe malnutrition, metabolic encephalopathy, and acute kidney injury (AKI). My involvement in the denials management process has made me a better CDI professional, as I continue to stay abreast of conditions documented and of the presence (or lack) of clinical indicators to support those conditions. Here are some of the things I’ve learned along the way.

**Sepsis**

Systemic inflammatory response syndrome (SIRS) criteria versus sequential organ failure assessment (SOFA) criteria is one large reason that sepsis is commonly denied. Although we do not yet have defined criteria set systemwide at Penn Highlands, we currently use Sepsis-2, which uses SIRS criteria (white blood cell count, respiratory rate, heart rate, and temperature) in addition to a source of infection. It’s important to make sure sepsis is supported with the source of infection as well as severe organ dysfunction.

Although we use Sepsis-2 criteria, it seems that most of our private pay auditors use Sepsis-3 (which is based on SOFA). A growing number of our physicians are starting to include the quick SOFA (qSOFA) score (systolic blood pressure less than or equal to 100 mmHg, respiratory rate greater than or equal to 22, and altered mental status represented by a Glasgow Coma Scale score less than 15), which adds to the clinical validation.

Despite this reference, though, we occasionally receive clinical validation denials. We are hoping to develop a protocol that would use SOFA. In addressing these denials, we have had some success in presenting a combination of the two criteria. I have found we often receive denials based on physician documentation stating supportive criteria for the diagnosis as being SIRS criteria and the infection source. After researching further, the cases often meet SOFA criteria with a score greater than or equal to 2.

**Gram-negative pneumonia**

There are a few things that make Gram-negative pneumonia a tricky diagnosis when it comes to denials. Lack of appropriate treatment (not just on one or two broad-spectrum antibiotics like levofloxacin or azithromycin) is one issue I frequently see. Lack of clinical indicators, such as not including a chest x-ray, mention of sputum, or recent hospitalization on the patient chart, is another reason.

When I review a case to evaluate the validity of a Gram-negative pneumonia diagnosis, I look for the following indicators:

- Elevated temperature
- Mucopurulent sputum
- Intravenous antibiotics or chemotherapy in the last month
- Nursing home residence
- Recent acute care hospitalization within the last 90 days
- Dependence on hemodialysis and/or immunocompromised
- Radiology findings of a “patchy” infiltrate
- Sputum culture
- Elevated white blood cell count

The treatment is also an important consideration. Is more than one antibiotic being used, and do the
antibiotics reflect treatment of Gram-negative organisms? If several of these indicators are not present, I send a clinical validation query. Also, if several indicators are present but the provider has documented a diagnosis of simple pneumonia, I will query for the Gram-negative pneumonia as it better reflects the level of care provided.

Acute respiratory failure was our most frequent denial at my organization. We began a rather aggressive attempt to reduce this by providing more education and consistently issuing clinical validation queries. [...] We’ve also had a great deal of success with queries for conflicting documentation.

Brian Simpson, MS, RRT, CCDS, CDIP, CCS, CRC

In reviewing a denial, I look to see if the auditor has mentioned a lack of documentation of the above criteria. If the clinical criteria are present and the auditor did not include them in their denial letter, your appeal will likely be successful.

Acute respiratory failure

The main reason I see for acute respiratory failure denials is a lack of clinical indicators. Appropriate treatment and not just two liters of oxygen with complete resolution of symptoms can also lead to denials. Another common issue I see is with conflicting documentation. A patient may have a diagnosis of acute respiratory failure documented in the chart, but then the documentation also says “no respiratory distress noted” or that the patient is “breathing comfortably.”

Acute respiratory failure was our most frequent denial at my organization. We began a rather aggressive attempt to reduce this by providing more education and consistently issuing clinical validation queries. We included the clinical indicators and tried to impress upon our providers that a room air oxygen saturation of 89% with a respiratory rate of 20, resolved with one nebulizer treatment or two liters per minute of nasal oxygen, does not really reflect the life-threatening condition of acute respiratory failure. We also included provider documentation that may include “alert and oriented, no distress noted” in our queries in an attempt to present the lack of clinical indicators.

In addition to traditional clinical validation queries, we’ve also had a great deal of success with queries for conflicting documentation. For example, if one physician documents acute respiratory failure, but another documents just hypoxia, we would send a conflicting documentation query.

Severe protein calorie malnutrition

Typically, even though our patients meet the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria, the payers often say the treatment was not significant enough. In an appeal, we include the ASPEN criteria as documented by the registered dietitian, as well as the recommended intervention, whether it be G-tube insertion and tube feeds, or supplementation.

The denial always seems to be based on lack of sufficient or appropriate treatment, specifically in cases that are based on acute disease or injury-related malnutrition. The diagnosis of severe protein-calorie malnutrition doesn’t seem to be in question, just the treatment. We try to base an appeal on the treatment offered, but we’re still struggling with this one.

Metabolic encephalopathy

When reviewing metabolic encephalopathy documentation, look for whether there is a documented source or cause of the encephalopathy. The biggest issue is conflicting documentation between one doctor and the next, or even one clinician conflicting himself or herself in the same note. Also, the doctors tend to forget to document when the metabolic encephalopathy is getting better and resolving.

We often send clinical validation queries when we see conflicting documentation or a lack of causative process. When we see opposing documentation in the record—which can even be the statements “increased confusion from baseline” as well as “alert and oriented” in the same note—we do our best to get the documentation corrected or the diagnosis ruled out. We have found that it is very difficult to build a strong defense in
an appeal with such a conflict, so you’re much better off catching it before the bill goes out the door.

**Acute kidney injury**

A large problem with AKI is a lack of indicators and that the condition may resolve too quickly. I also see that auditors are not following the Kidney Disease: Improving Global Outcomes (KDIGO) criteria.

When we review for validity of AKI, we follow KDIGO criteria. This criteria includes an increase in serum creatinine by at least 0.3 mg/dL within 48 hours, or an increase in serum creatinine to greater than or equal to 1.5 times baseline, which is presumed to have occurred within the prior seven days, or a decrease in urine volume less than 0.5 mL/kg/hr for six hours.

If the creatinine resolves quickly, we will query for the possibility of dehydration, and not AKI. Occasionally, the creatinine may appear as if it were an acute elevation, but upon review of the EHR, we often present the case of chronic kidney disease to the provider. If none of the above criteria are met, we will ask the provider for additional clinical support.

**General prevention tips**

For many of these problem diagnoses, the issue often boils down to conflicting documentation. The physicians also tend not to include their thought process that can help validate the disease’s presence. Working with physicians on their documentation and educating them is a huge part of preventing denials on the front end.

At my facility, we are not allotted official educational sessions with our physicians, but rather we rely on individual education provided through face-to-face interactions, phone conversations, or queries. We are working on a more formal approach to educational sessions.

A good tool for education can be to involve attending physicians in the appeals process and make them aware of our reasoning for clinical validation queries. It’s imperative to make them aware that we aren’t personally questioning their judgment and diagnosis, but rather trying to follow standard clinical indicators in an effort to improve documentation. Improved and concise documentation that reflects the level of care provided is our goal.

If I am faced with a denial, the first thing I do is see if I agree with the auditor. Occasionally, the CDI specialist has already sent a clinical validation query to the provider in hopes of gaining support for the diagnosis, or having it ruled out. If we have sent a query and the physician disagrees, and then we see a denial, it makes it difficult to defend the diagnosis. Unfortunately, at this point, there isn’t much we can do. Involving the attending in the appeals process can help with this; alternatively, if the physician continues to carry the diagnosis but adds clinical support, this can help avoid a denial.

We have tried to do more one-on-one education with the providers as often as we can. This is often through face-to-face interaction, but we also rely on phone conversations. Usually we’re successful, as the intervention often comes down to presenting our approach and giving reasons, such as coding guidelines. This education helps the doctors understand that even though we as CDI specialists understand what is being documented, that doesn’t mean it translates to accurate coding language.

---

**Editor’s note:** Simpson is a CDI and risk adjustment specialist at Penn Highlands Healthcare in DuBois, Pennsylvania. Contact him at blsimpson@phhealthcare.org. Opinions expressed are those of the author and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.
WANT TO STAY UP-TO-DATE ON ALL THINGS ACDIS?
SUBSCRIBE TO CDI STRATEGIES!
DECEMBER 2020

VISIT THE ACDIS BLOG WEEKLY TO FIND OUT WHAT EVENTS ARE COMING UP IN YOUR AREA!
Poster seances and mortality reviews

by Howard Rodenberg, MD, MPH, CCDS

I’m writing this a few weeks before Halloween, but I’m already feeling haunted. The spirit in question is the ghost of the ACDIS conference, our annual springtime gathering in the city where everything that happens stays there as long as nobody has pictures on a cellphone. Our 2020 conference couldn’t happen in person. But I’m still living under its specter, because it’s the poster presentations at the conference that provide my material for these research columns.

Fortunately, I’ve discovered that I can hold a poster seance. The poster proposals had already been submitted to ACDIS prior to the worldwide shutdown we call the pandemic. So with bell, book, and candle, and a bit of magic on the part of the ACDIS staff, I was able to resurrect the poster presentations so they can live once more.

This being the spooky season, I was struck by the number of projects that focused on the role of CDI in accurately reflecting measures of mortality. That sounds appropriately ghoulish, don’t you think?

Improving the observed over expected mortality ratio: A joint effort between CDI, palliative care, and quality

by Nasir Khan, MBBS, MPH, CCS, Nuvance Health in Danbury, Connecticut

Let’s start by defining something called the observed to expected (O:E) mortality ratio. This ratio compares the number of deaths that actually occur within a population to the number of deaths that would be predicted within the same group based on measures of illness severity such as relative weight (RW), severity of illness (SOI) scales, or risk of mortality (ROM) scores. A ratio greater than 1.0 suggests an excessive mortality rate; a ratio of less than 1.0 reflects a lower than expected number of deaths.

It’s pretty easy to presume that a higher O:E ratio means that patients receive a worse quality of care. In this case, less is clearly more, right? Well, not necessarily. Recall that measures of illness severity fully depend upon the provider documentation within the medical record. So even if your hospital provides the best care possible to the sickest of the sick, unless the medical record fully illustrates the complexity of those patients, they won’t appear to be as sick as they truly are, and any deaths may be considered as unexpected.

In this work, the authors began by noting that their institution’s O:E ratio was higher than the benchmark value of 1.0 or less, but they suspected that something was amiss. They learned that the number of patients who died in the hospital was larger than that which might be predicted by SOI/ROM scores; only 62% of patients who died were assigned the maximum SOI/ROM score of 4/4. Were there opportunities to better reflect what was really going on within the records of patients who died?

The project set a goal of reducing the institution’s reported O:E ratio from 1.22 to 1.10 by the end of fiscal year 2020, and to concurrently raise the proportion of expired patients with a 4/4 SOI/ROM score to 85% through enhanced documentation. With focused effort on reviewing all inpatient deaths, they were able to achieve the latter goal early in the study period. In a third of these cases, additional query opportunities were identified. While we don’t have a final report on
how this effort impacted the O:E ratio, the preliminary work suggests that a focused review of patients who died in the hospital can provide opportunities for documentation that impacts measures of expected mortality.

One of the most important parts of this work was a focus on patients receiving palliative care who die in-house. I think we have an unconscious tendency to not chase down diagnoses in patients served by palliative care—almost as if once a terminal diagnosis has been established, there’s no value in further detail. But the inpatient mortality of these patients is counted the same as any other in-hospital death, so capturing the full complexity of care in these cases is key to ensuring accurate calculation of expected mortality. Indeed, fully two-thirds of patients within the SOI/ROM 4/4 high-risk group had consultations with palliative care, suggesting that palliative care involvement in and of itself may clue us in to a record requiring more extensive CDI review.

The grim reality of mortality: How coding impacts mortality metrics and reporting

by Suzan Morrison, RN, BSN, CCDS, James Montgomery, RN, CCDS, Alexis Wells, RN, BSN, MSN, CCDS, Shawan Hagan, BS, MBA, John Peter Smith Hospital in Fort Worth, Texas

While I hope I do a good job of summarizing the best parts of a study, I often regret that I’m not able to show you the actual poster. From the pun in the title to the listing of the authors as “Grim Reapers” and the copious use of gravestones and skulls in the graphic presentation, this is really a fun read.

Similar to the prior work, this poster detailed an effort to decrease the O:E ratio using CDI chart review of hospital deaths to identify opportunities to better reflect the patient’s SOI and mortality risks. The interesting twist here is the recognition that the nature of the O:E ratio, which through risk adjustment takes into account demographics and all concurrent conditions rather than just those that impact SOI/ROM scores, provides incentive to document conditions not reflected in usual measures of risk of death. This may seem counterintuitive—after all, if it’s clinically significant, it would be counted in the SOI or ROM score, right? But we see this all the time in Coding World, where things that matter to us clinically have no effect on DRG assignment. Comorbidities and concurrent conditions that may not count toward measures of SOI/ROM may still impact the risk-adjusted calculation of expected mortality.

The results of the authors’ focused efforts showed that in 12% of the cases reviewed, there were opportunities to shift SOI/ROM scores to 4/4. The shift occurred, however, in only about a sixth of these cases. It’s uncertain if a lack of physician engagement or internal policies governing queries, recoding, or rebilling prevented a more robust shift.

Despite what appears to be a relatively minimal impact of the review process upon SOI/ROM shift, the O:E ratio still fell from greater than 1.0 to less than 1.0 throughout the study period. The low incidence of SOI/ROM shift coupled with notable improvement in the O:E ratio supports the authors’ suggestion that mortality review is not all about racking up points for SOI and ROM, but should instead focus on making the record complete.

One final thought on this topic: It’s critical to realize that improved documentation in and of itself does not change mortality. This seems self-evident, but I can’t tell you how many times our CDI program has been asked to “fix” problems with readmission rates or length of stay. Better documentation can help clarify a diagnosis for inclusion within a readmission cohort or buy time, as a more complete record usually results in assignment to a DRG with a longer geometric length of stay. But CDI professionals do not diagnose, admit, or discharge. Similarly, CDI programs may improve the accuracy of O:E ratios, but they do not directly impact mortality. Be sure not to get caught up in requests to fix things that we simply have no power over.

Did I mention that it’s only October as I’m writing, and that when I was at Home Depot yesterday to buy light bulbs, the Christmas decorations were already on sale? Happy Holidays! 🎅

Editor’s note: Rodenberg is the adult physician advisor for CDI at Baptist Health in Jacksonville, Florida. Contact him at howard.rodenberg@bmcjax.com or follow his personal blog at writingwithscissors.blogspot.com. Opinions expressed are that of the author and do not necessarily represent those of ACDIS, HCPro, or any of its subsidiaries.
According to the 2020 CDI Week Industry Survey, more than 63% of respondents have a physician advisor working either part time or full time with their CDI department. Just under 60% of respondents also said that their CDI department is currently involved in the denials management process at their organization. As CDI continues to gain involvement in denials management, a good physician advisor can be a huge asset to the denials education and appeals process.

As with CDI’s involvement in any new project or venture, there are a number of avenues for involvement, and organizations may leverage their physician advisor differently. The two primary ways an organization can utilize their physician advisor are denials prevention (front end) and appeals (back end). Before a physician advisor jumps into the process, however, they need to be adequately trained in CDI processes and expectations.

Training a physician advisor

Physician advisors’ success in the denials management and appeals process begins with their onboarding, says Deepa Velayadikot, MD, CHCQM, medical director of hospital medicine and care coordination at Cooper University Hospital in Camden, New Jersey. “We developed a whole training program for them that has formal education and onboarding requirements,” she says. “Once trained, the physician advisors have their schedules integrated with weeks of physician advisor work and working clinically with patients.”

The physician advisors at Cooper University Hospital always start their onboarding with working on private payer denials, then once they become more experienced and comfortable with all the various rules and regulations, they move on to government case reviews. “At any given time, I have one person managing the government denials for Medicare and Medicaid, and another doing commercial payers,” Velayadikot says.

During the training process and after they’ve become physician advisors...
advisors, Velayadikot says Cooper University Hospital has structured their program so that the advisors are still involved with patient care. This serves two purposes: First, it keeps the advisors in touch with patients and their clinical knowledge sharp, and second, it shows the other physicians at the organization that the advisor is still “one of them.”

“Our feedback is very well received because we all work so closely together and are direct colleagues,” Velayadikot says. “[The physicians] realize, because we split our time clinically and with charts, that we are actually living their life and understand it.”

Of course, balancing clinical care responsibilities along with the role of a physician advisor will take some time, and each individual advisor needs to find his or her perfect rhythm, Velayadikot says. It’s all about the give and take, and the understanding that clinical care exercises different muscles than the denials management and appeals process.

“You have to gain the understanding that there’s a lot of gray area,” she says. “As clinicians, we’re so used to black and white, but all of physician advisor work is living in the gray area, so that’s where it becomes more challenging because you will be in positions where you could deny a chart or approve it and will have to figure out what to do.”

If you’re at a teaching facility, don’t be afraid to enlist the help of the medical students and residents as well, says Velayadikot. Together with the whole care coordination department, she has worked to develop a program for medical students and residents to rotate in with the advisor group and be educated on that role.

“I love getting the students because this is when they’re going into real life,” she says. “When you catch them at that level and have them understand care coordination or utilization review, that’s when they understand the ‘why’ behind it all before they get too far in.”

Frontend denials prevention

Once you have your physician advisors trained in the ways of CDI, you’ll need to determine the level and type of involvement they’ll have in the denials management process. Most CDI departments take a two-pronged approach: preventive education on the front end to prevent the denials from even occurring, and appeal writing on the back end to recoup some of the potential lost revenue.

“Our CDI team is getting more involved in the denials process, with their biggest area of focus on strengthening documentation to proactively avoid denials,” says Christopher M. Petrilli, MD, SFHM, medical director of CDI and clinical lead of value-based management at NYU Langone Health in New York City. “We’re focused on provider education about their documentation, including medical necessity for inpatient admission. This has led to improved overall query response rate and provider agreement rate and allows us to strengthen documentation to provide opportunities for better CC and MCC coding.”

Training the CDI team well and working to ensure the initial coding is correct alone has helped NYU Langone Health with lowering denial rates. To avoid medical necessity denials, for example, Petrilli says they began educating based on Milliman criteria.

“You can educate providers on the criteria and build it into the EHR that allows them to easily access that criteria. So, if someone in the emergency department puts in pneumonia, it should prepopulate with questions that are needed to fulfill Milliman criteria. [The questions ask] if any of certain criteria is present that would warrant an inpatient admission,” Petrilli says.

If Milliman criteria are included in the initial admission documentation, payers will find it difficult to argue that a patient didn’t need to be admitted as an inpatient. “Because these criteria are very stringent, if you meet those
guidelines it’s very hard for a payer to push back,” Petrilli says.

Alvin Gore, MD, CHCQM, physician advisor and director of utilization management at St. Joseph Health, Sonoma Co. in Santa Rosa, California, says developing a robust CDI program and processes is the first step to avoiding denials.

“We do a lot of CDI education that is physician facing. We try to do as much education with real-time monitoring as possible to avoid denials in the first place.”

Part of the training in Velayadikut’s organization involves assigning a physician advisor to the specific areas seeing the most denials, allowing for focused education to the clinicians working and documenting in that area.

For example, “a few years ago, we were seeing an increase of front-end denials from the emergency department, so at the request of leadership we assigned a physician advisor to work front-end with the emergency department and admitting services,” Velayadikut says. “They review to see if a patient should really be inpatient or if it’s more appropriate for them to be in observation. […] The observation utilization review nurse also works with the physician advisor and actively reaches out to clinicians throughout the day and clarifies patient care plans including discharge, or if a patient’s condition warrants a status change to inpatient.”

While clinician buy-in of CDI has seemed to increase over time, some physicians may bristle when asked to improve their documentation. While pushback may be eased by having a physician advisor address the issue from a peer-to-peer standpoint, there are other ways to connect with tricky physicians. Megan H. Cortazzo, MD, medical director, CDI and HIM director, and assistant professor of physical medicine and rehabilitation at University of Pittsburgh Medical Center, recommends taking a patient-centered track.

“I can step back and talk to a physician about specific conditions and what it is they need to focus on when they’re documenting,” she says. Rather than focusing on the reimbursement aspect, she recommends emphasizing that the physician should receive credit from the insurance company for the care they provided: “I want to make sure doctors are documenting appropriately so they get the credit they deserve.”

**Backend appeal writing**

Many organizations that involve their CDI program in the denials management process enlist the help of their physician advisor during the appeal writing process. In fact, according to the 2020 CDI Week Industry Survey, nearly 22% of those involved with the appeals process involve their advisor or champion. Cortazzo falls into that group and has a particularly large role when taking appeals to the Administrative Law Judge (ALJ) level.

“My role has really been helping our denials team with specific denials and how to craft a response,” says Cortazzo. “Physician advisors really add the clinical expertise to denials and appeals. […] When companies deny things, they use clinical indicators in their denials. It’s my job to look at a denial and ask if the arguments the company gives supports it. I can do that from a clinical perspective that coders or CDI specialists might not be able to.”

For Gore’s organization, the advisor’s involvement in the appeal writing process starts with them writing a “physician statement” to include as part of the appeal, lending the whole appeal letter clinical backing.

While he could write the statement himself, Gore uses this process as a way to loop in the original treating physician who cared for the patient. This gives Gore an inside look at the patient’s stay, but it also gives the treating physician some insight into the denials and appeals process.

“One doctor was very surprised when he had a clinical validation denial for an orthopedic trauma,” he
says. The physician, according to Gore, took the denial as a personal affront, but Gore was able to validate that the denial was incorrect.

If a case does escalate to the ALJ level, Gore also lends a helping hand, much like Cortazzo does. During this conversation, Gore leans on the appeal writer and a coding professional to help build out the case while he provides the clinical perspective for their appeal.

While this whole process can be time-consuming and strenuous, Cortazzo says that the most effective physician advisors are those who still have patient care as part of their workload because they can bring that experience with them to the appeal table.

“You need to make sure you’re still understanding the physician pain points and keep yourself fresh. Knowing the pain points helps tremendously with staying more efficient,” she says.

The work of appealing denials can also feed back into the preemptive, education-based methods of denials prevention on the front end of the process.

“There’s now a loop of feedback where we can see which conditions are being denied and why, then we’re able to give the feedback to CDI specialists, coders, and physicians,” Cortazzo says. “It helps with making decisions about clinical validation queries. Before CDI was involved in denials, we didn’t send [clinical validation queries] very often, but we now consider sending them in select cases.”

Not only can the education happen after the appeal has been written, but according to Gore, the conversation can begin during the peer-to-peer stage of the appeals process. This will strengthen the appeal itself and also give the physicians an inside look at both denials and appeals.

“The use of the discussion period Medicare defines, or the time frame payers provide for peer-to-peer discussion is invaluable,” he says. “If discussion is not successful in the peer-to-peer setting, then go for an appeal.”

**Closing the loop, monitoring**

Physician advisors’ role in denials management and appeals doesn’t end when the appeal is accepted. CDI leaders and physician advisors need to develop a process of closing the loop both with the physicians and with the CDI team to prevent denials in the future.

“Working with denials made me realize as a physician that we can definitely document a little more efficiently or thoroughly, so I always give that feedback to our physicians,” says Cortazzo. While adding a bit of extra information in the patient’s chart might take a physician a few more seconds, having those details helps preemptively avoid denials or can support an appeal should one need to be written.

While feedback on a case-by-case basis can help individual physicians improve their documentation practices, Velayadikot also suggests leaning on your hard data and metrics to see the payoff (or loss) associated with denials and appeals. Particularly, track your number of denials overall and the overturn rate so that you can track the trends over time to report out, she suggests.

“We always had access to see total denials, but now I’m able to see how many were overturned,” she says. “I have finance look through and give me amounts down to the cent that was recouped because of denials being overturned.”

The financial data is particularly helpful for staffing and resource allocation, as well as tracking which physician advisors working on the appeals are the most successful at getting the denials overturned, she says. And, of course, getting paid for the care provided ensures the organization can continue providing care to patients who need it.

“You can be saving lives and doing life-sustaining amazing surgery, but at the end of the day, if no one gets paid, your system won’t survive,” says Velayadikot. “We are the arterial blood supply to any healthcare institution.”
No one likes clinical validation denials—now what?

by Trey La Charité, MD, FACP, SFHM, CCS, CCDS

Few things evoke such a visceral response from CDI professionals as the phrase “payer denial.” Organizations with which I am familiar deal with constantly increasing payer denial volumes and continually evolving denial strategies as the available healthcare dollar perpetually shrinks.

In the CDI and coding world, actual ICD coding system denials that stem from guideline misinterpretations and misrepresentations are frustrating enough. Clinical validation denials, on the other hand, have raised the loathsome bar of medical recovery auditing. Unfortunately, this tactic is routinely employed, and there is no indication that relief is on the horizon. Therefore, I share my personal and my organization’s experiences with this problem in hopes of aiding your mitigation efforts.

Understand the motivation

To begin with, the only motivation behind clinical validation denials is money. Like all businesses, payers only make profits when expenses are less than revenues. Revenues are generated from the annual premiums payers charge companies and individuals in exchange for providing health insurance. Expenses are what payers must give to doctors, hospitals, pharmacies, skilled nursing facilities, etc. to take care of those patients. Therefore, the less they pay, the more they retain from their annual premiums.

Clinical validation denials are an attempt to further reduce expenses by recouping payments already made. Recovery auditors generate their profits by retaining a percentage of the monies they recover for the payers with which they contract. The more money they return, the more they make. Likewise, the more denials they issue, the higher the probability they will make more money. Unfortunately, patients and profits represent competing priorities, and, frequently, profits win.

While the motive behind clinical validation denials is disheartening, it should also make you angry. When a recovery auditor or payer issues a clinical validation denial, they are challenging the clinical acumen of your treating providers. They are negating the skills of your medical professionals by intentionally disputing what our board-certified colleagues believed was occurring with their patient. Considering that the “challenger” probably hasn’t seen a patient in years, and certainly hasn’t treated the one specifically involved in the case dispute, your blood should be boiling.

Be wary of clinical criteria selection

We know that the recovery auditors and payers select clinical criteria that suit their financial agenda. Their only goal is to claw back money that your organization has already earned, and they employ often-unscrupulous tactics to accomplish this goal. They insist on things like the risk, injury, failure, loss of kidney function, and end-stage kidney disease (RIFLE) criteria for defining acute kidney failure as opposed to the Kidney Disease: Improving Global Outcomes (KDIGO) criteria because, in RIFLE, it is harder to meet the clinical threshold to make that diagnosis.

For the same reason, Sepsis-3 criteria were rapidly employed by most payers over Sepsis-2 despite the continued clinical controversy over what sepsis is. Most recently, payers have begun insisting on the use of Global Leadership Initiative on Malnutrition (GLIM) criteria instead of the American Society for Parenteral and Enteral Nutrition (ASPEN)/Academy of Nutrition and Dietetics (AND) criteria for defining malnutrition without any clinical validity having been demonstrated.

The bottom line is that the recovery auditors and payers insist that they know more than the bedside clinicians about what criteria should be used. I find this intentionally deceitful behavior to be professionally unconscionable and ethically bankrupt, as should you.
The clinical validation problem

The key to managing this hostility is to channel energies toward combating clinical validation denials. There is much professional gratification from winning a clinical validation appeal or preventing an opportunity to issue a clinical validation denial. How dare a payer tell my respected bedside colleague they had no idea what they were taking about! I also take great satisfaction in making recovery auditors and payers spend significant time and resources reviewing our charts to ultimately find little to challenge.

In full disclosure, however, as of October 2019, I no longer write the clinical validation appeals for my organization. The simple reality is that my winning percentage became so low that it was no longer fiscally sound for me to continue those pursuits. My results simply no longer warranted the resource expenditure. The continually increasing clinical validation denial volume and subsequent appeal generation had become 25% or more of my entire workload.

With a win percentage dropping from 95% 10 years ago to about 15% now, continuing my appeal endeavors was becoming fruitless. It became obvious to me and my superiors that it would be much more cost-effective to contract out for our future clinical validation appeal needs, allowing me to spend my time in other areas. If I am no longer winning appeals, it is time to let someone else try. As I tell my residents, one of the great tenets of medicine is “if what you are doing is not working, do something else.” My organization’s success should certainly come before my ego.

You may ask why I was no longer winning. For the same reasons the recovery auditors and payers issue the clinical validation denials: They believe that they know better than the bedside clinician and that they have the right to demand the use of certain diagnostic criteria. Recovery auditors and payers are trying to establish the belief that they are the all-knowing soothsayers of medical knowledge. They are attempting to set the tone that their determinations should not be challenged, as they repeatedly refuse to admit wrongdoing even when presented with clinical evidence to the contrary.

Their stance is that they are right, and we are wrong. The end. A rubber-stamped “denied” on all appeals, with the truth be damned. However, use of their clinical criteria in the care of our patients would certainly produce less-desirable outcomes.

Focus on education

On that defeated and depressing note, let’s explore potential ways to reverse this onslaught. First and foremost is education, education, and then more education. In my situation, the suddenly freed-up 25% of my time has been redirected to educating the medical staff. Recovery auditors and payers cannot issue denials if there is no opportunity to misconstrue the provided clinical documentation.

While education alone will not shelter you from payers’ use of outdated or bogus criteria, it will ensure any other potential liabilities are minimized. Surprisingly, many providers will document the criteria they are using to make a diagnosis once they learn what some recovery auditors cite in their denial letters.

Examine coding, query practices

While a contested topic, I also advocate self-denial given the current recovery auditing environment. If a doctor writes a diagnosis that is clearly not clinically present, don’t code it. While the Official Guidelines for Coding and Reporting dictate that we should code whatever the doctor writes, my opinion is that submitting a claim with an ICD-10 code for a diagnosis that is not present is fraudulent. I do not believe our organizations should knowingly commit fraud to satisfy the guidelines. The stakes are simply too high as the Office
of Inspector General loves nothing more than to exploit these types of situations.

Ideally, a clinical validation query should be sent to clear up all documented diagnoses that are not clinically present. Sadly, experience has shown those efforts produce mixed results, depending on the doctor who is queried. After all, if a clinician maintains that a questionable diagnosis was present, they aren’t the one who will have to deal with the denial.

In extreme situations where you know a provider will always maintain the legitimacy of his or her diagnosis, don’t waste time with a query and don’t code it. I know many of you are squirming uncomfortably in your seat after reading this suggestion. However, no payer or recovery auditor is going to risk negative publicity by accusing your organization of not submitting nonexistent diagnoses in the effort to foil their recovery auditing efforts.

**Raise awareness**

Another suggestion is to continually raise awareness of this problem. While potentially complicated and expensive, a legal challenge might help accomplish this goal. None of us have the resources to individually initiate such an approach. A class action lawsuit filed by a group of healthcare organizations against a payer or recovery auditor, however, would make for a strong showing and is a feasible way to marshal the needed resources.

Additionally, we should make every effort to contact our state and federal legislators to bring this issue to their attention. If they knew what hospitals really experience, they may be less willing to support legislation proposed by the payers.

**Review contracts**

Lastly, don’t forget about payer contracting. While most payers are not going to adjust the specific clinical criteria they use because of “national standards” that are “rigorously researched and vetted,” you can negotiate how often they can request records to review, how many charts they can review, and how long they have to review them before issuing a determination.

Additionally, you can ask a payer to remove a particularly problematic recovery auditor with which they contract from reviewing your future charts, as my organization has successfully done with more than one unscrupulous recovery auditing company.

Finally, you can simply refuse to negotiate or sign any new contract until the payer returns all the funds they reclaimed from your organization through their unfair clinical validation denial efforts. Amazingly, payers often seem to be able to quickly produce a little cash in such situations. The bottom line is that your organization should not be afraid to point out the harmful practices of its alleged “partners.”

Clinical validation denials are not going away in the foreseeable future. And, unfortunately, your organization must continue to appeal every one that was issued inappropriately because not appealing spurious denials attracts even more denials.

While no magic bullet exists for the problem that clinical validation denials create, there are steps our organizations can take to mitigate their negative effects on patient care. Those efforts will need to be purposeful, deliberate, and consistent as the traditional appeal letters appear to be increasingly ineffectual.

**Editor’s note:** La Charité is a hospitalist at the University of Tennessee Medical Center at Knoxville, a clinical assistant professor, and the medical director of UTMC’s CDI program. He is a past member of the ACDIS Advisory Board and the author of three books. La Charité’s comments and opinions do not reflect necessarily those of UTMC, ACDIS, or its Advisory Board. To reach La Charité, email him at Clachari@utmck.edu.
MEET A MEMBER  
CDI just clicked

Merle Zuel, RN, CCDS, is a CDI advisor at Kansas City VA Medical Center (KCVA) and an active member of ACDIS’ Kansas City chapter since 2018. He is a member of the 2020/2021 ACDIS CDI Leadership Council and earned his CCDS this year.

ACDIS: What did you do before entering CDI?

Zuel: My background is in mental healthcare with a focus on crisis intervention and acute psychiatric treatment. I was the mental health nurse educator for the KCVA prior to accepting the CDI advisor role. Prior to becoming an RN, I worked as an assessment and referral counselor performing assessments and care for psychiatric patients in private hospitals. I was a member of the corporate startup team during expansion and performed training for crisis management at several locations in California.

ACDIS: Why did you get into this line of work?

Zuel: I decided to get into CDI when my wife became a CDI specialist in 2014. I helped her with her studies and developed an interest in the field. It seemed to click with me, and it aligned with my desire to do administrative nursing instead of direct patient care. I have a wealth of experiential knowledge that I also bring to the table as a heart transplant recipient and patient advocate.

ACDIS: What has been your biggest challenge?

Zuel: Starting up a new CDI department at the KCVA medical center as part of a team. The VA system has unique perspectives on the distinct roles of CDI team members that do not align with the private sector. The system has some unique quality metrics and funding mechanisms that bring some challenges. These differences can create confusion when seeking training or advice from peers in the private sector.

ACDIS: What has been your biggest reward?

Zuel: I really thrive on the constantly evolving and complex world of healthcare. It stimulates my need for knowledge and continuous learning. Having a chance to serve veterans has become my way of “serving” since I joined the KCVA team in 2017. Satisfaction in a job well done is its own reward.

ACDIS: How has the field changed since you began working in CDI?

Zuel: Even in my short time, I have witnessed the litany of updates, Coding Clinics, CMS regulations, and endless software updates and other issues that indicate a nonstop challenge to keep up. We are using more sophisticated technology and telework now more than ever before.

ACDIS: Can you mention a few of the “gold nuggets” of information you’ve received from colleagues on The Forum or through ACDIS?

Zuel: My colleagues in the Kansas City ACDIS chapter have helped nurture my career by presenting a community of professionals as a sounding board for CDI industry best practices. One of my colleagues is famous for responding “it depends on the documentation,” and darn it if she isn’t right. Documentation is the key, but so is the CDI professional’s ability to interpret and extrapolate information and meaning from a record in order to be effective.
ACDIS: What piece of advice would you offer to a new CDI specialist?

Zuel: Be prepared for constant learning. "CDI is not for everybody" was a good bit of information. I understand why, now that I’ve been in the profession for a while. I work as hard or harder now than I did when I was in direct patient care; it’s just a different type of work. You have to constantly be learning or you get left behind.

ACDIS: If you could have any other job, what would it be?

Zuel: Music impresario. I really enjoy the live music business as a hobby and have enjoyed some success promoting concerts and events. It is very similar to CDI/healthcare in that you are only as good as your last review.

ACDIS: What was your first job?

Zuel: My first job was long before high school. I grew up on a farm in small-town Kansas. I started working when I was 12 and bought my first vehicle at age 14 when I got my learner’s permit. Putting up hay bales was always a good way to make money in the summer. I also worked as a cook at the local A&W and Sonic while in high school.

ACDIS: Can you tell us about a few of your favorite things?

- Hobbies: Video editing and music promotions via social media.
- Non-alcoholic beverage: H2O—nectar of the gods.
- Foods: Scallops grilled to perfection, shrimp and grits, medium rare steak.
- Activity: I love to drive and enjoy day trips or weekend getaways whenever possible. Attending concerts is a favorite pastime also.

ACDIS: Tell us about your family and how you like to spend your time away from CDI.

Zuel: My wife Kim and I have been married since 2009, and we both work in the CDI profession. We are both currently teleworking and have two canine CDI consultants helping out (Rosie and Benny). We have five lovely granddaughters. The oldest is 10 and the youngest is almost 1. Kim and I both like to travel and prefer to spend time near the ocean when possible.

ACDIS: Is there anything else you’d like to add?

Zuel: Organ donation saved my life, so I always ask: Are you registered to be an organ donor? Visit www.registerme.org to sign up today.