In the trenches: Frontline appeal writing advice

According to the 2019 CDI Week Industry Survey, 27.77% of respondents who are currently involved in the denials management/appeals process work directly by writing appeal letters.

Particularly with the increased focus on clinical validation denials, more and more CDI professionals are finding themselves involved in this process and may initially feel a bit overwhelmed by the magnitude of the job. (For more insight into current denial trends, see the article on p. 9.)

"In the beginning, it took a very long time because we were new and there was nothing in writing out there about the level of appeals we could actually do," says Shirlivia Parker, MHA, RHIA, CDIP, BS, interim CDI physician educator at Sacred Heart Medical Center. "I would sometimes do three written levels of appeals, and each of those were in 30-day increments."

Keeping track of that level of back-and-forth requires a deeper understanding, and perhaps even development or adjustment, of existing denials management practices.

In order to provide you with the best possible arsenal of appeal tactics, ACDIS spent some time in this edition talking to the CDI professionals in the appeal trenches about their best practices and advice for those on the frontlines.

Do some digging

CDI professionals get dragged into the denials management and appeals process in a variety of ways. Perhaps the denials team, or the person handling the denials, reached out to CDI for help on a particular appeal and the involvement grew from there.

Or, perhaps the involvement came out of a request from the organization's leadership (after all, everyone's familiar with the "you're already in the chart" argument for program expansion). Regardless of the avenue, the first step to building a robust CDI appeals process is to determine the administrative side of things..

If the organization doesn't have a set denials management team

in place, start by asking around to determine who receives the denial notices, suggests Parker. It could be someone in patient financial services, contracting, or elsewhere.

"The denial letters often go to someone else before it gets to the person who actually kicks the appeal process off," says Parker. "We had to reach out to the third parties to find out where they sent the letters in the first place."

Once you determine where the letter comes in, set up a procedure for having the denial sent to the appropriate party for review and appeal. CDI will likely not be involved in every type of denial. For example, the case management team may handle all the medical necessity denials and the HIM team may handle coding-based denials.

Parker suggests building a contact list for the letter receiver to use when communicating the denial's arrival, so no time is wasted getting the information into the correct hands.

At Sacred Heart, the letter goes to the patient financial services team, then gets sent to coding and CDI, Parker says. That way, there is a central repository, but financial services doesn't need to determine the type of the denial; they only need to track the process.

Know the details

As with any administrative task, denials and appeals come with a slew of details to keep organized, so make sure you build out some sort of filing system to keep track of all the relevant details, including due dates for filing appeal letters.

"Organize your denials by due dates. The payers have hard stops on the due dates—they're a little lenient once, but not more than that," says Angela Geiger, RN, BSN, CCS, CPC, CDI specialist at Penn State Health in Hershey, Pennsylvania, who formerly worked as an auditor for an insurance company.

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> *Angela Geiger, RN, BSN, CCS, CPC*

With a simple and navigable process in place, take time to review the scope of the denial. For example, identify the type of denial, the reason for the denial, and the payer's details. This will help you determine what type of appeal is appropriate and whether an appeal is even warranted.

"Some of the denials are just because not all of the medical record was sent in," so you may just need to send in the relevant documentation with an explanation of what was missing, says Susanne Warford, MBA-HCM, RN, CCDS, system CDI analyst and appeals nurse at Baptist Health in Louisville, Kentucky. This scenario may feel like wasted time since it could have been avoided by sending all the correct information up front, but it's a much faster process than writing a whole clinical validation appeal.

Always keep a copy of the appeal on file, and make sure that the letter itself contains not just the counterarguments to the denial, but all the administrative details to file and track it easily, suggests Rani Stoddard, MBA, RN, CPHQ, RHIA, CCDS, CCS, CDIP, CDI supervisor at Henry Mayo Newhall Hospital in Valencia, California.

"In the header of the letter, make sure you put the insurance company information, and save yourself some time and put the level of appeal in the header too," she says.

Build your argument

Building an effective argument is both the most important and most substantive part of appeal writing. It is possibly the most difficult and time-consuming aspect of the process. It's also the part where things get real, according to Geiger.

"You can read the denial and know it's wrong, but then you need to do the research and write out your arguments. That's where the rubber hits the road. You'll really know if you can argue it well once you're writing the appeal," she says. "You have to get past your defensiveness and logically argue your point on paper. That's when you'll actually see any deficiencies or inconsistencies in the documentation; [that's where you can see] how things could become confusing for a third party."

Don't get overwhelmed by the magnitude of what's ahead of you, though; just take each argument one at a time and build and explain your case against it, Stoddard recommends.

"Once you're in the letter, quoting them and what you're going against is a good idea," she says. "Make sure you understand what they're denying. Go through each piece of their letter so that you can respond to each piece in your own letter. When I've found on the second-level appeals is that they'll come back on one piece of their original denial; they'll rarely restate all three."

Whether you have a facilitywide clinical definition for the diagnosis the payer is denying or not, make sure you cite all the relevant and current clinical literature in your letter, Geiger says. Some payers may be using outdated criteria to deny your claim, so counter with the up-to-date criteria used to diagnose the patient and justify the coding. (For more information about writing organizational clinical criteria, read the article on p. 20.)

"My appeal letters always come with a 'works cited' at the beginning. It's very important to have literature in the community that supports what you're claiming," Geiger says.

"We try to make sure we have up-to-date references and that we have plenty of them," Stoddard agrees. "And make sure all the documentation is there. My letters are getting longer and longer."

Don't just rely on the literature, either. Reach out to others in your organization for help writing the appeal, especially if the denial falls outside of your realm of professional expertise. For example, if you have a denial that's citing a particular *Coding Clinic* or something from the *Official Guidelines for Coding and Reporting*, reach out to the coding department for help reviewing the appeal letter. They may find something you missed.

"Let's say you got a denial for malnutrition," says Seth Katz, MPH, RHIA, FAHIMA, associate chief information manager at Truman Medical Center in Kansas City, Missouri. "The CDI specialists will write the appeal up, send it to coding to add to it, send it to the dietitians for review, send it to the nurses and physicians who cared for the patient—it's like crowdsourcing the letter. It also helps to have everyone sign the letter at the end to show how many people are reviewing the denial and support the appeal."

Argue, argue, argue. Do not accept their denial. Use all your resources. Any time you can have a team approach to these denials, that's the best scenario. If you can have a physician, a coder, and a nurse all help, you're in much better shape.

Suzanne Warforrd, MBA-HCM, RN, CCDS

At the end of the day, Warford says, just don't give up or get discouraged.

"Argue, argue, argue. Do not accept their denial," she says. "Use all your resources. My coders have been a huge resource for me. Any time you can have a team approach to these denials, that's the best scenario. If you can have a physician, coder, and nurse all help, you're in much better shape."

Track your progress

Take the time to track success rates and progress in reducing denials. This provides the program ammunition to either fight more effectively in the future or catch documentation issues on the front end and avoid the denial altogether.

"I kept a spreadsheet because we didn't have internal software to track denials," says Geiger. "Record what you're being denied for and what their argument was, where we may have failed in the documentation, and where CDI may have failed in reviewing the chart."

If resources exist, Katz suggests looking into a third-party tracking system for denials to reduce some of the administrative burden and streamline the process. Part of the issue, he says, is that an organization managing a large quantity of denials runs the risk of human error when using a simple Excel® spreadsheet.

"With the software available now, you can build all the payer contracts in there, so you'll always know your deadlines and the details you need for the appeal letter," he says.

Armed with a few months or even a year's worth of data, the team (be it CDI administrators, analysts, or a denials management work group) should start piecing together the effect of the CDI program's involvement and communicating that back out to the various stakeholders.

Stoddard and her team are just at this point now. Seeing the clear benefits of their involvement reinvigorated the staff writing the appeals, she says. In addition, she is hopeful that showing the results to administrative staff will help her effectively argue for additional involvement or personnel.

"We're just now gathering our statistics, but I've seen some [denial] overturns that I'm excited about," Stoddard says. "Just the other day I had a double overturn where they tried to deny both respiratory failure and encephalopathy, and I got them both. They're very casual with our money."

Know your rights and negotiate

While many CDI professionals involved in the denials management/appeals process aren't privy to the details of payer contracting, it's worth getting looped in and knowing what the organization's rights are when appealing, says Parker.

For example, if the same denial comes in from a particular payer over and over again, regardless of how the organization appeals it, track this fact and raise the concern with your organization's administrators or denials management department. If such patterns exist, they may warrant a discussion between the payer and stakeholders within the organization. Try to get on the phone with the payer and ask some questions about their process, Parker suggests. When one payer essentially sent the same original denial letter back in response to an appeal, she did just that.

"I asked if we could do a peer-to-peer conference call during the second-level reviews, which they agreed to," she says. "I went over the case with our physician advisor in advance of the call, and then we did our first peer-to-peer call with [the company's] medical director."

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Although she did not win, she learned important information that helped her later on. "What I did learn was that if it's still denied after the peer-to-peer, you can ask the medical director who denied your claim to push it back to the medical director of the insurance company for a final review."

CDI programs with the opportunity to be involved in payer contracting can open up a lot of doors too, Katz says. Reviewing the contracts will show the CDI team what, if any, clinical criteria the payer uses to review claims, what the payer's deadlines for appeals are, and what the organization's rights are during the appeals process. CDI involvement may not be able to change the contracting language right then and there, but knowing what language currently exists can help frame data collection and help the facility build up its argument for future changes come renewal time.

"A lot of the contracts are not written in a way to support clinical appeals. They weren't written in a way to support a physician-to-physician appeal," he says. "A lot of hospitals don't have the leverage to renegotiate mid-contract. If it's a six-year agreement and you're only in year two, you're in it for the long haul, but you should still collect data to justify the changes to the contract when it's time. […] It's a long game."

The needle may be slow moving, but the work is worth it. A concerted, cross-disciplinary effort with assistance of the CDI department can pay off in the short term with overturned denials, denial-proofing on the front end, and potentially better, clearer payer contracts down the line.

"It's amazing how many hospitals don't fight denials. That's leaving money on the table, and we have a responsibility to be paid for the work we do. It's important," Stoddard says. "That's why CDI is so important. The best way to fight a denial is to prevent a denial. And you do that through education and proper documentation up front."