Date:
RA/Payer:
Address:

Patient Name:
DOB:
MR#:
Admit Date:
Discharge Date:
Claim #:

Dear RA/Payer:

We are in receipt of your denial for the services rendered in the care of the patient named above. You have suggested changing the MS-DRG submitted from 246 to 247 by removing a valid diagnosis code from this claim. Specifically, you believe that Encephalopathy, unspecified (G93.40) should not have been coded as this diagnosis was "not validated." As the Medical Director for Clinical Documentation Integrity and Coding, I have reviewed this case in its entirety as well as the assigned codes. Your conclusion is incorrect as this patient's clinical picture was consistent with an acute encephalopathy which was documented by our providers and appropriately coded. I disagree with your assertion that this MS-DRG was incorrectly chosen.

Encephalopathy, unspecified (G93.40) clinically present

The definition of a toxic-metabolic encephalopathy is "an acute condition of global cerebral dysfunction in the absence of primary structural brain disease." (Please see **Acute Toxic-Metabolic Encephalopathy in Adults.** *Up To Date*, last updated June 2018.) Therefore, patients who present with changes in their mental status due to an acute illness, adverse effects of medications, or toxic ingestions clearly meet this definition since there is no cerebral architectural damage such as an intracranial hemorrhage. In this case, this patient's clinical situation clearly meets this definition based on the following:

1. This patient underwent cardiac catheterization with PTCA and stent placement on the morning of 10/18/2017.
2. This patient's cognitive status acutely decompensated after this procedure. That afternoon, she was noted to "Becoming more agitated and combative" for which this patient was "Ordered for Haldol" at 3:47 pm. (Please see attached and underlined 10/18/2017 hospitalist progress note.)
3. By 7pm, the nurse noted that this patient "very confused, combative, trying to get out of bed" and that the patient's daughter at the bedside "cannot redirect patient." (Please see attached and underlined 10/18/2017 nurses note.) This same nurse also noted that this patient "will not follow commands" that "restraints were ordered if needed" after communication with the covering physician.
4. The following morning, this patient was noted to be "less agitated" and that her acute decompensation was at least partly due to a newly discovered urinary tract

infection for which antibiotics were instituted. (Please see attached and underlined 10/19/2017 hospitalist progress note.)

5. On the day of discharge, 10/20/2017, when this patient was noted to be back to her baseline mental status, it should be noted that she had absolutely no recollection of the events of the afternoon and night of 10/18/2017 for which she required a 3mg intravenous injection of Haldol to control. Per the 10/20/2017 hospitalist note, this patient "Does not remember the events that happened yesterday." (Please see attached and underlined 10/20/2017 hospitalist progress note.)
6. Finally, in the discharge summary, the attending physician for this case clearly says, "Patient did become severely agitated, confused post procedure. Suspect from the medications as well as urinary tract infection. Has been on levofloxacin, clinically improved within the past day." (Please see attached and underlined 10/20/2017 discharge summary.)

With these facts in mind, there can be no question that this patient's clinical condition met the definition of an acute encephalopathy. Contrary to the statement made in your denial letter, encephalopathy is NOT defined as a "degenerative disease of the brain." Additionally, there is NO requirement for neurological diagnostic studies, multiple specialty consultations, and ICU monitoring to make this diagnosis all of which are erroneously suggested in your denial letter. Your position stands in stark contrast to the one provided by Up To Date. By accepted definition, acute encephalopathies are rapidly reversible with appropriate treatment as clearly occurred in this case. Your position and this denial can only be taken as an intentional misrepresentations of this patient's clinical condition and currently accepted diagnostic criteria.

Payer clinical criteria superseded by bedside clinicians

It is the position of both the American Health Information Management Association (AHIMA) and the Association of Clinical Documentation Improvement Specialists (ACDIS) that parties not directly involved in the care of the patient should not be making decisions as to what disease processes a patient may or may not have. In the section entitled "Clinical Indicators" of the *Guidelines for Achieving a Compliant Query Practice (2019 Update)*, it clearly states "While organizations, payers, and other entities may establish guidelines for clinical indicators for a diagnosis, ***providers make the final determination as to what clinical indicators define a diagnosis***." (Please see this combined AHIMA/ACDIS position paper at either organization's website.) Therefore, since our board-certified clinicians, who actually interviewed, examined, and treated this patient during this hospitalization, felt she was encephalopathic, that medical determination should be respected and accepted by RA/Payer Z.

In summary, I disagree with the suggested change in MS-DRG for this case. The documentation in this chart incontrovertibly establishes that this patient was acutely encephalopathic during this hospitalization. As we have provided you with clear documentation, widely accepted clinical criteria, and current AHIMA/ACDIS opinion that support our appropriate and accurate coding of Encephalopathy, unspecified (G93.40) for this case, we ask that the MS-DRG of 246 remain as was originally submitted.

Sincerely,

Trey La Charité, MD, FACP, SFHM, CCS, CCDS
Hospitalist and Medical Director for Clinical Documentation Integrity and Coding
Clinical Assistant Professor