Clinical Documentation Excellence Part 3: Complex & Clinical Denials
Using Clinical Documentation to Help Reduce Denials & Win Appeals

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February 19, 2026

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Learning Objectives

Identify documentation gaps that lead to denials.

Strengthen documentation to support successful appeals.

Apply proactive documentation strategies to help reduce denial rates.

Why This Matters

Payor denials are a major source of preventable revenue loss.

Most denials originate in the clinical record.

Strong, proactive documentation can help prevent denials & support appeals.

Denial Prevention Best Practices

Admission Documentation
Denial Prevention Starts Here

Why is the patient here today?

- What treatment failed in the outpatient setting?
- What changed since last encounter?

Why inpatient vs. observation or outpatient?

- Inpatient-only services required
- Risk if care delayed or downgraded

Severity of Illness & Medical Necessity

Note abnormal vitals & labs.

Document comorbidities impacting care.

Clearly state clinical instability.

Include an explicit medical necessity statement.

Daily Progress Notes
Help Prevent Continued Stay Denials

What changed since yesterday? Explain why.	Why does the patient still require inpatient care today?	Document barriers to discharge.	State risk if discharged today.

Orders & Documentation Alignment

Orders must match documented acuity.

Telemetry, IV meds, labs must be justified.

Consultant notes should align with attending assessment.

Red flag: Low-acuity documentation with high-intensity orders.

Diagnosis-Specific Documentation

Diagnosis supported by signs, symptoms, & data.	Include clinical judgment.	Clearly state acuity & severity.	Document & manage complications & comorbidities.

Discharge Documentation
Appeal Protection

Final diagnosis clearly stated.	Hospital course explains need for admission.	Ongoing risk or resolution documented.	Discharge timing explained.

How Payors Review Clinical Records

Was care medically necessary?

Was the level of care supported daily?

Is the clinical story consistent & defensible?

Common Denial Triggers

Short stays & one-day admissions.	Status conversions without documentation to support.	Vague language like “stable” or “monitoring.”	Copy-forward documentation.

Documentation Language Matters

Avoid

"Stable," "improving," "monitoring"

Example Documentation to Use

- "High risk due to …"
- "Requires inpatient-level care because …"
- "Unable to safely manage outpatient due to …"

Case Study

Short Stay Denial

Denial Reason	Before	After
Lack of medical necessity.	Admitted for chest pain. Troponins negative.	High-risk chest pain requiring telemetry & serial enzymes.

Outcome:

Appeal overturned.

Appeal Best Practices

How Documentation Affects Appeal Outcomes

Appeals rely on contemporaneous documentation.

Post-denial explanations are ineffective.

Clear physician intent is critical.

Proactive Documentation Strategies

Document the “why.”	Justify level of care daily.	Use explicit, risk-based language.	Anticipate payor scrutiny.

Appeal-Focused Example
Congestive Heart Failure

Avoid	Example Documentation to Use
“CHF exacerbation, improving”	“Acute decompensated heart failure with pulmonary edema requiring IV diuresis and close monitoring due to high risk of respiratory failure.”

Appeal-Focused Example
Sepsis

Avoid	Example Documentation to Use
“Possible sepsis on antibiotics”	“Sepsis with hypotension and lactic acidosis requiring IV fluids, IV antibiotics, and frequent reassessment due to risk of shock.”

Appeal-Focused Example
Pneumonia

Avoid	Example Documentation to Use
“Pneumonia, stable”	“Pneumonia with hypoxia requiring supplemental oxygen and IV antibiotics, with risk of respiratory decompensation if discharged.”

Appeal-Focused Example
Gastrointestinal Bleed

Avoid	Example Documentation to Use
“GI bleed, monitoring labs”	“Acute GI bleed with declining hemoglobin requiring serial labs, IV therapy, and high risk of hemodynamic instability.”

Navigating the CMS WISeR Model

CMS Wasteful & Inappropriate Service Reduction (WISeR) Model
Why It Matters & What It Is

CMS initiative focused on reducing inappropriate utilization.

Additional authorization & pre-payment review requirements

Increased scrutiny of medical necessity.

How WISeR Impacts Denials & Appeals

Greater importance of clinical documentation.

Increased scrutiny of medical necessity & documentation.

Increased administrative work for organizations.

WISeR & Appeals
Setting Yourself Up for Success

Appeals depend on strong documentation.

Strong documentation helps protect against audits.

Proactive documentation helps reduce downstream rework.

CMS WISeR & Documentation
How They Work Together

WISeR Model:
Focuses on appropriateness, utilization, & documentation.

Relies heavily on clear physician documentation.

WISeR expands scrutiny beyond admission decision alone.

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Why Documentation Matters Under WISeR

WISeR increases scrutiny of medical necessity.

Documentation directly influences payment, audit risk, & appeal outcomes.

Clear medical necessity must be evident at admission & throughout the stay.

Strong documentation helps protect against medical necessity denials.

Key Takeaways

Admission Documentation & Level-of-Care Rationale

- Explicit inpatient vs. observation rationale.
- Severity of illness details (clinical indicators, abnormal findings, worsening status).
- Risk of deterioration or adverse outcomes if lower level of care used.
- Diagnosis-specific clarity:
  - CHF: acute decompensation, IV diuresis needs
  - Sepsis: organ dysfunction, hypotension, lactate elevation
  - Pneumonia: hypoxia, oxygen requirements

Daily Progression & Continued Stay Documentation

Daily notes must demonstrate:

- Clinical progression: improvement, worsening, or lack of change.
- Ongoing need for inpatient-level treatment or monitoring.
- Barriers to discharge (medical, functional, social).
- Reassessment of risk if level of care is downgraded.
- Avoidance of nonspecific terms (“stable,” “monitoring,” “patient doing well”).

Documentation for Appeals & Audit Protection

- Appeals depend fully on contemporaneous documentation, not retroactive explanation.
- Strong documentation helps reduce risk in:
  - Short inpatient stays (0–1 midnight)
  - OBS-to-IP conversions
  - High-cost or high-risk DRGs
- Detailed daily & discharge documentation helps strengthen appeal defensibility.
- Proactive documentation helps reduce rework, denials, & lost revenue.

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Denial → Documentation → Appeal Success Workflow

Step 1	Step 2	Step 3	Step 4	Step 5
Proactive documentation at admission.	Daily justification of level of care.	Denial issued based on review.	Appeal supported by strong documentation.	Payment upheld or denial overturned.

Key Takeaways

Denials are documentation problems first.

Appeals are only as strong as the record.

Strong documentation helps prevent denials & support appeals.

Final Thought

The best appeal is the one you never have to file.

Other sessions in this series:

Clinical Documentation Excellence Pt. 1: Compliance & Risk Mitigation

On Demand

Clinical Documentation Excellence Pt. 2: Reimbursement & Revenue

On Demand

Thought leadership:

Improving Clinical Documentation for Compliance & Reimbursement

CMS WISeR Model: What Providers Need to Know by January 2026

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