

Clinical Documentation Optimization and Coding Assurance

Healthcare Risk Management & Advisory

Ensuring quality clinical documentation and accurate coding and claims submission are essential as healthcare organizations face increased payer scrutiny, complex denial patterns, and ongoing margin pressure. Accurate, defensible documentation and coding across inpatient, outpatient and professional settings are critical to supporting medical necessity, reducing audit risk, and ensuring appropriate reimbursement.

In Federal Fiscal Year ending 2025¹ there was a record breaking \$6.8 billion in recovery under the False Claims Act (“FCA”) with health-care related settlements accounting for over \$5.7 billion, or 84% of the total². This was driven by coding, billing and kickback violations, reflecting a focus on improper payments by Medicare and Medicaid. As government continues to expand its regulatory enforcement activities, providers are forced to focus their resources on ensuring accurate clinical documentation, coding, billing and reimbursement for services to avoid becoming the target of a whistleblower complaint or payer investigation.



Our Capabilities

FTI Consulting delivers holistic clinical documentation solutions that integrate the connection between clinical operations and clinical documentation, coding assurance, and regulatory expertise to optimize documentation, improve charge capture, ensure accurate coding and billing, and defend against denials and audits. We help healthcare organizations ensure accurate reimbursement, reduce denials and unpaid claims, respond to government and commercial payer audits, enhance compliance, and sustain long-term performance improvement.

Our Services Span:

- Coding Audits — Inpatient, Outpatient, Professional, HCC
- Clinical Documentation Improvement (“CDI”)
- Denial Management Services - Clinical Denials
- CDI Education
- Charge Capture Services - Inpatient, Outpatient, Professional
- Charge Description Master (“CDM”) Optimization
- Clinical Appeals Support

Coding Auditing (Inpatient, Outpatient, Professional, HCC)

FTI Consulting provides comprehensive coding audit services spanning inpatient, outpatient, professional, and risk adjustment coding. We assess the alignment of provider documentation with ICD-10-PCS, ICD-10-CM, CPT, HCPCS, DRG, APC, and HCC regulatory and coding requirements, with a specific focus on clinical validity, medical necessity, and compliance with coding guidelines and payer policies.

Our approach integrates data analytics, benchmarking, clinical review, and regulatory insight to support both proactive compliance and audit/investigation response. We go beyond code accuracy to evaluate whether documentation fully supports diagnoses, procedures, and risk capture. Our analysis identifies documentation gaps that drive audit exposure and denials, and we translate findings into actionable recommendations, education, and documentation enhancements.

Denial Management Services - Clinical Denials

FTI Consulting addresses complex clinical denials related to medical necessity, level of care, DRG downgrades, and diagnoses. We evaluate whether the medical record, inclusive of physician documentation, nursing notes, ancillary records, as well as billing and coding documentation, demonstrates the clinical rationale for services rendered by the provider.

Using targeted medical record reviews and data driven trend analysis, we uncover systemic denial drivers and documentation gaps; we partner with clinical and operational teams to strengthen documentation practices, reduce avoidable denials, and protect revenue.

CDM Management

FTI Consulting aligns charge structures with underlying documentation, coding guidance, and regulatory requirements. We assess the accuracy of CPT and HCPCS assignment, revenue codes, units, and modifiers to ensure consistency and defensibility across departments.

Our approach includes governance design, process controls, and ongoing monitoring resulting in a compliant and defensible CDM that supports accurate charge capture, enhances transparency across clinical service lines, and reduces audit risk.

Charge Capture Services (Inpatient, Outpatient, Professional)

FTI Consulting helps organizations capture the full value of services rendered in the inpatient, outpatient, and professional/clinic settings by ensuring documentation supports all billable activity. We evaluate clinical intent, documentation completeness, and alignment with ICD-10-CM, ICD-10-PCS, CPT, HCPCS, and payer requirements.

Through workflow and process analysis, from point of care to claim submission, we identify missed revenue opportunities, overcharging risk, and inefficiencies. Our recommendations improve accuracy, reduce rework, and support compliant reimbursement.



CDI Optimization

FTI Consulting enhances CDI programs by aligning clinical documentation with coding, quality, and reimbursement requirements. We assess CDI program workflows, query practices, staffing models, technology, and physician engagement to identify improvement opportunities

We implement practical, sustainable solutions, including standardized processes, performance metrics, and integration with coding, utilization management, and denial management in order to strengthen documentation integrity and accurately reflect patient acuity and resource utilization

CDI Education Services

FTI Consulting delivers targeted education to providers, CDI specialists, coders, focused on clinical specificity, medical necessity, and regulatory alignment.

Our training is role-specific, specialty-focused, and informed by real audit and denial findings which helps organizations build internal capability and sustain long-term improvements.

Clinical Appeals Support

FTI Consulting develops defensible, clinically grounded appeals that tell the patient story and support medical necessity, level of care, and coding decisions. We develop appeal narratives that clearly articulate the clinical picture in alignment with regulatory guidance and payer policies.

Beyond individual cases, we provide root cause insights and feedback loops to improve documentation, standardize appeal strategies, and increase overturn rates while reducing administrative burden and repeat denials.

Endnotes

¹ Federal Fiscal Year 2025 ends September 30.

² [False Claims Act Settlements and Judgments Exceed \\$6.8B in Fiscal Year 2025," Office of Public Affairs, U.S. Department of Justice \(January 16, 2026\)](#)

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