vitalware by HealthCatalyst

Improving your Chances of Overturning a Coding Denial:

Building Successful Appeals

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Mikki Fazzio

RHIT, CCS, Content Integrity Consultant

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Disclaimer Statement

This presentation was current at the time it was published or provided via the web and is designed to provide accurate and authoritative information in regard to the subject matter covered. The information provided is only intended to be a general overview with the understanding that neither the presenter nor the event sponsor is engaged in rendering specific coding advice. It is not intended to take the place of either the written policies or regulations. We encourage participants to review the specific regulations and other interpretive materials as necessary.

All CPT® codes are trademarked by the American Medical Association (AMA) and all revenue codes are copyrighted by the American Hospital Association (AHA).

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Agenda

- Denial Statistics
- Types of Denials
- Common Reasons for Denials
- Proactively Avoiding a Denial
- Common Denial Scenarios and Tips
- Successfully Building an Appeal Case

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Denial Statistics

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Denial Statistics

- Denial rates are up 23% since 2016 and the numbers keep rising
- In 2021, over 40% of COVID claims were denied
- Appeals from facilities have dropped over 10%
- About 60-80% of denials are overturned or reversed when appealed
- Each facility can anticipate 6-13% of claims being denied
- Nearly 65% of denials do not get resubmitted

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Types of Denials

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Types of Denials

- Medical Necessity Denial
- MS-DRG Coding Denial
- Technical Denial
- Outpatient Claim Denial
- Clinical Validation Denial

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Reasons for Denials

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Reasons for Denials

- Missing documentation in sent record
- Auditor missed seeing documentation that was sent
- Misunderstanding of coding guidelines by the payor auditor
- Using only a portion of the record to make a coding determination
- Queries are missed during review by the payor auditor

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Reasons for Denials

- Payor is using a specific set of criteria for validating a specific diagnosis
- Missed query opportunities
- Payor not following the official coding guidelines or newest coding guidance
- Lack of clinical evidence that a condition exists
- Incomplete, unclear, or inconsistent documentation of a specific diagnosis

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Proactively Avoiding a Denial

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Proactively Avoiding a Denial

- Validate principal diagnosis, MCCs, and CCs- clinically and coding-wise. Especially those with only one MCC or CC.
- Query when there is any question on codes that are “driving” the DRG.
- When there is conflicting documentation in the record between providers query for clarification before reporting the code in question.
- If a diagnosis is documented and then dropped in the record then query. Do not assume this was present, treated and gone. It may be that the condition was dropped due to the physician ruling it out without the appropriate documentation of such. Should be on discharge summary.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Proactively Avoiding a Denial

- Make sure there is documentation in the record that a condition is clinically valid.
- Keep up to date on all the newest coding guidance
- Know the clinical criteria for reporting the most denied diagnoses
- Submit claims timely before the timely filing deadline

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 1:

Cases with only one Comorbid Condition (CC) or Major Comorbid Condition (MCC)

- Validate clinical indicators–a clinical validation query may be appropriate.
- Validate documentation is consistent and not conflicting- bring diagnosis to discharge summary

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Section III. Reporting Additional Diagnoses

For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring:

clinical evaluation; or

therapeutic treatment; or

diagnostic procedures; or

extended length of hospital stay; or

increased nursing care and/or monitoring.

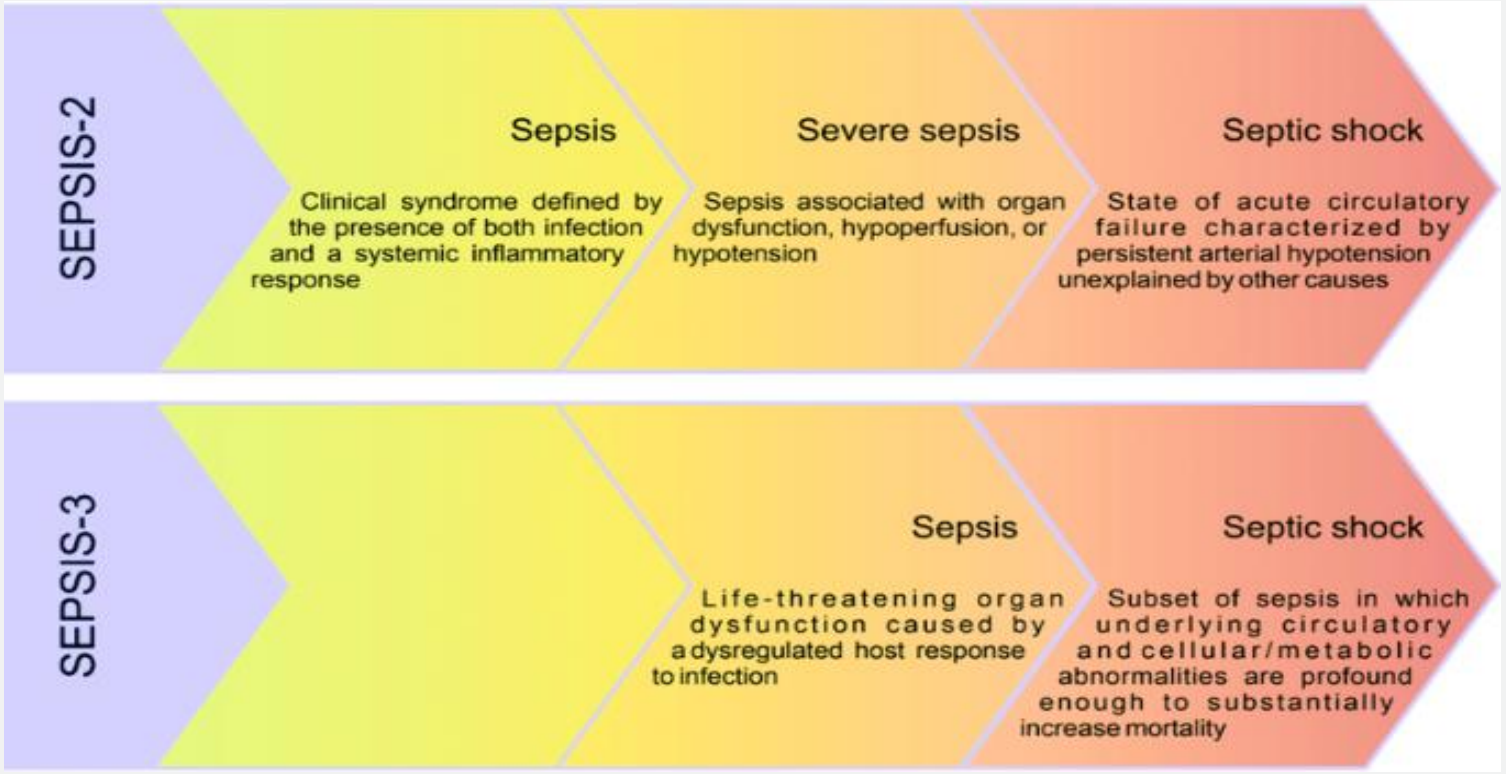
The UHDDS item #11-b defines Other Diagnoses as “all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded.”

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 2:

Sepsis 2 vs Sepsis 3 Criteria



CMS is currently still using Sepsis 2 criteria. Ensure payer contracts specify which sepsis criteria is being used!

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Sepsis Clinical indicators:

- Fever > 100.4 (38 C) ro hypothermia < 96.8 F (36 C), shaking, chills
- WBC less than 4,000 or greater than 12,000
- Tachycardia (Heart rate > 90)
- Confirmed (positive blood culture) or suspected localized infection
- Decreased mental status
- Tachypnea (respiratory rate > 20 breaths per minute)
- Hypotension

For Sepsis 3 clinical criteria, organ failure/dysfunction must also be present to diagnose sepsis.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Common Medications Used to Treat Sepsis

Broad Spectrum Antibiotics:

- Vancomycin
- Rocephin (ceftriaxone)
- Zosyn (piperacillin-tazobactam)
- Cefepime
- Primaxin IV (imipenem-cilastatin)
- Gentamicin

Vasopressors:

- Epinephrine
- Vasopressin

Inotropes:

- Dobutamine

Corticosteroids:

- Solu-Cortef (hydrocortisone sodium succinate)

If these medications are on the record and you do not see a related diagnosis, it's time to query!

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Sepsis – Coding Guidelines

- Assign appropriate code for the underlying systemic infection. If type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism.
- Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Severe sepsis – Coding Guidelines

- Requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis.
- Severe sepsis cannot be assigned as principal diagnosis
- If causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection.
- Additional code(s) for the associated acute organ dysfunction are also required.
- A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.
- If acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Septic shock – Coding Guidelines

- Code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Postprocedural septic shock.
- Any additional codes for the other acute organ dysfunctions should also be assigned.
- Septic shock cannot be assigned as a principal diagnosis.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Sepsis or Severe Sepsis with a Localized Infection – Coding Guidelines

- If the reason for admission is sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis.
- If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis.
- If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn't develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Sepsis due to a postprocedural infection – Coding Guidelines

- Provider must document relationship between procedure and sepsis.
- For infections following a procedure, a code from T81.40, to T81.43 Infection following a procedure, or a code from O86.00 to O86.03, Infection of obstetric surgical wound, that identifies the site of the infection should be coded first, if known.
- Assign an additional code for sepsis following a procedure (T81.44) or sepsis following an obstetrical procedure (O86.04).
- Use an additional code to identify the infectious agent.
- If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Sepsis and Severe Sepsis Associated with a Noninfectious Process (Ex. Trauma or burns) – Coding Guidelines

- If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition should be sequenced first, followed by the code for the resulting infection. If the infection meets the definition of principal diagnosis, it should be sequenced before the non-infectious condition.
- When both the associated non-infectious condition and the infection meet the definition of principal diagnosis, either may be assigned as principal diagnosis

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 3:

Acute Respiratory Failure

Acute respiratory failure is defined as respiratory dysfunction resulting in hypoxemia (low arterial oxygen levels), hypercapnia (elevated levels of carbon dioxide gas), or a combination of the two.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Acute Respiratory Failure Clinical Indicators:

- Shortness of breath, dyspnea, tachypnea, labored breathing, wheezing, stridor, use of accessory muscles, nasal flaring, intercostal retractions, cyanosis, lethargy, inability to speak in full sentences
- Arterial blood gases: pH below 7.35, pCO_2 > 50 mmHg, PaO_2 < 60 mmHg, SpO_2 < 91% on room air, P/F ratio < 300 while breathing supplemental oxygen
- Supplemental oxygen needed

For patients on continuous home O2:

- PO_2 <60mmHg / SpO_2 <91% while receiving their usual home O2 flow rate or more confirms an acute decompensation of chronic hypoxemic respiratory failure

https://www.pinsonandtang.com/resources/pf-ratio/ **- Calculate P/F ratio**

Review for conflicting documentation. (Ex. Documentation of ARF and documentation of "no respiratory distress noted" or "patient is breathing comfortably")

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Acute Respiratory Failure:

- What was the patient's baseline respiratory function?
- Did they have chronic respiratory failure on home oxygen?
- What, if any, was the patient's baseline morbidity in regard to their respiratory function?
- How much from baseline has the oxygen requirements increased and or oxygen saturation decreased?
- Was the patient in any visible sign of distress in the emergency department or on admission on physical assessment?
- Is physician documenting an acute respiratory failure in the post-operative period even though it is usual and customary for the procedure?

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Acute Respiratory Failure – Coding Guidelines

- A code from subcategory J96.0, Acute respiratory failure, or subcategory J96.2, Acute and chronic respiratory failure, may be assigned as a principal diagnosis when it is the condition established after study to be chiefly responsible for occasioning the admission to the hospital, and the selection is supported by the Alphabetic Index and Tabular List. However, chapter- specific coding guidelines (such as obstetrics, poisoning, HIV, newborn) that provide sequencing direction take precedence.
- When a patient is admitted with respiratory failure and another acute condition, (e.g., myocardial infarction, cerebrovascular accident, aspiration pneumonia), the principal diagnosis will not be the same in every situation. If both the respiratory failure and the other acute condition are equally responsible for occasioning the admission to the hospital, and there are no chapter-specific sequencing rules, the guideline regarding two or more diagnoses that equally meet the definition for principal diagnosis (Section II, C.) may be applied in these situations.
- When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses. For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 4:

ASPEN Criteria-Malnutrition in Acute Care Setting:

To meet the American Society for Parenteral and Enteral Nutrition (ASPEN) criteria for severe malnutrition in an acute care setting, a patient must present with the following symptoms:

- Energy intake: less than (<) 50% estimates energy requirement for greater than (>) 5 days
- Weight loss (% of body weight):
  - >2% in one week; or
  - >5% in one month; or
  - >7.5% in three months
- Muscle mass loss: moderate
- Body fat loss: moderate
- Edema masking weight loss: moderate to severe
- Reduced grip strength: measurably reduced

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

ASPEN Criteria-Malnutrition in Chronic Disease:

- Energy intake: less than (<) 75% estimates energy requirement for greater than (>) 1 month
- Weight loss (% of body weight):
  - >5% in one month; or
  - >7.5% in three months; or
  - >10% in six months
  - >20% in a year
- Muscle mass loss: severe
- Body fat loss: severe
- Edema masking weight loss: severe
- Reduced grip strength: measurably reduced

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Global Leadership Initiative on Malnutrition (GLIM) Criteria

Etiologic Criteria

Reduced Nutritional Intake	<50% of requirement > 1 week, or any reduction > 2 weeks, or chronic GI disorders with adverse nutritional impact
Inflammation	Chronic disease or acute disease/injury with severe systemic inflammation, or any socio-economic starvation

Phenotypic Criteria

% of unintended weight loss	5% < 6 months or 10% > 6 months
Low BMI	<20 if <70 years <22 if > 70 years
Reduced muscle mass	Reduced by objective measure and/or physical exam

The phenotypic criteria assist in grading severity. The GLIM criteria for the severe level are listed below. One criterion from these listed must be met.

Criterion	**Stage 2- Severe**
Unintended weight loss	> 10% within the past 6 months or > 20% beyond 6 months
Low BMI	< 18.5 if less than 70 years <20 if ≥ 70 years
Reduced muscle mass	Severe deficit (per validated assessment methods)

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Malnutrition Coding Clinic 2020 Q1:

Question:

Is malnutrition considered integral to chronic illnesses like cancer? For example, if a provider documents malnutrition in a cancer patient receiving chemotherapy may malnutrition be coded separately?

Answer:

While loss of appetite is a common side effect of chemotherapy, malnutrition is not routinely associated with cancer and therefore the Official Guidelines for Coding and Reporting Section I.B.5 regarding conditions that are an integral part of a disease process does not apply. Assign the appropriate malnutrition code in addition to the code for the specific type of cancer.

Question:

The attending physician states “malnutrition” with unspecified severity in the record. The final impression on the dietitian’s consultation was “Severe Malnutrition.” Could the malnutrition be further specified as severe malnutrition by using the specificity in the dietitian’s documentation?

Answer:

No, there are no guidelines permitting the use of a registered dietician’s documentation of the degree/severity of malnutrition for code assignment. The degree/severity of malnutrition (i.e., moderate, mild, severe) is a part of the diagnosis of malnutrition, which can only be made by the provider. According to the Official Guidelines for Coding and Reporting, “Code assignment is based on the documentation by patient’s provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient’s diagnosis).”

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Severe Malnutrition Coding Clinic 2017 Q3:

Question:

Can code E40, Kwashiorkor or code E42, Marasmic kwashiorkor, be assigned to capture a diagnosis of severe malnutrition?

Answer:

No, do not assign code E40, Kwashiorkor or code E42, Marasmic kwashiorkor, for severe malnutrition unless this condition is specifically documented. Assign code E43, Unspecified severe protein-calorie malnutrition. Code E43 can found by looking up “Malnutrition, severe” in the Alphabetic Index as follows:

Malnutrition E46
degree
first E44.1
mild (protein) E44.1
moderate (protein) E44.0
second E44.0
severe (protein-energy) E43
intermediate form E42
with
kwashiorkor (and marasmus) E42
marasmus E41

Kwashiorkor is a condition caused by severe protein deficiency that is usually seen in poor, underdeveloped countries. It is extremely rare in the United States.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 5:

COVID-19

- Positive laboratory result MUST be on the record.
- Active case of COVID-19 vs history code
- Follow most up-to-date ICD-10-CM guidelines
- No “probable” or “possible” COVID-19 diagnosis

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

COVID-19 Infection Coding Guidelines:

- Code only confirmed cases as documented by the provider.
- When COVID-19 meets the definition of principal diagnosis, it should be sequenced first followed by manifestations EXCEPT when another guideline requires that certain codes be sequenced first such as obstetrics, sepsis, or transplant complications.
- For patients with signs/symptoms of COVID-19, but a definitive diagnosis has not been established, code the signs and symptoms instead of the COVID-19 code.
- For patients with a history of COVID-19, assign code Z86.16, Personal history of COVID-19.
- For sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection, assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known, and code U09.9, Post COVID-19 condition, unspecified. Code U09.9 should not be assigned for manifestations of an active (current) COVID-19 infection.
- If a patient has a condition(s) associated with a previous COVID-19 infection and develops a new active (current) COVID-19 infection, code U09.9, Post COVID-19 condition may be assigned in conjunction with code U07.1, COVID-19, to identify that the patient also has a condition(s) associated with a previous COVID-19 infection. Code(s) for the specific condition(s) associated with the previous COVID-19 infection and code(s) for manifestation(s) of the new active (current) COVID-19 infection should also be assigned.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 6:

Implanted Spinal Neurostimulators

Conditions for Coverage

No payment may be made for the implantation of dorsal column or depth brain stimulators or services and supplies related to such implantation, unless all of the conditions listed below have been met:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- With respect to item a, other treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation);
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow up of the patient (including that required to satisfy item c) must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Implanted Spinal Neurostimulators

General Documentation Requirements for trial or permanent Implanted Spinal Neurostimulators:

- Indicate if this request is for a trial or permanent placement
- Physician office notes including:
  - Condition requiring procedure
  - Physical examination
  - Treatments tried and failed including but are not limited to: Spine surgery, Physical therapy, Medications, Injections, Psychological therapy
- Documentation of appropriate psychological evaluation
- For permanent placement, include all the above documentation, as well as documentation of pain relief with the temporary implanted electrode(s).
  - A successful trial should be associated with at least 50% reduction of target pain or 50% reduction of analgesic medications.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Scenario 7:

Mechanical Ventilation

- >96 hours between time patient was intubated and extubated
- Weaning process counts toward this time even if other forms of support are used such as CPAP

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

Mechanical Ventilation Start Time:

- The time when the Endotracheal intubation in the hospital or hospital emergency department, followed in initiation of mechanical ventilation was performed;
- The initiation of the mechanical ventilation through a tracheostomy which was performed in a hospital or hospital emergency department;
- If the patient was previously intubated or if they have a tracheostomy AND are on mechanical ventilation and come to the hospital, then the time of admission is used as the starting time.

Mechanical Ventilation End Time:

- The endotracheal tube is removed (extubation)
- There is a discontinuation of ventilation for a patient with tracheostomy after the weaning period is completed.
- When the patient is discharged or transferred while STILL ON mechanical ventilation.

Mechanical Ventilation time should not be counted if it is only being used during a surgical procedure. It is considered integral to the procedure.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Common Denial Scenarios and Tips

To stay up to date with what OIG is targeting:

https://oig.hhs.gov/reports-and-publications/workplan/active-item-table.asp

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How To Successfully Build an Appeal Case

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

Patient information and reasons for denial

Date

Claim ID/Case Number

Patient Name

Patient's MRN and Visit #

Dates of Service

To Whom It May Concern:

I am writing a formal appeal for the denial on {Insert Patient Name}, {Insert Claim ID/Case Number}. It was stated in the letter that {Insert Code denied} was denied due to {Insert reason for denial}.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

Address denial reasons one by one

- Clinically validate the diagnoses
- Provide evidence of documentation in the record (ex. See progress note, page 3)
- Provide coding guidelines, coding clinics, or other official references

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

Date

Claim ID/Case Number

Patient Name

Patient's MRN and Visit #

Dates of Service

To Whom It May Concern:

I am writing a formal appeal for the denial on {Insert Patient Name}, {Insert Claim ID/Case Number}. It was stated in the letter that {Insert Code denied} was denied due to {Insert reason for denial}. This patient had the following clinical indicators of this condition: {Insert patient's clinical indicators and official resources where clinical indicators can be found (Ex. ASPEN criteria)} This diagnosis was documented consistently throughout the record on the following documents: {Insert document names and page numbers}. According to ICD-10-CM Official Guidelines for Coding and Reporting, {Insert justification for how it was coded}. Also, according to AHA Coding Clinic for AHA, {Insert more justification for how it was coded}.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

- Close the letter by thanking auditor for their time and giving contact information for questions.
- Request a certified mail receipt at the time of mailing, and always track the mail.

Please consider overturning this denial based on the above information provided. Thank you for your time and attention to this matter. If you have any questions, please feel free to contact {Insert contact name, email, and phone number}.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

Most payers will have several levels of appeal. If your first appeal gets upheld, move to next level!

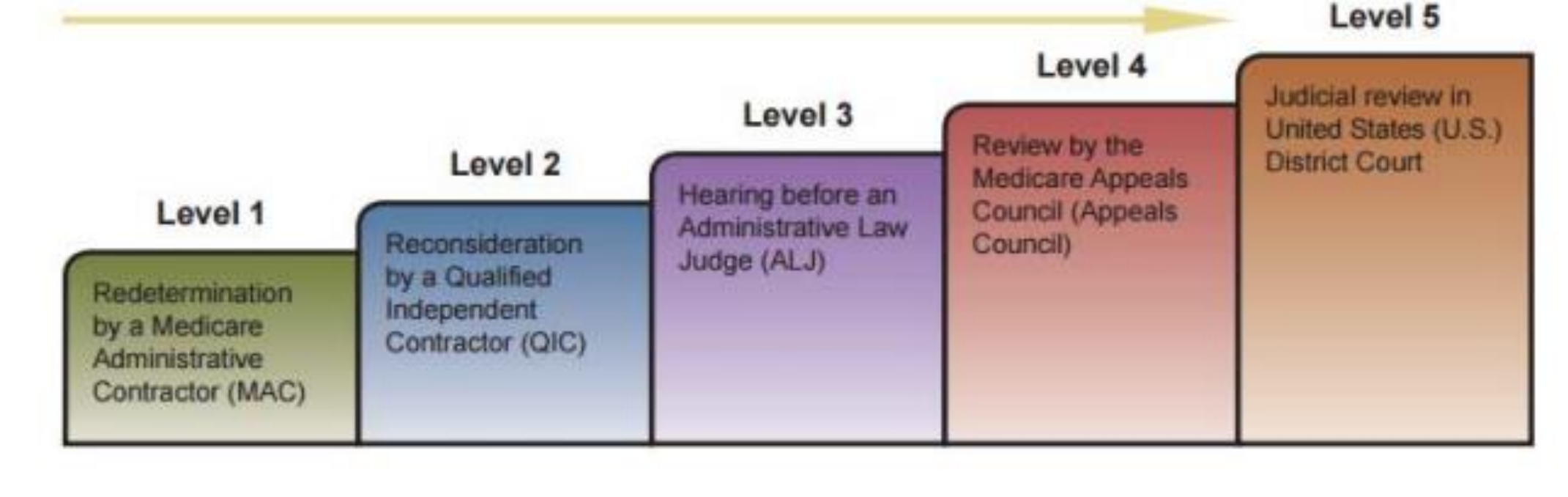
Example:

- Level One: Written letter of appeal is required to entity denying the claim.
- Level Two: Letter goes to next level of appeal, such as a board, independent contractor, etc.
- Level Three: Peer-to-peer (physician to physician) can be requested in writing and must be scheduled. Peer-to-peer is physician to physician conversation, but the organization can invite anyone they want to attend, as it is typically a conference call.
- Level Four: Final decision made by payer medical director.

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

How to Successfully Build an Appeal Case

Medicare Appeals Process



Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Vitalware® by HealthCatalyst®

A single, connected solution for managing your hospital's revenue integrity.

Core Solutions

VitalKnowledge®
Regulatory and Coding Content

VitalCDM®
Chargemaster Management

VitalIntegrity™ | VitalAnalysis
Charge Capture

Hospital Price Index (HPI)
Price Transparency Compliance

#1 in KLAS Revenue Cycle, Chargemaster Management Four Years in a Row

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Resources

Are Clinical Indicators Present to Support the Diagnosis of Sepsis? | Sepsis Series

https://hiacode.com/blog/education/sepsis-clinical-indicators

Audit Alley: How to Expel Acute Respiratory Failure Denials

https://www.fortherecordmag.com/archives/SO20p8.shtml

CMS and OIG Focus on Improper ICD-10-PCS Ventilation Coding

https://www.mrahis.com/blog/cms-and-oig-focus-on-improper-icd-10-pcs-ventilation-coding

Coding Tip: Never-ending Denials

https://hiacode.com/blog/coding-denials

Everything counts: Ensuring accurate coding and reimbursement for mechanical ventilation

https://nahri.org/articles/everything-counts-ensuring-accurate-coding-and-reimbursement-mechanical-ventilation

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Resources

Fight Until the Very End: Sepsis and Malnutrition Denials

https://acdis.org/articles/fight-until-very-end-sepsis-and-malnutrition-denials

How CDI Professionals Can Lead the Clinical Validation Denials Process

https://journal.ahima.org/page/how-cdi-professionals-can-lead-the-clinical-validation-denials-process

ICD-10-CM Official Guidelines for Coding and Reporting FY 2023

https://www.cms.gov/files/document/fy-2023-icd-10-cm-coding-guidelines.pdf

National Coverage Determination (NCD) 160.7: Electrical Nerve Stimulators

https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=240&DocID=160.7

Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services: Operational Guide

https://www.cms.gov/files/document/opd-operational-guide.pdf

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Resources

Q&A: Documenting and Coding Severe Malnutrition|ACDIS

https://acdis.org/articles/qa-documenting-and-coding-severe-malnutrition

Q&A: Handling respiratory failure denials

https://acdis.org/articles/qa-handling-respiratory-failure-denials

Sepsis Treatments and Medications

https://www.singlecare.com/conditions/sepsis-treatment-and-medications#:~:text=When%20all%20the%20signs%20point,cilastatin%2C%20gentamicin%2C%20and%20others.

The Medicare Appeals Process

https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf

What is Sepsis? | Sepsis Series

https://hiacode.com/blog/education/sepsis-series-what-is-sepsis

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

Thank you!

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.

The Healthcare Analytics Summit

September 13-15, 2022 | Salt Lake City, Utah

Embracing the Human Side of Analytics

HAS 22 will explore trends and best practice experiences where analytics meets humanity.

Learn more at **hasummit.com**

Questions?

Confidential • Do not distribute • ©Copyright Vitalware, LLC. All rights reserved.