Following the trends: CDI in a changing denials landscape

Every year, organizations receive more denials, and payers' tactics are shifting based on coding rules, clinical criteria, and their own whims.

As a result, many CDI teams find themselves involved with the denials management and appeals process—whether that means weighing in on a case-by-case basis or helping to craft the appeal letters and following each case through to its conclusion. While others are in the same boat, it can feel isolating to navigate these choppy waters.

Taking a 10,000-foot view, though, there are denial practices that stretch across organizations. CDI programs can use these larger trends, as well as patterns from their own organization, to shape their CDI practice and help make their providers' documentation denial-proof.

Denial types and volume

The number of denials hitting hospitals monthly no doubt helped to incentivize CDI involvement in the denials management process. Of those who knew their denial rate, nearly 40% said their organization received at least 20 denials per month, according to the 2019 CDI Week Industry Survey.

"We got heavily involved with denials management when we started seeing the DRG downgrades pick up seven or eight years ago," says Emily Vollmeier, RN-BSN, CCS, CCDS, system director of hospital coding, HIM, at INTEGRIS Health in Oklahoma.

The volume of DRG downgrades across all payers has become increasingly difficult to navigate, requiring additional resources to successfully manage, Vollmeier says. This can lead to a decreased appeal rate and substantial reimbursement loss because of it. CDI can step in and help to stem the tide, assisting with coverage. At INTEGRIS, one coding professional in the HIM department was previously in charge of all the DRG downgrade denials, but the volume became overwhelming.

"Before that point, we weren't seeing more than 40 a month for our entire health system. […] Now, we're averaging 100 or more a month, which is unmanageable for one person. We have two full-time seasoned coders managing the process in collaboration with CDI, the business office, and payer contracting. Denials can't be effectively managed in siloes," says Vollmeier. "It takes a village, really."

Along with an increase in volume comes an increase in different types of denials. Several years ago, most denials were related to coding errors and medical necessity. Over the years, however, payers shifted focus to the clinical concerns questioning the legitimacy of the condition coded—commonly known as clinical validation denials.

"Denial trends transitioned over time from coding-related, to [being] more and more [focused on] clinical validation issues," says Amanda Just, RN, BSN, CCDS, CDI system director at INTEGRIS Health. Because of this shift, Just says, CDI teams have increasingly lent a helping hand to their coding colleagues.

The denials used to be more technical and coding-based, but hospitals identified these opportunities and leveraged CDI teams to help manage them, says Seth Katz, MPH, RHIA, FAHIMA, associate chief information manager at Truman Medical Centers in Kansas City, Missouri. "But now we've gone into the clinical validation denials, and that's where CDI can be really helpful," he says.

Even if a CDI department isn't directly involved with the appeal writing process, CDI professionals can help to shore up documentation through clinical validation. Many programs have even worked to help create organizational clinical criteria for physicians to use which CDI specialists can leverage in the query process (as discussed in the article on p. 20).

> **One of our payers is using the WHO guidelines from the 1990s. The payers are trying to find new ways to deny as the industry gets better at fighting the old tactics**
>
> *Seth Katz, MPH, RHIA, FAHIMA*

Even with that supportive information available during appeals, payers might still deny the case, says Just.

"We are also seeing denials on cases we clinically validated concurrently. When the physician doesn't add any additional clinical information and simply repeats the diagnosis, we consider that a disagree response. In this instance, we are still being denied on those diagnoses," she says.

But tracking that information can be just the ammunition the program needs to spur further action, Just adds.

"We're tracking the physician disagreement rate on our clinical validation queries and take them to leadership to justify the need for more facilitywide education and accepted clinical criteria for commonly denied diagnoses."

Sepsis and malnutrition

One of the most widespread clinical validation denial trends has been the increase in sepsis denials due to the various sepsis criteria (i.e., Sepsis-1, Sepsis-2, and Sepsis-3) being used by different agencies for different reasons, according to Susanne Warford, MBA-HCM, RN, CCDS, system CDI analyst and appeals nurse at Baptist Health in Louisville, Kentucky.

"Our denials have ramped up, and sepsis is still our main denial—primarily focused on Sepsis-3," she says.

Enacting organizationwide clinical criteria for sepsis may help, even if the payer tries to deny based on alternative clinical criteria, says Shirlivia Parker, MHA, RHIA, CDIP, BS, interim CDI physician educator at Sacred Heart Medical Center in Spokane, Washington, whose facility uses Sepsis-2 organizationwide.

"The sepsis diagnosis has always been the one that's challenging for us," Parker says. "Lean on the clinical definitions you have in place and fight back. We won every one of our sepsis denials."

Warford agrees. Don't hesitate to fight back and take things to the peer-to-peer level, she says, adding that her organization's denial overturn rate improved drastically at that level.

Organizations need to identify the clinical criteria payers use to deny claims, Katz recommends, and then

combat payers' often-outdated criteria with the organization's own up-to-date industry best practices and supportive rationale.

"Malnutrition is a big one for us," Katz says. "One of our payers is using the WHO guidelines from the 1990s. The payers are trying to find new ways to deny as the industry gets better at fighting the old tactics," he says. "The more citations you can include in your appeal, the merrier. Cite all the supporting material. For example, if the WHO published something more recently than what the payer's using, and then it gets picked up by all the trade publications, point that out. [But] it can be really hard to argue the clinical side of things if the payer is using criteria from 1998."

Payer tactics

To complicate things further, payers frequently deny claims in a way that makes it difficult for hospitals to fight back.

"We've seen a decrease in transparency from the payers and audit vendors in the denial letters we receive," Vollmeier says.

"Payer audit practices have changed considerably over time. For example, when we began, we were receiving detailed explanations of the root cause of the denial by stating the revised DRG and exactly which diagnosis or procedure codes were in question and why. Now, some payers are vague in the justification, simply stating the diagnoses on the claim could not be validated in the record and providing only the revised DRG."

In addition, payers often don't provide the auditor's name or credentials, just an ID number. This provides little insight into whether the auditor is qualified. These practices, of course, make denials very challenging and resource intensive to fight—"It's difficult to appeal a denial when the payer's rationale hasn't been clearly stated," says Vollmeier.

For INTEGRIS, Vollmeier says a multi-faceted approach is the best way forward. Involving CDI, physicians, executive leadership, and payer contracting is key to successfully navigating and preventing denials.

> **Payer audit practices have changed considerably over time. Now, some payers are vague in the justification, simply stating the diagnoses on the claim could not be validated in the record and providing only the revised DRG.**
>
> *Emily Vollmeier, RN-BSN, CCS, CCDS*

According to Parker, this isn't the only tactic payers are wont to employ of late. Payers have been known to send letters attempting to take back the money before the appeals process ends, she says.

"We've followed the guidelines they said we had to follow, but sometimes before our appeal process is complete, they're notifying patient financial services and saying they're taking the money back," she says. "Contracting told me they aren't allowed to do that. They need to answer the appeal letter before they can take your money back. Understanding your rights will give you power."

Payers can also more easily find reasons to deny claims thanks to the advent of software and artificial intelligence (AI) programs.

"Payers, like hospitals, are using very detailed AI and algorithms to sort through the charts and find things to deny," says Katz. "The days of us getting a request for 500 charts, printing them out, and shipping them are gone. Now, they can get them digitally and then run them through software."

Trend use

CDI programs need to leverage trends to prevent payers from denying the same diagnoses repeatedly. Physicians are frequently left out of the loop when it comes to denial trends, but since clinical validation denials are based on an incongruity related to the clinical support in their documentation, CDI staff can help bring them into the conversation.

"Physicians are often completely unaware of denial trends," says Vollmeier. "We want to create a better physician feedback loop to engage them in denial prevention through improved documentation."

Knowing which physicians have the most denials to their name will allow CDI professionals to tailor education for that individual and help them audit-proof their documentation for the future.

While reporting the trends to the physicians themselves can be

helpful, the rest of the CDI team—regardless of whether they're involved with denials management—can take the lead on physician education based on larger facility or organizational denial trends, Just says.

"We have daily morning huddles and once a month we have the coder involved in denials give an overview of the trends for that month. For example, if a certain physician is having an increase in denials, we can focus on providing education to them," she says.

Those new to the denials arena may not have the data at hand yet to provide physician and CDI education, but Parker recommends taking special care to amass that information.

"You should track and trend everything. The only way you're going to prove your worth is to have data," she says. "You should know your overturn rate immediately, for example."

Those patterns and egregious payer tactics can and should be used during the payer contracting process to change the landscape for the future, Warford says.

"We circle back with the CDI team on what we're finding in the denials—trends, opportunities, etc.—and providing education," says Warford. "And we're starting to take this back around to our contracts and we're working with our contracting department. Our denials will be a focus when it comes to our contract renewals now, which they really weren't before."

While denials are here to stay—whether they be based on legitimate insufficiencies in the documentation or coding or payer tactics to recoup reimbursement—they're still worth fighting.

Many hospitals can't afford to forgo reimbursement for the care they provide, which could lead to their doors closing and their patients left without care. Hospitals should be properly reimbursed and recognized for the care they provide. Though it's ultimately tied to reimbursement, fighting denials comes back to the heart of CDI: Making sure the documentation and coding accurately portrays that patient's unique clinical situation and care, Vollmeier says.

"Even if our documentation and coding were complete and accurate, it's highly likely we would still see denials," she says. "Our goal isn't simply to fight for reimbursement, we want our patients to look as sick in our claims data as they do in the bed."