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Clinical Validation and Denials Management

Sepsis, respiratory failure, malnutrition top list of denied and queried diagnoses

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Sepsis, respiratory failure, malnutrition top list of denied and queried diagnoses

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It seems that denials have only been increasing over the years. In the wake of the COVID-19 pandemic, healthcare organizations simply cannot afford to hemorrhage money to unwarranted and unfounded denials. This imperative creates a natural entry point for CDI programs to help stem the tide. CDI professionals are *already* working to improve documentation and ensure the record paints an accurate picture of the patient's condition and care, making them particularly equipped to shore up documentation for denial prevention. Getting involved in the denials management and appeals process, however, can pose challenges for workflow and bandwidth.

In partnership with 3M, the Association of Clinical Documentation Integrity Specialists (ACDIS) CDI Leadership Council asked several of its members to evaluate the results of a nationwide survey detailing the current state of CDI's involvement with the denials management and appeals process, who on the team handles such efforts, staffing constraints, top queried and denied diagnoses, and technology for clinical validation efforts. The Council members were then asked to discuss their organizational approach to denials management and clinical validation. The following is a review of the survey results and a summary of the discussion.

CDI involvement with denials management

No two CDI programs are exactly alike, and therefore the methods for engaging in the denials management process can look different at each organization. According to survey respondents, the most popular method for CDI's involvement with the denials management process was to clinically validate high-risk diagnoses concurrently (nearly 66%), which aligns with the prevailing workflow in which most inpatient CDI professionals review records concurrently. The next most popular methods were to review denials on a case-by-case

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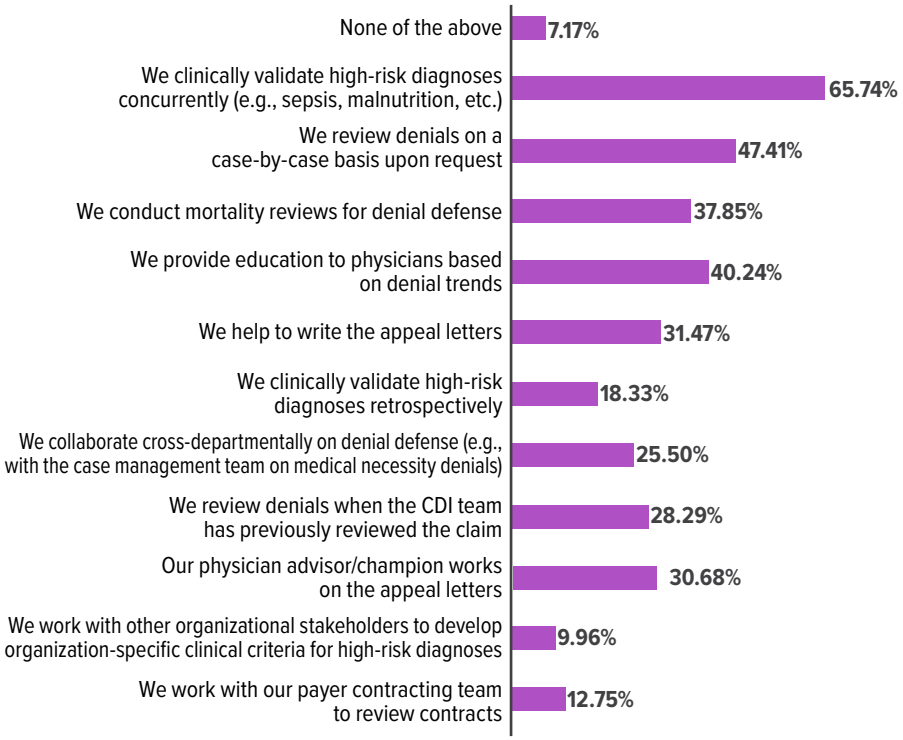
—Melanie Reineke, RHIA, CCS, CPC

basis (47%), conduct mortality reviews (38%), and clinically validate high-risk diagnoses retrospectively (37%). (See Figure 1.)

Bringing the CDI team into the equation on the front end through concurrent clinical validation reviews offers a valuable educational opportunity, according to **Melanie Reineke, RHIA, CCS, CPC,** hospital coding and CDI manager at Nebraska Medicine in Omaha. At the same time, CDI staff might be reticent during their reviews if they know a diagnosis will be denied on the back end.

"We felt that having CDI involved in the denial process would help them in their front-end work when they're doing clinical validation reviews, when they're looking to send a query, or working with providers for education," Reineke says. "On the flip side, we have to really advocate for the CDI not to let the insurance companies get into their heads. When they're doing their reviews, they still need to be aggressively looking for a clinically supported diagnosis, and not back off because they're afraid it might get denied on the back end."

Figure 1. CDI involvement with denials management



Selected other responses:

- Having an auditing team that handles denials and reaches out as needed
- Working on closing the loop to follow-up and educate providers on their denials
- Working with an outside vendor to learn best practices
- Collaborating with another department (e.g., rev cycle management, DRG denials, etc.)

No matter where your CDI team comes into play with denials management, make sure everyone understands that this work is a team sport, says **Jeanette Lyons, RN, BGS, CCDS, CRCR,** director of CDI and coding quality at Corewell Health in Southfield, Michigan. Lean on your colleagues in other departments, as well as your technology, to further the mission.

"We collaborate with utilization management, patient financial services, which is billing, payment integrity, compliance, and coding. And we are able to get denial trends," says Lyons. "We pull reports from our EMR to evaluate denial trends, and we created a dashboard to monitor volumes. We share those volumes with leadership, physician leadership, as well as our coding and CDI teams."

Don't forget to evaluate your outcomes as you proceed. You might start with one approach to denials management and appeals, but much like everything in CDI, your method shouldn't remain stagnant. Let the data you collect help evolve your approach. For the CDI team at Avera Health in Sioux Falls, South Dakota, this means

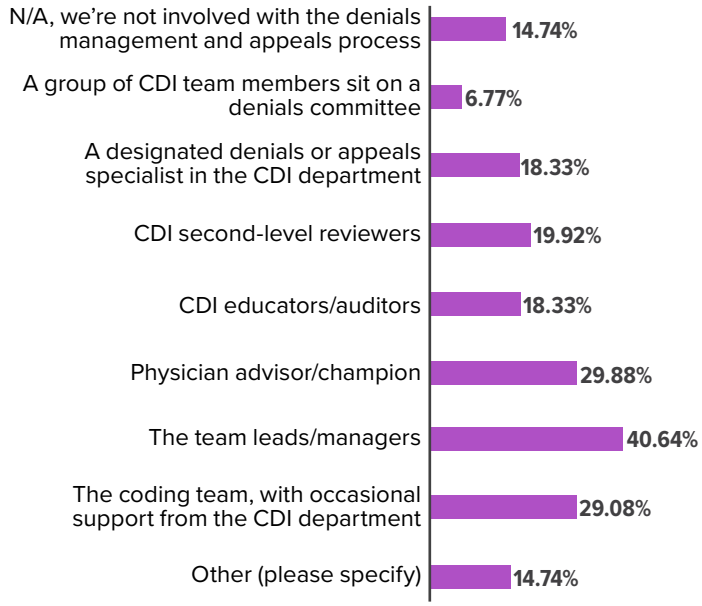
an upcoming centralization of the appeals process to improve overturn rates.

"All of our CDI denials will be going to the central office, and they will all be written by physician advisors," says **Clarissa Barnes, MD, FACP,** system physician advisor in CDI and utilization management at Avera Health and a consultant with 3M Health Information Systems. "We do still have CDI professionals involved in the concurrent reviews, queries, and clinical indicators. […] We're doing this because we have found that the system we were using at the central office was, in fact, more successful."

Responsibility for denials management activity

When deciding who will be involved with the denials management process, there are a number of factors to consider, including staff bandwidth, interest level, and potential impact. According to survey respondents, most (40.64%) said their team leads and managers were involved, followed by those who cited involvement from their physician advisor or champion (29.88%) and those who named the coding department with occasional support from the CDI team (29.08%). (See Figure 2.)

Figure 2. Individuals responsible for denials management activities



Selected other responses:

- The denials or auditing department
- A combination of multiple departments working on different types of denials
- The CDI supervisor on a case-by-case basis
- Outsourced to a vendor
- The finance department

Though having provider support for this process can be a huge benefit, not every CDI department has an official physician advisor or champion at their disposal. In these cases, Reineke suggests leveraging your other provider contacts to help guide your denials management efforts.

"We do have CDOC, which is the Clinical Documentation Outcomes Committee, so we leverage them. It's a group of providers that can give us input and help us with both clinical validation indicators and what we should be doing on the front end, as well as giving us articles and insight on how to win more appeals," Reineke says. "We also have partnered strongly with our quality team, because we're a Vizient organization. A lot of the items that we see come up with the clinical validation denials are the same or have some level of O:E [observed to expected mortality] impact."

Regardless of who on your CDI team is involved with these efforts, it's important to widely share the information gleaned from the process. Much like query efforts without accompanying education can lead to querying the same conditions in perpetuity, fighting appeals without following up with education means you'll likely be facing the same battles over and over again.

"It does take a village. It is a team effort. We continually evaluate our priorities, volumes, denial timelines. And so, we share our trending and education opportunities gleaned from our reviews with our coders, providers, and of course with our CDI teams for updates," says Lyons. "We change our processes to assist with denial prevention, and I think the query process is such a powerful tool to help assist with that."

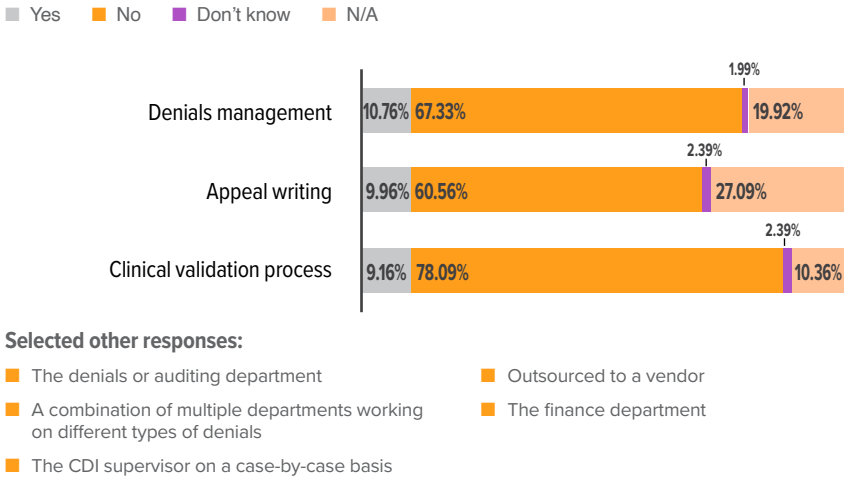
The most important part of denials management is to resist getting burned out and continue fighting the good fight, according to Barnes. Denials aren't going anywhere, so CDI teams shouldn't budge either. If your team currently designates one person to handle the denials, it may be time to build out the team or open channels for communication and collaboration with other departments or providers so you can sustain your efforts for the long haul.

"I like to think of insurance companies like the velociraptors in *Jurassic Park*, where they're always trying to test the fences and figure out where your weaknesses are," says Barnes. "As the people writing the letters and holding the line on denials, you do have to keep pushing back; you have to not be afraid. Because otherwise, they're going to say, 'OK, well, that's an easy place for us to start taking money back from you.' "

Staffing and denials management work

While in an ideal world, added work would always mean more staff members added to the team, everyone knows that is generally not the case in reality. Unsurprisingly, most survey respondents said that they have not hired for the additional work posed by denials management efforts. Only 10.76% said they increased FTEs for denials management, 9.96% increased staffing specifically for appeal writing efforts, and 9.16% hired for the clinical validation process. Most respondents who did hire said they added anywhere from 0.5 to seven FTEs. (See Figure 3.)

Figure 3. Staffing and denials management work



The staffing question is a complicated one. Depending on what denials your team handles and in what capacity (e.g., clinically validating diagnoses concurrently versus writing appeal letters), staffing needs will vary. For her department, a shift in responsibilities surrounding denials actually resulted in a *decrease* in FTEs, Lyons says.

"We currently have approximately five FTEs dedicated to the DRG denials, and we modified our processes and we transitioned other types of denials to another department, so those FTEs transitioned with them. Technically, we didn't gain, we lost, but appropriately because we focused now on DRG denials," she says. "But when the program was first initiated, there were dedicated staff for denials. We didn't just make staff do more or have them do dual work."

If you're not able to hire new staff, introducing a career ladder that recognizes the expertise of the staff members involved with denials management or appeals will go a long way toward making sure they feel valued and appreciated. It can also introduce an opportunity for professional development that may be attractive to job candidates if you end up hiring in the future.

"[Hiring more staff is] something that I've been working on and that I'm hoping to have approved. Right now, though, we're exploring more of a CDI career ladder and building some of this denials work into a higher level for the CDI staff as part of that career level. That's the option that we're exploring right now," says Reineke.

Sometimes, shifting responsibilities so that team members have specific and dedicated roles within the CDI department means you may not need to hire at all, Barnes says. Doing several roles simultaneously means staff members have their focuses pulled in different directions, which could lead to inefficiencies and a lack of ability to specialize and become a true expert.

When you're faced with added work from denials management, appeals, or clinical validation, look at your staff responsibilities and see where you can move people into dedicated roles and centralize activities under single people or groups. You may find this enables your team to do the work more efficiently and effectively.

"We didn't have to hire so much as we reshuffled people," says Barnes. "When we had everybody trying to do everything, everybody felt very sort of split and fractured. And with the centralization, we're going to be able to pull some people out to do work in a focused way and not necessarily have the world split between a million different people. So, I don't think we're going to end up with any increase in FTEs per se, I think it's just going to be more focused."

Top queried, denied diagnoses

It likely won't surprise many CDI professionals to read the top queried and top denied diagnoses reported by survey respondents. As ACDIS has seen on many surveys over the years, the top queried diagnoses according to respondents were sepsis (76.92%), respiratory failure (75.54%), and malnutrition (54.39%). The top denied diagnoses according to respondents mirrored the same diagnoses: sepsis (71.66%), respiratory failure (62.66%), and malnutrition (52.05%). (See Figure 4.)

These diagnoses have been on the top of many organizations' lists for years now, in part due to the differing criteria sets used to support them. For example, when the Sepsis-3 criteria set was introduced several years ago and the debate between using these newer criteria or using Sepsis-2 criteria heated up, some insurance companies seized the opportunity to deny sepsis diagnoses based on whichever clinical indicators the organization wasn't using. A similar occurrence has taken place with GLIM and ASPEN criteria for malnutrition diagnoses, which compounded the existing denial focus from the Office of Inspector General.

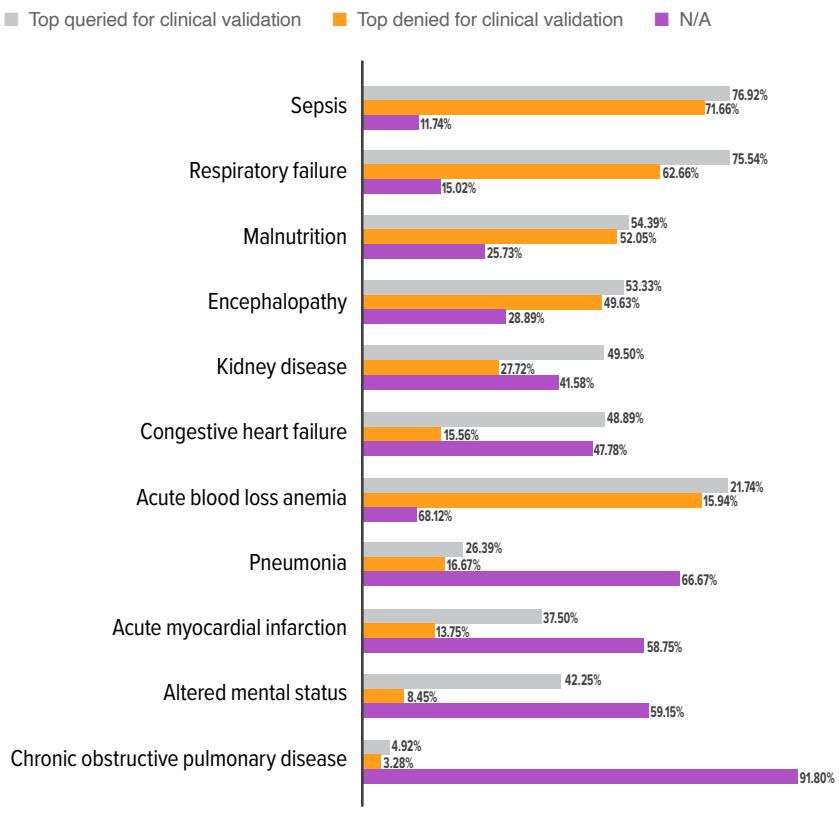
"I think it goes in waves. Sepsis and respiratory failure were two of the early ones in my career with CDI," Reineke says. "I also think that, when I look at sepsis, when I look at respiratory failure, and even now with malnutrition with GLIM and ASPEN, these are all areas where the insurance companies can kind of pick and choose criteria that fits their denials. So, we'll see one insurance company one time use Sepsis-2 criteria or Sepsis-3. They just seem to pick and choose what fits them."

Unfortunately, it's unlikely that these diagnoses will wane in their denial supremacy any time soon, according to Barnes.

When faced with payers' shifting clinical definitions and tactics, the best defense is to get everyone at your organization on the same page about the criteria you use to diagnose these conditions, then put your decisions in writing so you can use them when crafting appeals.

"Sepsis is going to continue to be the number one for everybody. […] We, as a hospital system, have decided we're doing Sepsis-2. We have payers that say Sepsis-3. So, we're going to have to fight those denials. I can't prevent them," Barnes says. "[Payers] just sort of get to add additional criteria and you have to fight them on that. It's the moving target for what they add in terms of the criteria or the things that they decide. It definitely keeps it from getting boring, let's put it that way."

Figure 4. Top three queried, denied diagnoses



Selected comments:

- AKI
- Unknown
- Outpatient procedure denials related to lack of medical necessity
- Diabetes
- Unspecified CKD
- Cancer
- Major depressive disorders
- Weight-related diagnoses
- Type 2 MI
- Renal failure

If preventing these denials entirely is out of reach, developing a multipronged approach to fighting them is the next best option. Instead of just doing the cleanup on the back end with the appeals process, Lyons suggests coupling your appeals with a concerted effort to clinically validate your at-risk diagnoses in real time. Though the case may still be denied on the back end, ensuring that documentation is present in the record will make the appeal writing process easier.

"We work hard to ensure the diagnosis is sound in the record," Lyons says. "As the CDI team, we continually clinically validate these diagnoses. And, as the denials team, we defend the clinical validation denials on these three diagnoses as well. And we educate and reinforce."

Technology for clinical validation efforts

When it comes to technology for clinical validation, 39.44% said that they use prioritization software to bring potential issues to the surface for CDI review and 29.08% said they have clinical validation issues managed by edits/audits and/or flagged by the review process. Nearly 34%, however, said they did not have any technology to aid in this process. (See Figure 5.)

Leveraging technology can help smooth out the bumps along

the road of the clinical validation and appeals process and further your limited staffing resources too. Some CDI programs have the resources to invest in a new CDI-specific tool to prioritize cases for clinical validation, but if your program doesn't, there are certainly ways to make use of your existing solutions for this process. For example, Lyons suggests combining the powers of your CDI solution with the capabilities in your electronic health record (EHR) to create a robust, technology-supported process.

"We successfully implemented a CDI AI software tool and it's the same tool across the entire system now, so we're very fortunate. We're on one platform, and it does have embedded the clinical validation piece to that," she says. "Additionally, enhancing the [EHR] to leverage technology with your documentation opportunities—you know, BPAs, flags, edits, things of that nature—have been very successful, I think, with the combination of the two: a CDI software tool, as well as enhancing your [EHR]."

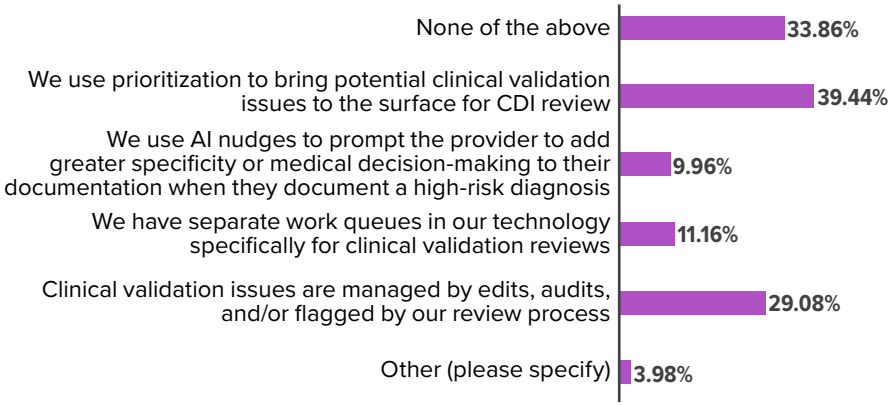
As with all denials management efforts, leveraging your technology effectively often involves departments working in concert, according to Reineke. Though her program does not have an outside solution in place, they've been able to work with their coding colleagues to develop a process in their EHR to catch clinical validation issues for CDI review.

"We have I guess a home-grown system, so we built some edits into our Epic system to flag the coders at the time of discharge to move it on for a final CDI review," Reineke says. "With a lot of our clinical validation, we wait until the time of discharge, just because we don't want to query during the stay and then have the discharge summary take us in a different direction."

The most difficult thing to tackle without a solution isn't on the front end during the review process, according to Barnes, but on the back end when trying to track and trend your impact. Without that data, you won't have a clear path illuminated to guide your next steps in denials management, which can make the whole endeavor feel fruitless.

"If [your organization is] small enough, even if you don't have a tool, it's fine. You can see the trends because you're the only person touching the data. Once you get big enough, it gets tricky," says Barnes. "You always do have some data, even if you don't have a tool. It just won't be the complete picture unless you're the only one and all the data is, in fact, yours." ■

Figure 5. Technology for clinical validation efforts



Selected other responses:

- CDI reviews only
- We use an outside physician group to aid in appeal letter writing
- CDIs concurrently validate diagnoses & Coding will alert us if they identify cases of concern for a second review. We also work with vendors that will bring cases of concern up for second level reviews often suggesting a clinical validation query
- Nudges are not turned on yet-but will be
- We review all cases and ask queries to clinically validate any applicable diagnosis
- CDI nurse reviews and knows trends and asks queries for all clinical validity
- Our CDI software has clinical validation markers to draw CDI attention to the potential opportunity but besides that clinical validation is handled as part of the normal CDI dept. review process
- Moving to 3M 360 in February for prioritization
- Retrospective NLP