Date:
RA/Payer:
Address:

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

Dear RA/Payer:

We are in receipt of your letter regarding services rendered in the care of the patient listed above. You have suggested denying this entire claim by overlooking a valid IP order and by downgrading the submitted MS-DRG from 280 to 281 by deleting a valid secondary diagnosis code. Specifically, you believe that Acute on Chronic systolic (congestive) heart failure (I50.23) should not have been coded as it was "not validated". As the Medical Director for Clinical Documentation Integrity and Coding, I have reviewed this case in detail as well as the assigned codes. Your conclusions are incorrect as there was a valid Inpatient order for this hospitalization and this patient's clinical condition was consistent with an acute exacerbation of his underlying chronic heart failure. I disagree with the suggested change in MS-DRG for this claim.

A valid Inpatient order present

At the top of this patient's computerized physician orders is the Bed Request which clearly shows an inpatient admission was ordered at 22:18 on 9/9/2018. (Please see attached and underlined Orders.) This order was subsequently cosigned by the admitting attending, Dr. X, at 22:21 on 9/9/2018. (Please see attached and underlined Bed Request detail.) Therefore, there can be no question that a valid inpatient order was entered in a timely manner for this hospitalization and the initial intent of this hospitalization was that it would require an Inpatient stay.

Acute on chronic systolic (congestive) heart failure (I50.23) clinically present

First, this patient clearly meets **two major** criteria in the Framingham heart failure diagnosis system as this patient had both cardiomegaly and pulmonary edema on his admission chest x-ray. (Please see attached and underlined chest x-ray report.) With these facts in mind, there can be no question that this patient's clinical condition met the requirements of this widely recognized and accepted diagnostic tool.

Second, per the **2013 ACCF/AHA Guideline for the Management of Heart Failure** (*Journal of the American College of Cardiology*, vol. 62, no. 16, 2013), heart failure is defined as "a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood. The cardinal manifestations of HF are dyspnea and fatigue, which may limit exercise tolerance, and fluid retention, which may lead to pulmonary and/or splanchnic congestion and/or peripheral edema. **Some**

patients have exercise intolerance but little evidence of fluid retention, whereas others complain primarily of edema, dyspnea, or fatigue. Because some patients present without signs or symptoms of volume overload, the term 'heart failure' is preferred over 'congestive heart failure'. There is no single diagnostic test for HF because it is largely a clinical diagnosis based on a careful history and physical examination." This same language is again reiterated in **Evaluation of the Patient with Suspected Heart Failure** (W. S. Colucci in *Up To Date*, last updated January, 2018) which you cite in your denial letter. In this case, our patient presented with cardiomegaly, acute pulmonary edema, ***and*** a functional impairment of his ventricular ejection function as his transthoracic echocardiogram from 9/10/2018 revealed an ejection fraction of 45-50%. With these things in mind, there can be no question that this patient meets these requirements for the diagnosis of acute congestive heart failure as well as the Framingham Criteria.

Third, per the **2017 ACCF/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure** (*Circulation*, vol. 136, 2017), "In patients presenting with dyspnea, measurement of natriuretic peptide biomarkers is useful to support a diagnosis or exclusion of heart failure." This same reference goes on to say that "higher values have reasonably high positive predictive value to diagnose heart failure." In this case, our patient presented with a significantly elevated beta-natriuretic peptide level of 391 pg/ml which is almost three times the upper limit of normal. Therefore, this patient clearly had acutely decompensated heart failure by this definition.

Fourth, in none of these references does it say that treatment with intravenous diuretics or an increased oral diuretic regimen is necessary to make the diagnosis of heart failure. To insist on additional criteria to prove clinical validity of any diagnosis is misleading and deceptive. The definition of heart failure simply does not include a treatment requirement. In this case, the patient's home diuretic regimen was instituted as appropriate therapy.

Lastly, 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 which is available at either organization's website.) Therefore, since a board-certified hospitalist and a board-certified cardiologist, who actually interviewed, examined, and treated this patient during this hospitalization, believed he was suffering from an acute heart failure exacerbation, that medical determination should be respected and accepted by RA/Payer Q.

In conclusion, we disagree with the proposed change in MS-DRG from 280 to 281. First, we have provided you with clear and incontrovertible evidence that a valid inpatient

order does exist for this hospitalization. Second, this patient presented with an acute exacerbation of his underlying systolic congestive heart failure which was treated and documented by our providers during this hospitalization. Therefore, we ask that this hospitalization be reimbursed in full for the MS-DRG of 280.

Sincerely,

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