Please return all correspondence to:

«TableStart:PATIENTINFO»«Facility_Description»

NPI: «Facility_NPI»
Tax ID: «Facility_Tax_ID»
PTAN: «PTAN»
«TableEnd:PATIENTINFO»
April 9, 2020
«TableStart:PAYERINFO»
«PAY_Payer_Address1»
«PAY_Payer_City», «PAY_Payer_State» «PAY_Payer_Zip_Code»
«TableEnd:PAYERINFO»
«TableStart:PATIENTINFO»«Salutation_Recipient»:

This is a request for «Appeal_Description» on «PAT_Full_Name»'s denied claim for services at «Facility». The following is a summary of the denial from «Prior_Reviewing_Agency», as well as substantiation of the ICD-10-CM codes that supports the proper DRG assignment.

Beneficiary Name	«PAT_Full_Name»
Member ID or HIC Number:	«MEMBER_ID»
Claim Dates of Service	«Svc_From» - «Svc_To»
Reason(s) for Denial	Allegation: Lack of clinical documentation to support the inclusion of *specify diagnosis* as a valid diagnosis on the claim
Reimbursement change	Reassignment of DRG *specify original DRG number and description* to DRG *specify new DRG number and description*
Principal or Secondary Diagnosis in Question	ICD-10-CM *specify diagnosis or diagnoses in question with ICD-10 number and description*

Justification for Appeal

The arguments presented below justify the inclusion of *specify diagnosis or diagnoses in question with ICD-10 number and description* as a valid diagnosis for the following reasons:

1. The patient's diagnosis was documented in the medical record, by the providers responsible for the care of the patient. The clinical assessment, treatment plan, and care rendered was commensurate with the findings. Pertinent medical record documentation is as follows:

Interdisciplinary Documentation

Identify where the specific diagnosis is entered by the physician or individual licensed to diagnose patients. Document the utilization of hospital resources (e.g., orders, test results, unit protocols and nursing records).

Document Source & Date	Pertinent Information	Page(s)

Diagnostic Test Results
(Specify pertinent results)

Test	Date	Result	Reference Range	Page

2. The billed claim was in accordance with the Uniform Hospital Discharge Data Set (UHDDS), Official Coding Guidelines, and AHA Coding Clinics, as referenced below.

3. There is no disclosure indicating the payer's contract provisions vary from Uniform Hospital Discharge Data Set (UHDDS) and Official Coding Guidelines. *Further, there is no disclosure regarding consultation with a coder who has the expertise to understand and apply these guidelines.* Accordingly, disclosure of this information is requested.

Coding References
ICD-10 Coding References
Selection of Principal Diagnosis
ICD-10-CM Official Guidelines for Coding and Reporting
Effective October 1, 2016 - September 30, 2017

Section II. Selection of Principal Diagnosis

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the

patient to the hospital for care." The UHDDS definitions are used by hospitals to report inpatient data elements in a standardized manner. These data elements and their definitions can be found in the July 31, 1985, Federal Register (Vol. 50, No, 147), pp. 31038-40.

A. Codes for symptoms, signs, and ill-defined conditions
Codes for symptoms, signs, and ill-defined conditions from Chapter 18 are not to be used as principal diagnosis when a related definitive diagnosis has been established.

B. Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.
When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

C. Two or more diagnoses that equally meet the definition for principal diagnosis
In the unusual instance when two or more diagnoses equally meet the criteria for principal diagnosis as determined by the circumstances of admission, diagnostic workup and/or therapy provided, and the Alphabetic Index, Tabular List, or another coding guidelines does not provide sequencing direction, any one of the diagnoses may be sequenced first.

D. Two or more comparative or contrasting conditions
In those rare instances when two or more contrasting or comparative diagnoses are documented as "either/or" (or similar terminology), they are coded as if the diagnoses were confirmed and the diagnoses are sequenced according to the circumstances of the admission. If no further determination can be made as to which diagnosis should be principal, either diagnosis may be sequenced first.

E. A symptom(s) followed by contrasting/comparative diagnoses
GUIDELINE HAS BEEN DELETED EFFECTIVE OCTOBER 1, 2014

F. Original treatment plan not carried out
Sequence as the principal diagnosis the condition, which after study occasioned the admission to the hospital, even though treatment may not have been carried out due to unforeseen circumstances.

G. Complications of surgery and other medical care
When the admission is for treatment of a complication resulting from surgery or other medical care, the complication code is sequenced as the principal diagnosis. If the complication is classified to the T80-T88 series and the code lacks the necessary specificity in describing the complication, an additional code for the specific complication should be assigned.

H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable", "suspected", "likely", "questionable", "possible", or "still to be ruled out", or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.

Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

Selection of Principal Procedure
ICD-10-PCS Official Guidelines for Coding and Reporting
Effective October 1, 2016

The following instructions should be applied in the selection of principal procedure and clarification on the importance of the relation to the principal diagnosis when more than one procedure is performed:

1. Procedure performed for definitive treatment of both principal diagnosis and secondary diagnosis.
    a. Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.
2. Procedure performed for definitive treatment and diagnostic procedures performed for both principal diagnosis and secondary diagnosis.
    a. Sequence procedure performed for definitive treatment most related to principal diagnosis as principal procedure.
3. A diagnostic procedure was performed for the principal diagnosis and a procedure is performed for definitive treatment of a secondary diagnosis.
    a. Sequence diagnostic procedure as principal procedure, since the procedure most related to the principal diagnosis takes precedence.
4. No procedures performed that are related to principal diagnosis; procedures performed for definitive treatment and diagnostic procedures were performed for secondary diagnosis.
    a. Sequence procedure performed for definitive treatment of secondary diagnosis as principal procedure, since there are no procedures (definitive or nondefinitive treatment) related to principal diagnosis.

Reporting Additional Diagnoses
ICD-10-CM Official Guidelines for Coding and Reporting
Effective October 1, 2015

Section III. Reporting Additional Diagnoses

GENERAL RULES FOR OTHER (ADDITIONAL) DIAGNOSES

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.

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.

Selected General Coding Guidelines
ICD-10-CM Official Guidelines for Coding and Reporting
Effective October 1, 2016 - September 30, 2017

Section I. Conventions, general coding guidelines and chapter specific guidelines

B. Selected General Coding Guidelines

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

14. Documentation for BMI, Depth of Non-pressure ulcers, Pressure Ulcer Stages, Coma Scale, and NIH Stroke Scale

For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes**,** code assignment may be based on medical record documentation from clinicians who are not the patient's provider (i.e., physician or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, since this information is typically documented by other clinicians involved in the care of the patient (e.g., a dietitian often documents the BMI, a nurse often documents the pressure ulcer stages, and an emergency medical technician often documents the coma scale). However, the associated diagnosis (such as overweight, obesity, acute stroke**,** or pressure ulcer) must be documented by the patient's provider. If there is conflicting medical record documentation, either from the same clinician or different clinicians, the patient's attending provider should be queried for clarification.

The BMI, coma scale, and NIHSS codes should only be reported as secondary diagnoses.

16. Documentation of Complications of Care

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification**.** The guideline extends to any complications of care, regardless of the chapter the code is located in. It is important to note that not all conditions that occur during or following medical care or surgery are classified as complications. There must be a cause-and-effect relationship between the care provided and the condition, and an indication in the documentation that it is a complication. Query the provider for clarification, if the complication is not clearly documented.

Selected Coding Clinics

(Bold the bullet points that apply and remove the sections from gray bar to gray bar if no bullet points in the section applies.)

Source/Reference	**Applying Past Issues of AHA Coding Clinic for ICD-9-CM to ICD-10** ***Coding Clinic*, Fourth Quarter 2015: Page 20** **Coding advice or code assignments contained in this issue effective with discharges November 13, 2015.**
Practice Guideline Recommendation	• The Central Office on ICD-10-CM and ICD-10-PCS has received numerous requests to advise users how past issues of AHA Coding Clinic for ICD-9-CM are to be utilized in the ICD-10 environment. ○ In general, clinical information and information on documentation best practices published in Coding Clinic were not unique to ICD-9-CM, and remain applicable for ICD-10-CM with some caveats. For example, Coding Clinic may still be useful to understand clinical clues when applying the guideline regarding not coding separately signs or symptoms that are integral to a condition. Users may continue to use that information, as clues—not clinical criteria. ○ As far as previously published advice on documentation is concerned, documentation issues would generally not be unique to ICD-9-CM, and so long as there is nothing new published in Coding Clinic for ICD-10-CM and ICD-10-PCS to replace it, the advice would stand.

Source/Reference	**Use of Coding Clinic as Clinical Criteria for Code Assignment** ***Coding Clinic*, Third Quarter 2008 Page: 16** **Effective with Discharges: September 19, 2008**
Practice Guideline Recommendation	**Question:** • Can background clinical information published in Coding Clinic be used as clinical criteria for code assignment? **Answer:** • No, background material published in *Coding Clinic* cannot be used as clinical criteria for code assignment. As stated in *Coding Clinic*, Second Quarter 1998, pages 4-5: "Any clinical information published in *Coding Clinic*, is provided as background material to aid the coder's understanding of disease processes. The information is intended to provide the coder with 'clues' to identify possible gaps in documentation where additional physician query may be necessary. It is not intended to replace the need for specific physician documentation to substantiate code assignment."
Source/Reference	**Documentation guidelines** ***Coding Clinic*, Second Quarter 2000 Page: 17 to 18** **Effective with discharges: July 1, 2000**
Practice Guideline Recommendation	• "…When the documentation in the medical record is clear and consistent, coders may assign and report codes…All diagnoses should be supported by physician documentation. Documentation is not limited to the face sheet, discharge summary, progress notes, history and physical, or other report designed to capture diagnostic information. This advice refers only to inpatient coding."
Source/Reference	**Clinical Criteria and Code Assignment** ***Coding Clinic*, Fourth Quarter 2016: Page 147** **Coding advice or code assignments contained in this issue effective with discharges October 1, 2016.**
Practice Guideline Recommendation	**Question:** • Please explain the intent of the new ICD-10-CM guideline regarding code assignment and clinical criteria that reads as follows: "The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis." Some people are interpreting this to mean that clinical documentation

	improvement (CDI) specialists should no longer question diagnostic statements that don't meet clinical criteria. Is this true? **Answer:** • Coding must be based on provider documentation. This guideline is not a new concept, although it had not been explicitly included in the official coding guidelines until now. *Coding Clinic* and the official coding guidelines have always stated that code assignment should be based on provider documentation. As has been repeatedly stated in *Coding Clinic* over the years, diagnosing a patient's condition is solely the responsibility of the provider. Only the physician, or other qualified healthcare practitioner legally accountable for establishing the patient's diagnosis, can "diagnose" the patient. As also stated in *Coding Clinic* in the past, clinical information published in *Coding Clinic* does not constitute clinical criteria for establishing a diagnosis, substitute for the provider's clinical judgment, or eliminate the need for provider documentation regarding the clinical significance of a patient's medical condition. • The guideline noted addresses coding, not clinical validation. It is appropriate for facilities to ensure that documentation is complete, accurate, and appropriately reflects the patient's clinical conditions. Although ultimately related to the accuracy of the coding, clinical validation is a separate function from the coding process and clinical skill. The distinction is described in the Centers for Medicare & Medicaid (CMS) definition of clinical validation from the Recovery Audit Contractors Scope of Work document and cited in the AHIMA Practice Brief ("Clinical Validation: The Next Level of CDI") published in the August issue of JAHIMA: "Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Clinical validation is performed by a clinician (RN, CMD, or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials."

	• While physicians may use a particular clinical definition or set of clinical criteria to establish a diagnosis, the code is based on his/her documentation, not on a particular clinical definition or criteria. In other words, regardless of whether a physician uses the new clinical criteria for sepsis, the old criteria, his personal clinical judgment, or something else to decide a patient has sepsis (and document it as such), the code for sepsis is the same—as long as sepsis is documented, regardless of how the diagnosis was arrived at, the code for sepsis can be assigned. Coders should not be disregarding physician documentation and deciding on their own, based on clinical criteria, abnormal test results, etc., whether or not a condition should be coded. For example, if the physician documents sepsis and the coder assigns the code for sepsis, and a clinical validation reviewer later disagrees with the physician's diagnosis, that is a clinical issue, but it is not a coding error. By the same token, coders shouldn't be coding sepsis in the absence of physician documentation because they believe the patient meets sepsis clinical criteria. A facility or a payer may require that a physician use a particular clinical definition or set of criteria when establishing a diagnosis, but that is a clinical issue outside the coding system.
Source/Reference	**Coding Chronic Conditions** **AHA *Coding Clinic* Guidelines 3Q 2007: Page 134**
Practice Guideline Recommendation	**Question:** • **We need to get clarification on the coding of chronic conditions.** One of the quality improvement organizations (QIOs) will not allow the inclusion of chronic obstructive pulmonary disease (COPD) as a secondary diagnosis when it is only mentioned as a history of COPD and no active treatment is documented. Am I correct in stating the presence of a documented history of COPD in the physician's history and physical on an inpatient record is enough to code COPD as a secondary diagnosis, since this is a chronic condition that always affects the patient's care and treatment to some extent? **Answer:** • "…If there is documentation in the medical record to indicate that the patient has COPD, it should be coded. Even if this condition is listed only in the history section with no contradictory information, the condition should be coded. Chronic conditions such as, but not limited to, hypertension,

	Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding."
Source/Reference	**Clinical Significance of Obesity** ***Coding Clinic*, Third Quarter 2011 Page: 4**
Practice Guideline Recommendation	**Question:** • If the provider documents obesity or morbid obesity in the history and physical and/or discharge summary only without any additional documentation to support clinical significance of this condition, can it be coded? There is no other documentation to support clinical significance such as evaluation, treatment, increased monitoring, or increased nursing care, etc., for this condition. **Answer:** • Individuals who are overweight, obese or morbidly obese are at an increased risk for certain medical conditions when compared to persons of normal weight. Therefore, these conditions are always clinically significant and reportable when documented by the provider. In addition, the body mass index (BMI) code meets the requirement for clinical significance when obesity is documented. Refer to Coding Clinic, Third Quarter 2007, pages 13-14, for additional information on coding chronic conditions.
Source/Reference	**Clarification, Body Mass Index (BMI) Reporting** ***Coding Clinic*, Second Quarter 2010 Page: 15**
Practice Guideline Recommendation	**Question:** • There has been some confusion as to whether nursing staff documentation is acceptable for assigning the body mass index (BMI). Since hospitals are allowed to code the BMI based on the dietitian's documentation, it would seem reasonable to assign the BMI based on the nurse's documentation as well. Can coders use nursing documentation to assign the BMI? **Answer:** • Yes, the BMI may be assigned based on medical record documentation from clinicians, including nurses and dietitians

	who are not the patient's provider. As stated in the *Official Guidelines for Coding and Reporting*, BMI code assignment may be based on medical record documentation from clinicians who are not the patient's provider, since this information is typically documented by other clinicians involved in the care of the patient. Dietitians were only mentioned as an example of a clinician that might document BMI information. However, the associated diagnosis (such as overweight, obesity, or underweight) must be documented by the provider. Refer to the *Official Guidelines for Coding and Reporting* for additional discussion.
Source/Reference	*Left empty for coder to add other coding clinics, if applicable.If not needed, please delete.*
Practice Guideline Recommendation	*Left empty for coder*
Source/Reference	*Left empty for coder to add other coding clinics, if applicable. If not needed, please delete.*
Practice Guideline Recommendation	*Left empty for coder*

Conclusion

«Facility» provided medically necessary services to «Patient_First» «Patient_Last» with the expectation that those services would be reimbursed according to the documentation in all UHDDS communications. «Facility» respectfully requests that you reconsider this claim and require payment to be made to «Facility» for the services provided to «Patient_First» «Patient_Last» in this case.

I appreciate your attention to this matter and invite you to contact me should you have any questions.

Respectfully,

Image_Signature

«Facility_Signature»

Submitted with the authority of the Provider,

Please return all correspondence to:

«Facility_Description»

NPI: «Facility_NPI»
Tax ID: «Facility_Tax_ID»
PTAN: «PTAN»
«TableEnd:PATIENTINFO»

«TableStart:PATIENTINFO»«PCN» - «Current_Level» «TableEnd:PATIENTINFO»