# 2025 Mastermind Hot Topic Guide, Part 1: Denials, staff audits, and second-level reviews

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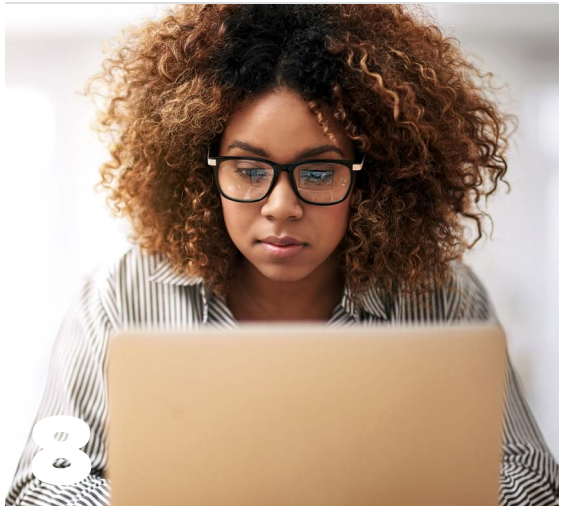

As the saying goes, it's lonely at the top. CDI leaders often find themselves in an isolated position without many peers at their organization who truly ***get it***. Often, leaders must look outside their organization's walls to collaborate with peers and trade stories and advice. The ACDIS CDI Leadership Council connects leaders nationwide for conversations about hot topics and industry trends, but a smaller subset of the Council, the Mastermind group, gives participants the opportunity for focused brainstorming and problem solving.

This multitopic report, produced in partnership with Solventum, formerly 3M Health Care, shares takeaways from the first half of the 2024/2025 CDI Leadership Council Mastermind term. These conversations cover a range of leadership topics, including DRG downgrades, CDI staff audits, and second-level reviews.

Denials management has become a prominent part of CDI's purview over the last few years as organizations have realized that their CDI teams (and often their associated physician advisors) are well equipped to fight the denial onslaught. According to the 2024 CDI Week Industry Overview Survey, of the 64.17% of respondents who are involved in the denials management process, 56.66% are specifically looking at DRG downgrade denials, and for good reason.

"We quickly recognized the CDI team was the right place for [DRG downgrades]," says **Anne Espinoza, RN, BSN, MBA, CDIP, CCDS, CCS**, executive director at Froedtert Health and the Medical College of Wisconsin (south region). "We're dissecting the clinical thinking in these charts, and we are building arguments – supported by the medical record for conditions that they are attempting to downgrade. [...] Our nurses have become deeply committed to assure we represent the clinical scenario and care delivered."

Involving the CDI staff in DRG downgrade appeals can improve denial outcomes, according to **Robin Gantea, RN, MSN, CRCR**, executive director at Baptist Health in Jacksonville, Florida. Though it's a substantial amount of work to add to CDI's already overflowing plate, and using an outside vendor or another department to fight the denials may seem more attractive, CDI's positive impact is hard to argue with.

"Our overturn rates have dramatically increased with keeping them in house. Our [CDI specialists] do a very, very good job of doing a first pass and getting them overturned, so we rarely have to pull in a physician advisor," says Gantea.

Knowing that CDI can have a significant impact is one thing, but operationalizing that involvement presents a challenge. At many organizations, the denials are routed through a specific department and then must be filtered to CDI. Finding out what department receives those denials and developing a system for routing them to CDI is, therefore, the necessary first step.

"Our coding team gets the denials, and they send anything that's clinical to the CDI team. I usually assign it to the CDI specialist that's touched that chart because they already have notes and they can go back, refresh, and write the letter," says **Blessy George, MSN, RN, CCDS**, CDI manager at Penn Medicine in Philadelphia.

Once the denial gets to the CDI team, however, there still needs to be a feedback loop established so that CDI

can track their overturn rate over time. Often, this is easier said than done, according to **Olusegun John Ajisefinni, MD, DHA, RN, MSIT, MBA, RHIA, CCS, CCDS**, director of CDI services at Cedars-Sinai Health System in Los Angeles.

“We review it and send it back to the coding team. They copy/paste what we wrote as the dispute and send it back to the payer. We don’t get any response back to the CDI team, but the denial team is working on that feedback loop,” he says.

If the CDI team receives information about their overturns, they need to develop a tracking system—even if that means starting with rudimentary spreadsheets, according to Espinoza. While this may be cumbersome, it’s a critical first step to understand the data before building or buying a more sophisticated tracking system.

“The data can be slow to arrive, as some cases don’t surface for months—or even years—and appeals may be addressed long after the original encounter,” she says. “We initially relied on spreadsheets. While helpful they require manual input and upkeep to effectively tell a story. We have since developed a ‘denials hub’ within our EHR. This allows us to be more efficient. It allows us to route denials between teams, responding more quickly, and access data. All the information now lives in one place.”

Once you’ve captured the data and can identify trends, you’ll need to “close the loop” with your providers about any concerning trends you uncover, adds Gantea.

“If we agree with the denial and it’s related to a coding or CDI issue, then we don’t take it back to the physician,” she says. “We do have education each month and meet with our hospitalist team. Part of that education is going through any trends we see.”

CDI is an ever-evolving field, and leaders need to ensure that staff continue to operate at a high level during their chart reviews, maintaining compliance and catching all possible opportunities. Often, this task is accomplished through chart audits. For staff, however, an audit can be perceived as punitive rather than instructive.

"At a previous organization, we had audits, and it was more punitive. There was a lot of discomfort from the staff," says **Katie Parsley, MSN, RN, CCDS, CPHQ**, CDI manager at Providence Health & Services in Oregon. "They would have a lot of rebuttals and try to get anything off their record, so it really wasn't seen as educational. [...] When I came to my current system, there was no audit process, so I started it with our educator, and we do it very differently. It's not called an audit, it's called one-on-one feedback, and I never say the word 'audit' because it has such a negative connotation with the staff."

While there's power in naming, clarity around the process and expectations will also help ease discomfort, according to **Sherri Holt, RN, BSN, CCDS**, CDI manager at Michigan Medicine in Ann Arbor, Michigan. When building new job descriptions for a revamped career ladder,

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Holt says she made sure audits were a part of the picture from the outset.

"The way I went about mitigating some of those feelings was by building the audits into the job descriptions and making sure everyone knew that right from the beginning, this is part of [the CDI lead and second-level reviewer] roles," she says.

"The audit itself does look like a third-party audit. About half of my staff are coder-trained, so they are familiar with a third-party audit."

While audits can help the staff being audited improve their chart review prowess, the auditors also benefit by getting to exercise some leadership skills,

according to **Ginger Tabor, RN, CCDS**, manager of CDI at Saint Francis Health System in Oklahoma. Senior staff have the opportunity to flex their CDI muscles and share their knowledge with more junior staff.

"On Thursdays and Fridays, [the team leads] take a reduced caseload and the target is to do concurrent peer reviews," Tabor says. "Part of the reasoning is to promote a sense of leadership within the team. [...] On average, it's about 16 charts a week that they're doing concurrent second-level reviews on."

If an organization doesn't have team leads or junior leadership titles available to help with audits, the task may fall to the department's leader, which can be a time management challenge, according to George. Rather than trying to do ***all*** the audits at once, she suggests staggering the type of audits you conduct and prioritizing those that will help staff most immediately.

"I try to mix it up based on my schedule," she says. "I do either retro audits or concurrent audits. I'll do three to five cases of concurrent audits on each CDI specialist. I think sometimes when it's a concurrent audit, it gives them the time to look at the case, make changes in real time, query if needed, etc. On the retro side, it's good to know, but they may not come across that exact scenario again. So I try to do both."

Another option, if the budget is there, is contracting with a vendor to provide audits instead of keeping them in-house. For **Anne Robertucci, MS, RHIA**, vice president of clinical revenue cycle at Prisma Health in Greenville, South Carolina, the expense is worth it to ensure compliant query practice.

"It's not an option for every organization, but we've invested in budgeting for external audits from a query compliance perspective," she says. "They look at the components of the review—was the query necessary? Was it appropriate? While it's not a full-blown audit of all actions done by the CDI specialist, it does look at one of the critical components of their review."

Regardless of ***who*** conducts the audits, however, the information gained from the audits must be used for education to better the CDI specialists' proficiency, according to Parsley.

"We do education for our team based on any trends we're seeing in the audits," she says. "What we've done historically is keep track of what query opportunities were missed and share that data with the team, so they know they're not alone, but [rather] that these are things people are missing and things to focus on."

These days, CDI specialists could spend hours on a single chart review because of all the various factors to review—from CC/MCC capture to clinical validation, quality measures, risk adjustment, and more. However, the more time spent on a single chart review, the fewer charts can be seen in a day. While technology such as chart prioritization can help with this challenge, many teams also institute targeted second-level reviews for specific concerns.

Staffing around second-level reviews, however, can be problematic as they typically take much longer than a "traditional" CDI review and pull staff or leaders away from their normal responsibilities.

"Right now, our managers and supervisors are active as the second-level reviewer, and it's taking a tremendous amount of their time to focus on those and then also do their management role, so we're looking into making a change," says Gantea. "One of the suggestions we had from talking to other organizations was moving the second-level review position into an auditor/educator role."

**"Combining the education role together with the second-level reviewer role is great because it allows for the integration of trends and areas of opportunity."**

— Chana Feinberg, RHIA, CDI product adoption manager at Solventum

This can be an effective solution, echoes **Chana Feinberg, RHIA**, CDI product adoption manager at Solventum, because it offers an opportunity for the two role responsibilities—second-level reviews and education—to play off one another.

"I think combining the education role together with the second-level reviewer role is great because it allows for the integration of trends and areas of opportunity from those second-level reviews," she says. "The role can be proactive and reactive at the same time."

Even if you don't officially have educators conducting second-level reviews, you can still informally leverage the knowledge of second-level review staff for the benefit of the whole team, according to Ajisefinni.

"I created a group email so when less experienced staff have questions, they email that group," says Ajisefinni. "The question can be about anything because a second-level reviewer is an advanced CDI specialist who is supposed to know almost everything that we do in the CDI space."

Those without the staff bandwidth or structure for a formal second-level review process aren't out of luck either. Being proactive on advanced review topics—quality measures, mortalities, risk adjustment, etc.—can ensure that you're catching opportunities even without a formalized second-level review process, according to Tabor. Regardless of structure, however, you will need to work across departments to ensure everyone's on the same page about priorities, especially if they will require a bill hold of any kind.

"We don't have a dedicated second-level reviewer program, but we do a lot of

proactive things like peer reviews by a team lead, work queues in the EHR, pre-bill holds to capture all our Value-Based Purchasing cohort patients," says Tabor. "We also have a hold based on discharge disposition, and my supervisor is responsible for reviewing mortalities. My staff are instructed that with a mortality, they are to share that chart for a second look by a peer, so mortalities are always reviewed by my supervisor and two peers."

Committees are another effective strategy for sharing the load, according to **Fakhar Khan, MD**, medical director of revenue cycle at Hartford Healthcare in Connecticut. He suggests leveraging interdisciplinary groups to tackle items traditionally in the purview of second-level reviewers.

"Coming up with a mortality review process where you have physician leaders, CDI, and coding on the same call could be a good way to kick-start a collaborative process," he says. "It's a great way to spark that relationship if it's not there at your organization yet."