# You Asked For It!  Appeal Strategies: Emergency Department Level of Care PLUS Clinical Validation of Acute CHF in the TAVR Setting

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February 26, 2025

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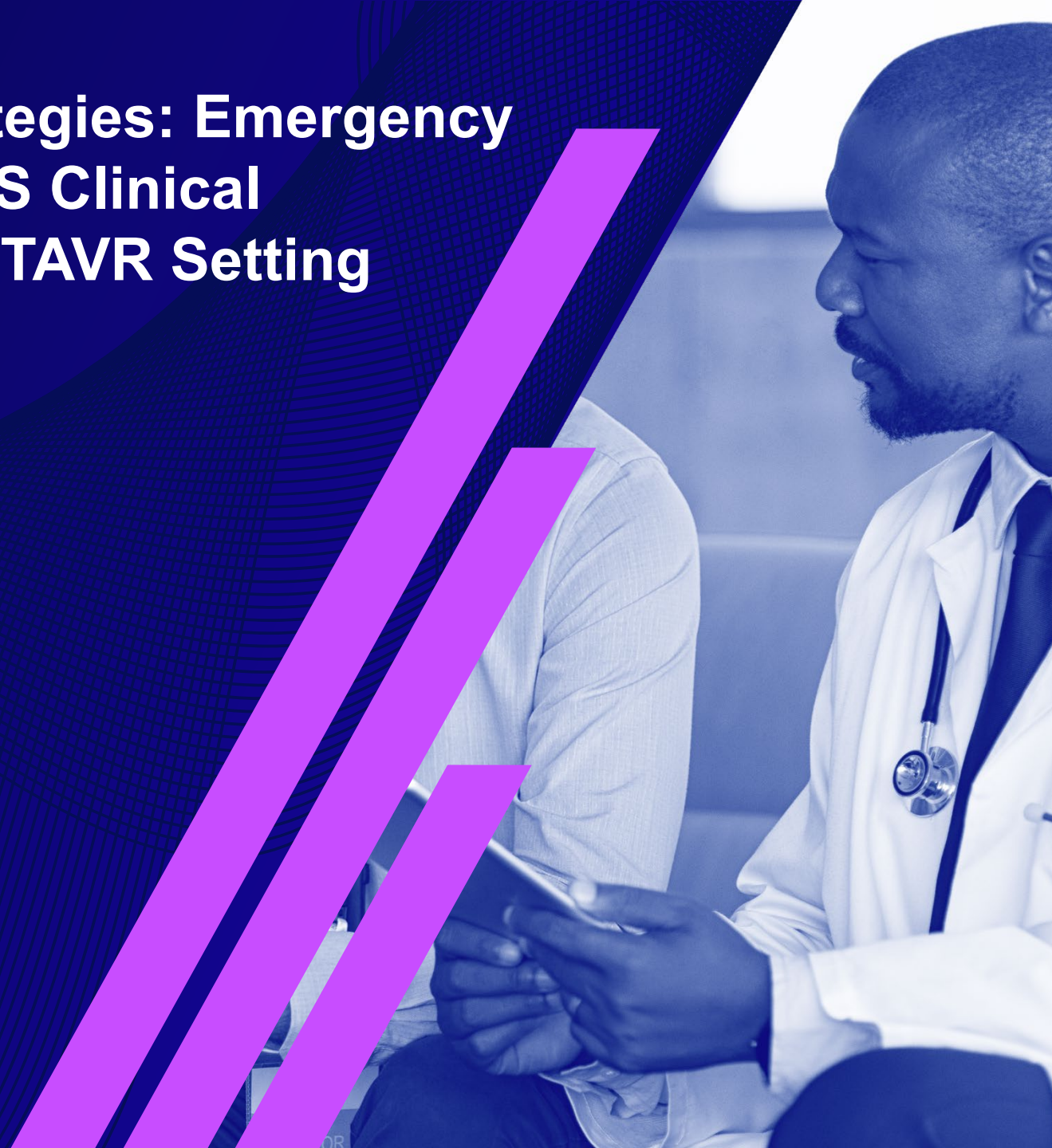

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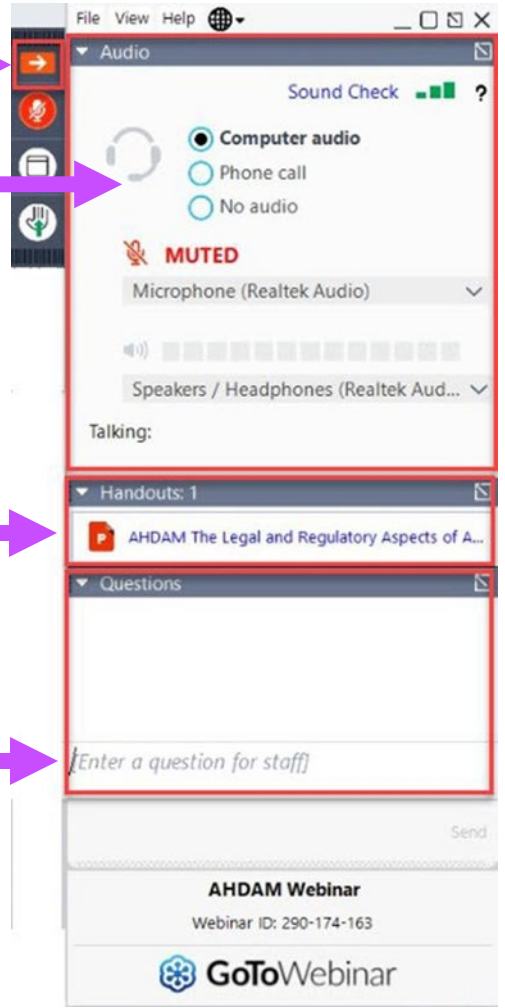

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Association for Healthcare Denial & Appeal Management

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Online

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**Objectives - After Attending This Program You Should Be Able To**

1.Identify key factors to include in emergency department appeals.

2.Choose an effective strategy to appeal an emergency department level of care denial.

3.Pick out specific clinical indicators in TAVR patients to clinically validate acute heart failure if diagnosed by the physician.

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| Reggie Allen | NA |
| Karla Hiravi | NA |
| Raymond Smith | NA |
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# Learning Outcomes

Upon conclusion of this activity, learners will be able to:

1. Determine key factors for use in emergency department level of care appeals.
2. Determine key strategies to employ in emergency department level of care appeals.
3. Determine key strategies to clinically validate the presence of acute heart failure in TAVR patients.

**Reggie Allen, MBA, RN, ACM**
**Senior Vice President | PayerWatch – AppealMasters**
**President - AHDAM**

Reggie has more than 35 years of experience in a variety of healthcare positions, including staff nurse, nurse manager, Chief Nursing Officer, Chief Operating Officer, and Vice President, Clinical/Business Operations Transformation. He has been recognized nationally as an expert in care management and clinical operations. He is a results-driven leader who emphasizes operational transformation by integrating clinical and financial care aspects. He obtained a bachelor's degree in nursing from Vanderbilt University and an MBA from the University of Phoenix. He is a member of the American Case Management Association (ACMA) and the American College of Healthcare Executives.

**Kendall Smith, MD, SFHM**
**Chief Physician Advisor | Chief Medical Officer PayerWatch - AppealMasters**

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor/Chief Medical Officer for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

# Emergency Department – Appeals Levels of Care

# Overview

E/M Code Categories: 99281–99285 (typical ED visit levels)

Key Factors:

- History (by physician)
- Examination (by physician)
- Medical Decision-Making (MDM)
- Resource Utilization (by hospital)
- Coding (by physician and hospital)
- Critical Care Codes: 99291–99292 (when applicable)

**Note:** Consistent documentation of the complexity and decision-making rationale is crucial.

# CMS Guidelines for E&M Coding

Acceptable standards of medical care within the community should always be a consideration in any decision to treat a patient's medical condition. Evidence-based guidelines presented below support the medical necessity of the services as provided.

| | |
|---|---|
| **Source/Reference** | Vannater-Berger, T. (2021). Uphold your ED E/M levels with a plan. AAPC. https://www.aapc.com/blog/80642-uphold-your-ed-e-m-levels-with-a-plan/ |
| **Evidence Based Guideline/Practice Guideline Recommendation** | CMS states facility ED billing guidelines should:<br>• Follow the intent of the CPT® code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.<br>• Be based on hospital facility resources, not on physician resources.<br>• Be clear to facilitate accurate payments and be usable for compliance purposes and audits.<br>• Meet the HIPPA requirements.<br>• Only require documentation that is clinically necessary for patient care. Such as nursing notes.<br>• Not facilitate upcoding or gaming.<br>• Be written or recorded, well-documented and provide the basis of selection of a specific code.<br>• Be applied consistently across patients in the clinic or emergency department to which they apply.<br>• Not change with great frequency.<br>• Be readily available for fiscal intermediary (or if applicable, MAC contractor) review.<br>• Result in coding decisions that could be verified by other hospital staff, as well as outside sources. |

# Common Reasons for E/M Denials

- Insufficient Documentation
  - ✓Missing or incomplete history/exam/MDM details
  - ✓Lack of medical necessity justification
- Incorrect Code Level
  - ✓Upcoding or downcoding discrepancies
- Medical Necessity Not Supported
  - ✓Payer deems visit level unwarranted
- Duplicative or Bundled Services
  - ✓Overlapping codes already included in the E/M code
- Invalid or Missing Modifiers
  - ✓E.g., -25 for significant, separately identifiable E/M service
- Non-covered Services
  - ✓Payer policy exclusions
- Out of network/Transfers to higher level of care/Inpatient Downgrades
  - ✓DO NOT ACCEPT – EMTALA overrides

# Preventing E/M Denials Best Practices

## Accurate Coding & Documentation

- ✓Ensure documentation supports the complexity of care.
- ✓Include any relevant comorbidities or complicating factors.

## Clear Medical Necessity

- ✓Describe the patient's presenting problem, diagnostic workup, and treatment.

## Training & Education

- ✓Regular coding and documentation training for ED physicians and coders.

## Use of Templates & Checklists

- ✓Standardize documentation

## Audit & Monitor

- ✓Conduct periodic internal or external coding audits.

# Payer Payment and Policy Guidelines

| Addendum B.-- OPPS Payment by HCPCS Code for CY 2025 | | | | | |
|---|---|---|---|---|---|
| HCPCS Code | Short Descriptor | APC | Relative Weight | Payment Rate | Minimum Unadjusted Copayment |
| 99281 | Emr dpt vst mayx req phy/qhp | 5021 | 0.9875 | $88.05 | $17.61 |
| 99282 | Emergency dept visit sf mdm | 5022 | 1.7759 | $158.36 | $31.68 |
| 99283 | Emergency dept visit low mdm | 5023 | 3.1052 | $276.89 | $55.38 |
| 99284 | Emergency dept visit mod mdm | 5024 | 4.7754 | $425.82 | $85.17 |
| 99285 | Emergency dept visit hi mdm | 5025 | 6.8757 | $613.10 | $122.62 |
| 99291 | Critical care first hour | 5041 | 9.4496 | $842.61 | $168.53 |

- Reimbursement Methodology
  - APC rates plus ancillary services
  - Flat rates and exclusions
- CMS Guidelines (no set criteria)
- Narrative – Humana Guidelines
- ED Claim Analyzer: calculated weights – Optum (United)

# Levels of Evaluation and Management Examples

- **99281: Simple and limited services such as:** prescription refill, wound recheck, dressing change, suture removal

- **99282: Acute episodic illness and/or minor injury evaluation such as:** preparation/assistance with minor laceration repair/I&D simple abscess, cast removal, foreign body removal (no anesthesia or suturing), venipuncture for labs, noninvasive cultures, Accu-Chek, ace wrap, D/C from ED after 1st or 2nd degree burn treatment

- **99283: Moderate severity problem requiring additional facility resources or nursing time such as:** 1 nebulizer treatment, placement of heparin/saline lock, cervical precautions, insertion or removal of Foley catheter/in and out catheter, Xray, PO prescription medication, simple fracture care, EKG, preparation/assistance with joint aspiration/injection, postmortem care, IVF, meds via IV push/IM/SQ, exams: rectal/GU/pelvic, direct admission via ED

# Levels of Evaluation and Management Examples

- **99284: Acute illness or injury requiring prolonged evaluation and diagnostic studies, repeat nursing evaluations. High severity – urgent evaluation needed such as.**

"Advanced imaging": CT/ECHO/MRI/US/VQ scan, 2 nebulizer treatments, 1 hour of continuous nebulizer, administration and monitoring of fluids/meds via IV/IM/IO, PICC/other central line insertion, placement or replacement of NG or PEG, trach tube replacement, insertion oral or nasal airway, 4 or more different types of tests such as labs without ABGs, ABGs, EKG, x-ray, bladder scan, sexual assault **without** specimen collection

- **99285: High severity problem and/or poses an immediate significant threat to life or physiological function such as:**

3 nebulizers or ≥2 hours continuous nebulizer, cooling/heating blanket, sexual assault **with** specimen collection; administration of physical/chemical restraints, coordinating patient transfer, suicide watch, fracture reduction/relocation, trach tube insertion, general anesthesia, precipitous delivery, 4 or more advanced imaging studies, preparation/assistance with gastric lavage, lumbar puncture/para or thoracentesis

➢ *Note: multiple tests of the same type are treated as 1 type. Exception: each x-ray is treated as a distinct type of diagnostic test.*

# Denial Management Workflow

1. Identify the Denial
   - ✓Letter, EOB, Remittance Advice
   - ✓Compare Code to UB-04; Field/Form locator 24 (FL 24) should have the assigned ED level:  CPT codes 99281-99285
2. Assess the Reason for Denial
   - ✓Check payer's rationale against clinical documentation
3. Review Supporting Documents
   - ✓ED records, labs, imaging, physician notes
4. Develop Appeal Strategy
   - ✓Use templates
   - ✓Reference payer policy guidelines and CPT®/CMS guidelines
5. Submit Appeal in a Timely Manner
   - ✓Observe strict payer deadlines
6. Follow Up
   - ✓Track appeal status; escalate if needed

# Writing Effective Emergency Department Appeals

1. Reference Payer Policies & Guidelines
   - ✓Include relevant sections from CMS, CPT®, or the payer's manual
2. Highlight Clinical Documentation
   - ✓Show how the ED notes justify the E/M level
3. Emphasize Medical Necessity
   - ✓Use evidence-based guidelines if appropriate
4. Include Any Corrective Actions
   - ✓If coding errors occurred, outline steps taken to prevent recurrence
5. Keep It Concise & Organized
   - ✓Use bullet points, subheadings, or short paragraphs. However, short paragraphs telling the story is preferable.
6. Insert State Legal Language
   - ✓Breach of Statutory Obligation to Investigate Claims in Good Faith and Fair Dealing
   - ✓Little to No Explanation Provided for the Code Downgrade

# Template Example

# Template Section: Background

**Background:**

On [Date of Service], [Patient's Name] presented via [mode of arrival]to the Emergency Department with [brief description of symptoms]. In compliance with the Emergency Medical Treatment and Labor Act (EMTALA), a comprehensive medical screening examination was conducted, and necessary stabilizing treatment was provided to determine if an emergency medical condition existed.

**Mode of arrival**: look and note if brought in by: police, BLS, ALS

**History:** Only include patient medical history if significant to the patient's presentation to the ED.

# Template Section: Nursing Assessment and Interventions

Assessments: [triage assessment, frequency of nursing documentation and interventions].

- Point out if the nursing triage note indicates an assessment of a body area or organ was provided (ex: were lungs assessed?).
- Look at the frequency of nursing notes to show proof of continuous intervention and observation
- Look for frequent nursing notes demonstrating that critical care was provided in the ED.

# Template Section: Medical Decision Making

- **Medical Decision Making (MDM)**: The MDM complexity was [moderate/high], due to:
  - Multiple differential diagnoses considered [list them]
  - Order & Process Management [lab tests, imaging, EKG/RT/Ancillary Services, consult MD, consult social/ancillary services, psych/social crisis, restraints, IV therapy]
  - High risk of morbidity/mortality without prompt intervention.

# Template Section: Disposition

**Disposition [**routine, referral, transfer to hospital/SNF, admitted to observation, admitted to inpatient status, expired**]**

- Routine disposition means discharged from ED to home. Use discharged home as opposed to routine discharge.

# Case Studies

# Example 1

Jane Doe, a 30-year-old lady, presented to the Emergency Department with an **overdose** after ingesting an unknown amount of medications, including Prozac, Trazodone, Olanzapine, and NyQuil. She was brought in by EMS after expressing suicidal ideations and attempting self-harm. Upon arrival, Ms. Doe was alert and oriented but admitted to wanting to harm herself. She was **placed on suicide precautions and monitored closely (1 to 1).** There was an **emergency detention order** obtained by the Police Department. Although her vital signs stable, she was also closely monitored via **cardiac monitoring**.

The suspected diagnoses included **suicidal ideation, poisoning by selective serotonin reuptake inhibitors, selective serotonin/norepinephrine reuptake inhibitors, and other antipsychotics/neuroleptics, as well as rhabdomyolysis, anxiety disorder, and depression**. **Laboratory tests** revealed slightly elevated RBC count and CK levels (1421 U/L), indicating rhabdomyolysis. **Urinalysis** was positive for cannabinoids, with a cloudy appearance and leukocyte esterase 2+. An **EKG** showed normal sinus rhythm with no significant abnormalities. The **drug screen was positive** for cannabinoids, and acetaminophen and salicylates levels were below therapeutic levels, indicating no acute toxicity.

During her stay, Ms. Doe received activated charcoal administered en route by EMS, and **IV fluids** were provided to manage rhabdomyolysis and ensure hydration. **Continuous cardiac monitoring** was conducted due to the risk of QT prolongation. **Consultations included Poison Control** for recommendations on monitoring and management, and a **hospital psychiatric screener** evaluated recommending outpatient follow-up. **Poison Control recommended she be closely observed for eight hours before discharge** with concerns for QT prolongation. Ms. Doe spent approximately **14 hours in the Emergency Department**, from her arrival at 22:54 on (date) until her discharge at 12:28 on (date). During this time, she was **closely monitored for any changes in her mental and physical status, ensuring her safety and stability before discharge.**

The comprehensive care provided in the Emergency Department was medically necessary to stabilize Ms. Doe following her overdose and suicidal ideation. The **interventions, including psychiatric evaluation, laboratory testing, and continuous monitoring, were critical in ensuring her safety and addressing her acute medical needs**.

The ED level was assigned using the LYNX ED Claim Analyzer to determine the appropriate visit level based on the intensity and extent of facility resources used during the patient encounter.

# Example 2

Ms. Special was a 51-year-old lady who arrived at the emergency department (ED) via ambulance on November 10, at 8:00 a.m. with chief complaints of **chest pain radiating to her back**. She also experienced **abdomen for the past two days** along with experiencing nausea and vomiting. She has no cardiac history. Upon arrival, she was anxious, **tachycardiac (104), and diaphoretic**. She was triaged immediately as a Level II and seen by the physician.

**Given her signs and symptoms, broad differential diagnoses were considered including a myocardial infarction, unstable angina, pleurisy, and gastroesophageal reflux disease.** To address these possible diagnosis **laboratory tests were performed including a CBC, comprehensive metabolic panel, serial troponin levels. A chest x-ray and abdominal series performed. A CAT scan of the abdomen was done to rule out an intra-abdominal infection and her unexplained abdominal pain.**

In the ED, Ms. Special was administered **sublinqual Nitroglycerin** (for her chest pain without resolution), placed on a **cardiac monitor and an IV** was started. She was given **IV Zofran** for nausea and **IV Ativan** for anxiety. The nursing staff performed a triage assessment, **frequent cardiac monitoring and observation** throughout the patient stay as documented in the medical record.

Although, the final diagnosis was gastroesophageal reflux, the risk of not evaluating the other differential diagnosis could have resulted in a missed cardiac diagnosis and even sudden death. Comprehensive discharge education was provided to the patient by the nurse regarding GERD management. The patient spent **5 hours and 20 minutes** in the ED before being discharged home.

# Example 3

Mr. Sick, a 49-year-old gentleman, arrived at the emergency department (ED) via ambulance on (date) at 15:36 with chief complaints of **generalized weakness and fever**. He reported a four-month history of weakness and abdominal pain. His past medical history was significant for follicular adenocarcinoma of the colon (diagnosed on *date*, declined surgery), chronic kidney disease stage 5, type 2 diabetes mellitus, atrial fibrillation, gastroesophageal reflux disease (GERD), hypercholesterolemia, hypertension, and neuropathy. Upon arrival, he was found to be **tachycardic with an irregular rhythm (120), febrile (101°F**), and had right-sided abdominal tenderness with a palpable mass.

**Given his complex medical history and presenting symptoms, a broad differential diagnosis was considered, including pyelonephritis, sepsis, urinary tract infection (UTI), pneumonia, and colitis. Laboratory test ordered included a CBC, comprehensive metabolic panel, iron studies, COVID/Flu/RSV PCR panel, urine, urinalysis, and blood cultures.** Laboratory studies revealed anemia (hemoglobin 6.8 g/dL, hematocrit 22.0%), leukocytosis (WBC 13.6), metabolic acidosis (CO2 17), elevated BUN (35) and creatinine (3.35), hypocalcemia (8.0 mg/dL), and elevated glucose (160 mg/dL). **Urinalysis** showed hazy urine with proteinuria and bacteria. A **chest x-ray** was done. Due to the patient's chronic kidney disease, a **CT of the abdomen and pelvis was performed with oral contrast** which revealed marked interval progression of the cecal and ascending colon mass with severe adjacent pericolonic inflammation and pneumatosis, raising concern for bowel ischemia or infection. An **EKG** showed atrial fibrillation with rapid ventricular response (rate 120 bpm). An **echocardiogram** was performed.

In the ED, Mr. Sick received acetaminophen for fever and was started on **IV piperacillin/tazobactam** for suspected infection. He was placed on a **cardiac monitor and administered IV diltiazem**. Extensive nursing resources were spent performing an initial triage assessment and frequently monitoring his heart rate, fever, administered medication, and documenting his response to treatment. He **also received one unit of packed red blood cells** for his anemia. **Lactated Ringers** were administered. The patient spent approximately **6 hours and 27 minutes in the ED before being admitted**.

# Example 4

On(date) at 12:19 Jane Doe, a 68-year-old lady, presented to the emergency department with a chief complaint of **palpitations**. She reported a history of idiopathic edema and polycythemia, for which she has been taking diuretics and potassium supplements. Eight days prior to her presentation, she had donated blood due to excess red blood cells, and three days after she donated blood, she began experiencing symptoms of shortness of breath, palpitations, chills, and hot flashes.

**Given her signs and symptoms, the initial differential diagnoses included electrolyte disturbances, particularly hypokalemia, due to her diuretic use, renal insufficiency, ACS, and sepsis.** The medical decision-making involved ordering and interpreting several diagnostic tests, including a **comprehensive metabolic panel, complete blood count (CBC), troponin assay, urinalysis, and an ECG.** The ECG showed nonspecific ST abnormalities and sinus arrhythmia. The complexity of these tests and the need to rule out conditions like electrolyte disturbances, renal insufficiency, acute coronary syndrome, infection, and sepsis indicated a moderate level of decision-making complexity.

In the Emergency Department, she was **under close observation, with an intravenous line established for blood collection and potential therapeutic intervention.** The nursing staff conducted a **triage assessment, implemented cardiac monitoring through a bedside electrocardiogram (EKG), and diligently monitored her vital signs**, as documented in the medical record.

Although the final diagnoses were palpitations and anxiety disorder, the risk of not evaluating the other differential diagnoses could have resulted in overlooking a potentially serious cardiac condition, infection, renal insufficiency, or underlying metabolic derangement, any of which could have had fatal consequences. **Comprehensive discharge education was provided to the patient by the nurse**, and she was advised to follow up with her primary care physician. She spent approximately 1 hour and 32 minutes in the emergency department before being discharged home. **The ED level was assigned using the xxx ED Claim Analyzer to determine the appropriate visit level based on the intensity and extent of facility resources used during the patient encounter**.

# Clinical Validation Appeals for Acute CHF in TAVR Surgery

# Denial Example

A Clinical Validation review was completed by a licensed, board-certified physician on the billed diagnosis of I50.31 (Acute diastolic (congestive) heart failure) based on specific criteria supported Modified Framingham Criteria and UpToDate (full reference below).

Based on the review of the medical record, this diagnosis was unable to be validated at this time. Humana requires the medical record meet the following guideline for Acute Heart Failure: 2 of the Major criteria OR 1 Major and 2 Minor criteria listed below:

2 of the Major criteria OR 1 Major and 2 Minor criteria listed below that cannot be attributed to another medical condition and that are an exacerbation of signs and symptoms beyond baseline:

Major Criteria:
Paroxysmal nocturnal dyspnea
Orthopnea
Pulmonary rales/crackles
Elevated jugular venous pressure (+JVD)
Third heart sound (S3 gallop) present
Cardiomegaly (i.e., enlarged heart/enlarged cardiac silhouette)
Pulmonary edema on chest x-ray
Weight loss of 4.5 (9.9 lbs) kg in five days in response to CHF treatment

Minor Criteria:
Bilateral leg edema
Nocturnal cough
Dyspnea on ordinary exertion/increased shortness of breath
Hepatomegaly
Pleural effusion
Tachycardia (heart rate 120 beats/min)

AND
Evidence of IV diuresis, which would indicate the treatment of Acute Decompensated CHF.

The member was admitted to the hospital with dyspnea due to aortic stenosis. An echocardiogram demonstrated an ejection fraction of 70%. None of the major criteria and none of the minor criteria listed above was present. The member did not have orthopnea or paroxysmal nocturnal dyspnea, and a physical examination did not document

# Payer Rationale

Key insurer arguments: No SOB, pleural effusions, clear CXR, no Lasix administration

Insurer's alternative diagnosis suggestion: Chronic CHF instead of acute CHF

Key Flaws in the Denial:

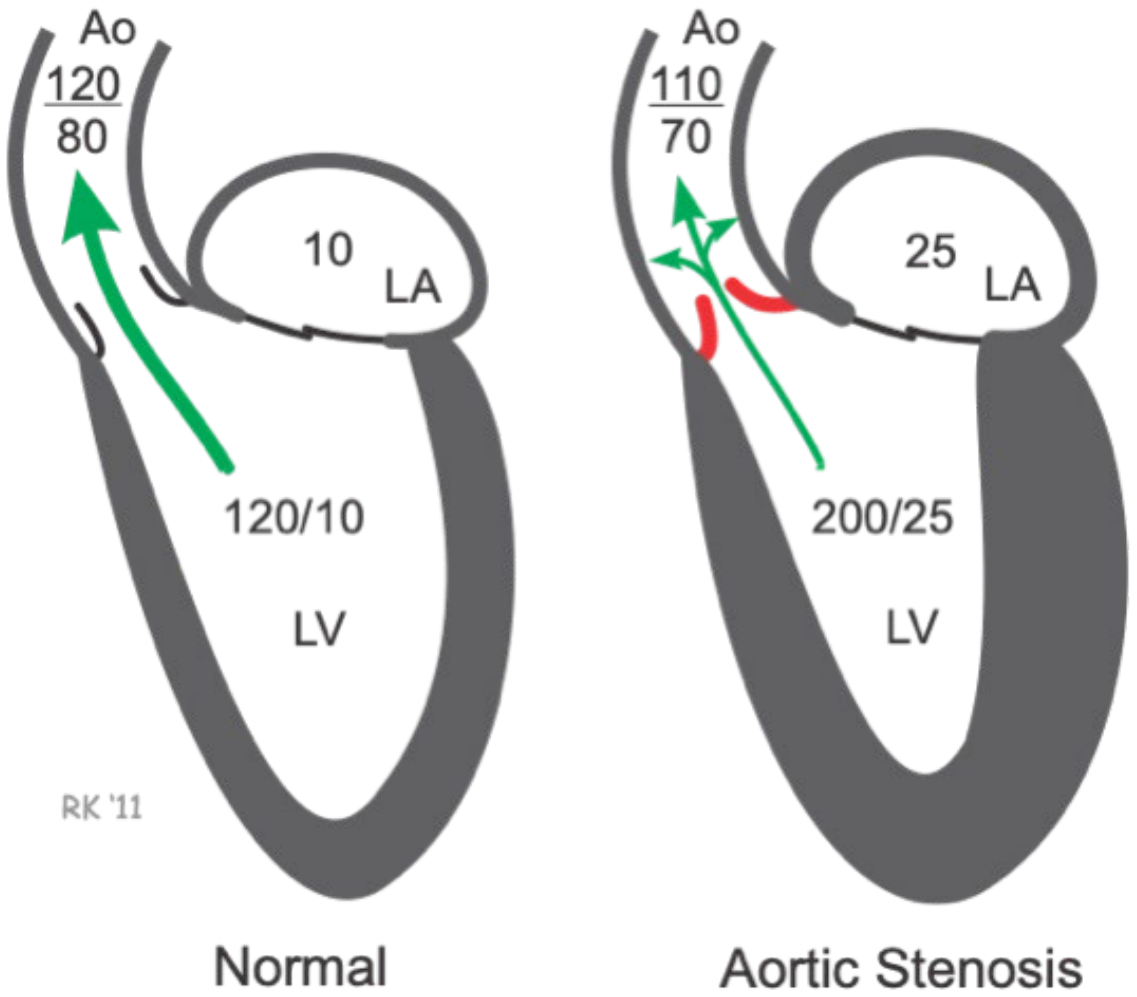
- Lack of recognition of hemodynamic criteria for CHF
- Overreliance on CXR and overt clinical symptoms
- Failure to account for TAVR-induced CHF exacerbations

# Pathophysiology of Acute CHF in TAVR Patients

Pathophysiology Overview:

- Severe aortic stenosis leads to chronic LV pressure overload
- Increased LVEDP due to restricted outflow
- Post-TAVR, transient worsening of CHF due to volume shifts and diastolic dysfunction
- Hemodynamic congestion can exist even in the absence of pulmonary edema

# Aortic Stenosis



# Key Hemodynamic Parameters Supporting Acute CHF

Normal LVEDP: 3-8 mmHg

LVEDP >15 mmHg: Biventricular HF reflex, increased mPAP

LVEDP >18 mmHg: Interstitial edema begins

LVEDP >25 mmHg: Alveolar edema occurs

Supporting Data: Right heart catheterization, echocardiography (E/e’ ratio > 15)

Key Argument: CHF should be defined based on filling pressures and diastolic dysfunction rather than overt volume overload

# Clinical Documentation Strategies

- Ensure detailed documentation of LVEDP, mPAP, and response to diuresis
- Echocardiographic parameters: E/e’ ratio, LA volume index, TR velocity
- BNP/NT-proBNP levels and their role in supporting CHF diagnosis
- Pulmonary capillary wedge pressure (PCWP) correlation with CHF
- Documentation Tips: Clearly differentiate between pre- and post-TAVR CHF

# Rebutting Insurer Arguments

- "No SOB or pulmonary congestion" ≠ No CHF
- Elevated LVEDP is a hallmark of CHF
- CHF in valvular heart disease often presents with exertional intolerance rather than overt pulmonary symptoms
- "No new diuretic administration" is irrelevant
- Absence of diuretic use does not negate CHF diagnosis
- Volume shifts post-TAVR may obviate need for diuresis
- "Clear CXR does not exclude CHF"
- CHF can manifest as increased LVEDP, abnormal diastolic function, and elevated filling pressures

# Case Study:

Successfully Overturned Appeal

Patient: 71-year-old female, severe AS, LVEDP 20 mmHg

Denial reason: "No overt CHF symptoms“

Appeal strategy:

- Highlighted LVEDP >15 mmHg, hemodynamic markers
- Cited absence of overt symptoms in valvular CHF
- Referenced Landsberg’s criteria on CHF pathophysiology

Outcome: Acute CHF diagnosis reinstated, claim approved

# Writing an Effective Appeal Letter

Structure:

- Start with insurer’s rationale and rebut each argument
- Use hemodynamic data to support CHF diagnosis
- Reference key sources (Landsberg, 2018) to validate clinical position
- Avoid vague terminology; use precise LVEDP, PCWP, and diastolic function markers

Sample Excerpt:

"The patient’s LVEDP was documented at 20 mmHg, consistent with acute CHF. This measurement, combined with pre-TAVR hemodynamic congestion, establishes the presence of acute CHF per Landsberg’s criteria."

## Summary & Key Takeaways

- Acute CHF in TAVR patients often denied due to lack of "classic" CHF symptoms
- LVEDP and hemodynamic markers are crucial for appeal success
- Strong documentation and appeal structuring are critical to overturning denials
- Utilize standardized references (Landsberg, 2018) and hemodynamic criteria

# References


Vannater-Berger, T. (2021). Uphold your ED E/M levels with a plan. *AAPC*. Retrieved from https://www.aapc.com/blog/80642-uphold-your-ed-e-m-levels-with-a-plan/

American Medical Association (AMA). (2023). *CPT Evaluation and Management (E/M)*. https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pd

Reddy YNV, El-Sabbagh A, Nishimura RA. Comparing Pulmonary Arterial Wedge Pressure and Left Ventricular End Diastolic Pressure for Assessment of Left-Sided Filling Pressures. *JAMA Cardiol.* 2018;3(6):453–454. doi:10.1001/jamacardio.2018.0318

Pieske, B., Tschöpe, C., de Boer, R. A., Fraser, A. G., Anker, S. D., Donal, E., Edelmann, F., Fu, M., Guazzi, M., Lam, C. S. P., et al. (2020). How to diagnose heart failure with preserved ejection fraction: The HFA–PEFF diagnostic algorithm: A consensus recommendation from the Heart Failure Association (HFA) of the European Society of Cardiology (ESC). *European Journal of Heart Failure*, *22*(3), 391-412. https://doi.org/10.1002/ejhf.1741

Landsberg, J. W. (2018). Chapter 6 - Heart failure for the pulmonary critical care physician. In *Manual for Pulmonary and Critical Care Medicine* (pp. 65-92). Elsevier Inc. Retrieved from https://doi.org/10.1016/B978-0-323-39952-4.00006-8

# Questions and Answers

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# Thank you for attending today's event!

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