Example 1

Approximately $4000.00 at risk of recoupment

Humana.

P.O. Box 14601
Lexington, KY 40512-4601

[redacted] Provider Request ID: [redacted]

[redacted]

RE: Postpayment Medical Record Review Initial Findings Letter

Dear Health Care Professional:

Humana Provider Payment Integrity ("PPI") has recently completed a review of medical records submitted by your facility in response to a DRG Validation review. The results of the review show that Humana has made an overpayment to your facility. The details of the review results are provided in the enclosed review findings summary.

- Humana will send a refund request letter stating the amount of overpayment ("Refund Request") within 30 days of this letter.
- We will recoup the overpayment if we have not received the attached PPI Dispute Request Form and all relevant documents within 45 days of the date of the refund request.
- All Dispute materials should be mailed to:

  Humana Provider Payment Integrity Disputes
  P.O. Box 14279
  Lexington, KY 40512-4279

- You also may fax dispute materials to 1-888-815-8912.

For additional information regarding Humana PPI reviews or the dispute process, visit Humana.com/providers, select the "Claim resources" link under "Key Resources," then choose the "Provider Payment Integrity Policies" link at the bottom.

If you have any questions or need further assistance, please leave us a message at 1-800-438-7885; this line is available 24 hours a day, seven days a week. Please be prepared with the following information: health care professional's name, tax identification number (TIN), phone and fax numbers, patient's name, member ID, claim number and date of service for the claim. **For timely processing of your inquiry, please do not mail disputes or requests to the return address on this letter.**

[redacted]

[redacted]

Humana.

Thank you for your continued care of our members.

Sincerely,

Gayle Kennedy

Gayle Kennedy
Provider Payment Integrity

Enclosure: Review Findings Summary; PPI Dispute Request Form

[redacted]

[redacted]

Review Finding Summary

Provider Request ID (Humana Use Only):	[redacted]
Member Name :	[redacted]
Member Identification Number:	[redacted]
Member Date of Birth:	[redacted]
Service Date(s):	[redacted]
Claim Number(s):	[redacted]
Legal Entity:	Humana Insurance Company

	Original	Revised		Original	Revised
PRINCIPAL DIAGNOSIS:	J69.0	J44.1	PRINCIPAL PROCEDURE:		
SECONDARY DIAGNOSIS:	I50.23	J69.0	SECONDARY PROCEDURE:		
DIAGNOSIS 3:	J96.11	I50.23	PROCEDURE 3:		
DIAGNOSIS 4:	R64	J96.11	PROCEDURE 4:		
DIAGNOSIS 5:	E440	R64	PROCEDURE 5:		
DIAGNOSIS 6:	R13.13	E44.0	PROCEDURE 6:		
DIAGNOSIS 7:	Z68.1	Z68.1			
DIAGNOSIS 8:	J44.1	R13.13	DISCHARGE STATUS:	01	01
DIAGNOSIS 9:	I11.0	I11.0	DRG ASSIGNED:	177	190

HDI Narrative:

The hospital reported a principal diagnosis code assignment of J69.0 PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT. According to coding guidelines and documentation in the medical record, this condition did not qualify for reporting as principal diagnosis on the claim. Aspiration pneumonia was documented, evaluated and managed. However, chronic obstructive pulmonary disease exacerbation clearly necessitated inpatient admission. Diagnosis code J69.0 PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT was replaced with diagnosis code J44.1 CHRONIC OBSTRUCTIVE PULMONARY DZ W/EXACERBATION as principal diagnosis code assignment consistent with documentation received.
The above change results in revised DRG 190.
Reference(s) that support the above determination are: Official Guidelines for Coding and Reporting - Section II Selection of principal diagnosis

Audit Message:

DRG change due to incorrect principal or secondary DX code(s)

[redacted]

[redacted]

Humana Provider Payment Integrity Disputes
P.O. Box 14279
Lexington, KY 40512-4279
VIA FACSIMILE: (888)-815-8912

RE:	**Dispute of Clinical Validation Findings**
Hospital Account #:	[redacted]
Patient Name:	[redacted]
Length of Stay:	**4 Days**
Date of Service:	[redacted]
Facility:	[redacted]
Insurance #:	[redacted]
Date of Birth:	[redacted]
Billed DRG:	177 RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC

To whom it may concern:

The complete medical record for the above account was submitted to Humana in response to the ADR dated 02/06/2018. Following Humana's review of our medical records, we received a post payment review initial findings letter dated 04/18/2018 stating the following:

> The hospital reported a principal diagnosis code assignment of J69.0 PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT. According to coding guidelines and documentation in the medical record, this condition did not qualify for reporting as principal diagnosis on the claim. Aspiration pneumonia was documented, evaluated and managed. However, chronic obstructive pulmonary disease exacerbation clearly necessitated inpatient admission. Diagnosis code J69.0 PNEUMONITIS DUE TO INHALATION OF FOOD AND VOMIT was replaced with diagnosis code J44.1 CHRONIC OBSTRUCTIVE PULMONARY DZ W/EXACERBATION as principal diagnosis code assignment consistent with documentation received. The above change results in revised DRG 190.

Upon review by our facility and by our coding specialist, [redacted], RHIT, we respectfully disagree with the recommendation that the principal diagnosis J69.0 (Pneumonitis due to Inhalation of Food and Vomit) be replaced with J44.1 (Chronic Obstructive Pulmonary Dz w/ Exacerbation) resulting in a DRG change of 177 to 190. Per the thorough review performed by [redacted], our reason for disagreement is based on the following review of the clinical documentation that the medical record (which Humana already has in possession), as well as coding guidelines, which clearly support the assignment of the principal diagnosis of J69.0. Our findings are as follows:

Aspiration pneumonia meets criteria for co-equal diagnosis in the clinical documentation as follows:

IV Zosyn was started on the day of admit with CTA performed 9/6 revealing the pneumonia. <u>After study, both conditions were responsible for the symptoms on presentation.</u>

[redacted]

[redacted]

Consult, [redacted], noted "Patient admits to some cough with consuming liquids, but denies issues with eating. Will consult for swallow study r/t suggestive liquid aspiration.

Xray Negative but CT suggestive of bilateral lower lobe pneumonia.

Will change antibiotics to zosyn to cover for aspiration pneumonia" on the day of admit.

FEES study performed the same day showed "Patient [redacted] presents with severe pharyngeal dysphagia characterized by decreased pharyngeal constriction/clearance, pharyngeal residue, decreased airway protection and aspiration. Patient demonstrated an absent cough response. Risk of Aspiration is: Severe."

Furthermore, aspiration pneumonia is coded as principal diagnosis in accordance with coding guidelines.

"The instructional note at code J44.0, Chronic obstructive pulmonary disease, with acute lower respiratory infection, stating "Use additional code to identify the infection," does not apply to aspiration pneumonia. The ICD-10-CM code for aspiration pneumonia does not fall in the "respiratory infection" codes. . . . Sequencing of the two conditions will depend on the circumstances of admission." [1]

For the aforementioned rationale and reasoning, we respectfully disagree with the original determination and further request restoration of our original billed DRG of 177. Should you have any questions or need anything other than what we have provided, please contact me directly at [redacted]. If possible, please submit your response via facsimile to [redacted] to my attention or via hard copy to the following address below:

[redacted]

Sincerely,

[redacted]

[1] Aspiration pneumonia and chronic obstructive pulmonary disease, ICD 10-CM/PCS Coding Clinic, First Quarter, ICD-10 2017 Page: 24 Effective with discharges: March 13, 2017

[redacted]

Humana.
Toll Free: 866-427-7478
P.O. Box 14601
Lexington KY 40512-4601

[redacted]

[redacted]

RE: Level 1 Medical Record Review Dispute Determination

Dear Health Care Professional:

This letter serves as notice of your Level 1 dispute determination regarding the claim referenced below.

A Certified Coder completed the Level 1 dispute review of the documentation you submitted with your request. Based on the submitted documentation, the original determination is overturned.

Insurance company:	Humana
Legal entity:	HUMANA HEALTH PLAN, INC.
Review conducted by:	Health Management Systems, HMS
Patient name:	[redacted]
Member identification number:	[redacted]
Patient date of birth:	[redacted]
Service date(s):	[redacted]
Claim number:	[redacted]
Review type:	MS-DRG Coding Review

The results of this review are outlined below:

Communication was reviewed and medical record documentation re-examined. We concur with original DRG as assigned. Prior determination is closed.

Humana Provider Payment Integrity Disputes
P.O. Box 14279
Lexington, KY 40512-4279

If you have additional questions or need further assistance, please reference the Humana Provider Payment Integrity dispute policy on Humana.com at **humana.com/ppidispute,** or please leave us a message at 1-800-438-7885; this line is available 24 hours a day, seven days a week. Please be prepared with the following information: health care professional's name, health care professional tax identification number (TIN), phone and fax numbers, patient's name, member ID, claim number and date of service for the claim.

Sincerely,

[redacted]

Example #2

UnitedHealthcare®

300 Unicorn Park Drive Woburn, MA 01801

[redacted]

[redacted]

[redacted]

[redacted]

Omni ID: [redacted]

Re: Finding for DRG Validation Review

Dear Hospital Representative:

As a UnitedHealthcare vendor, Omniclaim conducts reviews on their behalf, providing identification and recovery of overpaid claims. During a recent DRG review, we identified a claim that was paid incorrectly. The enclosed report outlines the specifics of our findings.

Please review the enclosed report within 30 **business days** of this notice and:

- If you agree with the findings, sign the document and send it to the return address listed above, or fax it to 781-240-0509. You do not need to submit a corrected claim.
- If you do not agree with the findings, please submit a written dispute letter and supporting documentation to the return address listed above, or fax it to 781-240-0509.

If we do not hear from you within 30 days after the date of this letter, we will reopen, and adjust the claim. We will provide information about your appeal and dispute rights on the Provider Remittance Advice (PRA) when the claim is adjusted.

If you have questions, please contact Omniclaim, Inc directly at (877) 787-2310. Thank you.

Sincerely,

Michael Santoro

Senior Vice President, UnitedHealthcare Payment Integrity

Enclosure(s)

Grouper Used: CMS 35

Patient Name: [redacted]

Audit Date: [redacted]

[redacted]

[redacted]

[redacted]

Date of Birth: [redacted]

Admit Date: [redacted]

Discharge Date: [redacted]

Medical Record#: [redacted]

DCN #: [redacted]

Omni ID: [redacted]

Patient Acct #: [redacted]

Dear Hospital Representative:

On behalf of UnitedHealthcare, OmniClaim, Inc. (OMN) has recently performed a medical record coding validation review. During this review, OMN has determined the above referenced claim's medical record does not support the coding under which DRG reimbursement was made. UnitedHealthcare has retained OMN (under a contract, which includes a Business Associate Agreement compliant with "HIPAA" regulations) to identify this incorrect coding.

The original claim was submitted with the following codes assigned.

DRG: 441

Diagnosis Codes:

K72.90 Y	R40.2122 Y	E72.20 Y
J96.10 Y	I50.22 Y	I48.2 Y
E11.9 Y	D64.9 Y	I25.5 Y

Procedure Codes:

Discharge Status:

6 - Home Health Service(UB-06)

After reviewing the medical record, we have determined the following codes to be validated.

DRG: 442

Diagnosis Codes:

K72.90 Y	I45.10 Y	E72.20 Y
J96.10 Y	I50.22 Y	I48.2 Y
E11.9 Y	D64.9 Y	I25.5 Y

Procedure Codes:

Discharge Status:

6 - Home Health Service(UB-06)

[redacted]

Reviewer Rationale

Secondary diagnosis code assignment of R402122, coma scale, eyes open to pain on arrival to er was reported by the hospital. According to coding guidelines and documentation in the medical record this condition did not qualify for reporting as a secondary diagnosis. The patient was just discharged the day before the present admission after episode of confusion, somnolence contributed to hepatic encephalopathy with liver disease. The following was documented in the history and physical, Hepatic encephalopathy with underlying liver disease, acute mental status changes secondary to elevated ammonia, with adm diagnosis listed as hepatic encephalopathy. Treatment plan included; to increase dose of lactulose increased, started on xifaxan, monitor ammonia levels. It was documented later in the stay that the patient had missed a dose of lactulose at home resulting in the deterioration. The h and p described the patient as alert with mild confusion and lethargy. When the patient initially presented to er he was alert and 0 x 3. A short time later he was awakened for lactulose, was able to follow commands and was alert enough to take his lactulose orally. This was in the am of 9/12. It was 6:40 am the following morning this was documented by the nurse, resting in bed, appears to be sleeping, arouses to tactile and light painful stimuli, oriented to person only He was then admitted to acute care a short time later. It appears that they initially felt patient would return to baseline after the lactulose dose but when this did not occur the patient was then admitted. The one episode where he was difficult to arouse was long after he presented to the emergency room and code R402122 would not be appropriate under those circumstances.

Please refer to ICD-10-CM Official Guidelines for Coding and Reporting addressing the importance of consistent, complete documentation in the medical record. Also refer to AHA ICD-10 Coding Clinic 4th Q 2015 pgs. 34-35, 3rd Q 2015 pgs. 7-8, pg. 4, pg. 3 and 1st Q 2014 pg. 14, pgs. 15-16 for further information addressing clear and consistent documentation.

Refer to AHA Coding Clinic 1st Q 2002 pg. 5, 2nd Q 2000 pgs. 15, 17-18, 1st Q 1998 pg. 5, 2nd Q 1997 pg. 6, 3rd Q 1996 pg. 10, 3rd Q 1994 pg. 10 and 4th Q 1989 pg. 11 for further information addressing only a physician can diagnose a condition; if the documentation is unclear the physician should be queried.

☐ The hospital agrees with the audit findings as determined by OmniClaim

☐ The hospital does Not agree with the audit findings as determined by Omniclaim And Is submitting additional documentation to substantiate the coding details in the original claim.

Your signature on this form indicates you agree with our findings.

Please return the form to us as soon as possible to the return address below Or fax it to (781)240-0509. If you have any questions, please contact Omniclaim DRG Validation Dept. at (877) 787-2310.

_____ _____

Provider Representative Signature **Date**

_____ _____

Provider Representative Name(print) **Phone Number**

OMNICLAIM
POWERED BY EQUIAN

DRG VALIDATION REVIEW

[redacted]

Facility Name: [redacted]

Claim ID	Patient Account Number	Patient Name	Dates of Service	Paid Amount	Corrected Payment	Refund Amount	Overpayment Rationale
[redacted]	[redacted]	[redacted]	[redacted]	7,873.78	6,057.35	1,816.43	Upon audits it was found the billed DRG 441 should have been billed at 442.

[redacted]

UnitedHealthcare®

Equian
300 Unicorn Park Dr
Woburn, MA 01801

[redacted]

Dear Patient Account Refunds

Equian, a UnitedHealthcare vendor, conducts reviews on our behalf to identify when we've overpaid claims. During a recent Diagnostic Relateed Grouping audit, Equian found that we overpaid you for some patient claims. Please review the enclosed report, which lists the affected claims, including the patient name, the amounts overpaid and reason for the overpayment(s).

How to send in a refund for the overpayment
Within 45 days from the date of this letter, please send a check or money order for 1,816.43 (the overpaid amount), payable to UnitedHealthcare. Include a copy of this letter and the enclosed report with your payment and keep the original letter for your records. Please send the check and supporting documents to:

UnitedHealthcare
P.O. Box 845309
Boston, MA 02284-5309

If we don't receive the overpaid amount within 45 days, UnitedHealthcare may deduct the overpaid amount from future claim payments, as permitted by applicable state law(s).

What if the refund has already been sent?
If you've already discovered this overpayment and mailed a refund check to us, please let us know in one of two ways:

By phone: Call 855-980-3030
By mail: Send a copy of the front and back of the canceled check, any revised Explanation of Benefits (EOB) and/or Provider Remittance Advice (PRA) you've received, this letter and the attached list, to:

UnitedHealthcare
P.O. Box 845309
Boston, MA 02284-5309

The overpayment amounts in the attached list are up-to-date as of the date of this letter. Claims may be further adjusted if new information is received, or as a result of backdated pricing or coverage changes.

What if you don't agree with this refund request?
If you believe that the claim(s) were not overpaid, you can file an appeal within 14 days of the date of this letter. Please write a letter explaining why you disagree with this refund request. You will need to include a copy of this letter, a copy of the attached list and any supporting documents that show why you believe the claim amounts were paid correctly. Please send this information to:

Equian Attn: Appeals
300 Unicorn Park Dr
Woburn, MA 01801

Or fax to: 781-240-0509 ATTN: Appeals

Questions?
If you have questions about this refund request, please call Equian at 781-932-4600. To view claims status, payment information and copies of your Remittance Advice, go to UHCprovider.com, click on the Link button in the top right corner and sign in, then use the claimsLink app. Thank you.

Sincerely,

Michael Santoro
Senior Vice President
UnitedHealthcare Payment Integrity

Enclosure

[redacted]

UnitedHealthcare
300 Unicorn Park Drive
Woburn, MA 01801

[redacted]

Re: MS-DRG Reassignment
Review Results Letter Date: [redacted]
Request #: [redacted]

Claim / Ref #	Account #	Med Rec #	Begin DOS	End DOS	Mem DOB	Mem Last Nm
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

This is in response to the denial notification letter that was received from your agency regarding the above referenced case of a patient at [redacted]. The reviewer stated that secondary diagnosis code assignment of R402122, coma scale, eyes open to pain on arrival to ER does not qualify for reporting as a secondary diagnosis. This would result in a MS-DRG change from 441, Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis w MCC to 442, Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis w CC . **We disagree with this decision and provide the following rationale for appeal.**

This 74-year-old-male was admitted for hepatic encephalopathy secondary to hyperammonemia. The nursing triage note on 9/12 at 10:14 AM indicated that the patient pulled from car, patient is lethargic, mumbling words, unable to sit without assistance, wife and son at bedside provide information. Per the orders the patient was admitted to the hospital on 9/12 at 12:54 PM. Ammonia level on 171 was of marked elevation consistent with a significant alteration in mental status. Levels of ammonia decreased to 86 09/13/2018 and to 59 09/14/2018 as is consistent with improvement in altered mental status and hepatic encephalopathy. Such significantly altered mental status with corresponding laboratory findings is representative of a major complication consistent thus with the initial DRG of 441.

The denial letter stated that when the patient initially presented to the ER, he was alert and oriented times three. A short time later he was awakened for lactulose; was able to follow commands and was alert enough to take orally his lactulose. Further notation was one episode where he was difficult to arouse long after he presented to the emergency room, and code R40.2122 would not be appropriate under those circumstances. The nursing triage note, however, referenced above supports the fact that the patient was difficult to arouse when he presented to the Emergency Department. ICD-10-CM Official Guidelines for Coding and Reporting Section I.C.18.e. Coma scale: At a minimum, report the initial score documented on presentation at your facility. This may be a score from the emergency medicine technician (EMT) or in the emergency department. “Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under the Health Insurance Portability and Accountability Act (HIPAA).”

[redacted]

After review of the documentation, we are requesting a reconsideration of your decision. The documentation and treatment support assigning R402122, coma scale, eyes open to pain on arrival to ER, as a secondary diagnosis. This supports the original MS-DRG 441 Disorders of liver except malignancy, cirrhosis or alcoholic hepatitis w MCC. This advice follows Official Guidelines for Coding and Reporting.

[redacted]

[redacted]

[redacted]

UnitedHealthcare®

OMNICLAIM POWERED BY EQUIAN

Grouper Used:	CMS 35	**Patient Name:**	[redacted]
Date:	[redacted]	**Date of Birth:**	[redacted]
Address:	[redacted]	**Admit Date:**	[redacted]
	[redacted]	**Discharge Date:**	[redacted]
	[redacted]	**Claim #:**	[redacted]
Omni ID:	[redacted]	**Medical Record #:**	[redacted]
		Patient Acct #:	[redacted]

APPEAL DETERMINATION NOTICE

Upon review, the APPEAL DETERMINATION is to :

☒ Agree with Hospital Appeal

Upon review of your appeal, please note the following :

☒ Hospital coding upheld without change. No further hospital action required.

The original claim was submitted with the following codes assigned.

DRG: 441

Diagnosis Codes:

K72.90 Y	R40.2122 Y	E72.20 Y
J96.10 Y	I50.22 Y	I48.2 Y
E11.9 Y	D64.9 Y	I25.5 Y

Procedure Codes:

Discharge Status:

6 - Home Health Service(UB-06)

After reviewing the medical records, we have determined the following codes to be validated.

DRG: 441

K72.90 Y	R40.2122 Y	E72.20 Y
J96.10 Y	I50.22 Y	I48.2 Y
E11.9 Y	D64.9 Y	I25.5 Y

6 - Home Health Service(UB-06)

300 Unicorn Park Drive Woburn, Massachusetts 01801 phone: 877.787.2310 fax.781.240.0509

UnitedHealthcare®

OMNICLAIM POWERED BY EQUIAN

[redacted]

Reviewer Rationale:

The hospital correspondence was reviewed and the submitted documentation from the medical record was examined. Omniclaim agrees with your appeal that the DRG of 441 originally submitted by the hospital is correct. The original audit findings have been updated and no further hospital action is needed.

Please review the above. If you are in agreement, please sign and return to Omniclaim, as soon as possible to the return address below or fax it to (781)240-0509.

Please be advised that you have the right to submit another level of appeal by submitting written notice with reasoning, along with additional documentation to support your case and a copy of this letter to Omniclaim as soon as possible. Responses can be mailed to the address below or faxed to (781)240-0509

If you have any questions, please contact Omniclaim DRG Validation Dept. at (877) 787-2310

Provider Representative Signature	Date
Provider Representative Name (Print)	Phone Number

Example 3

Humana®

P.O. Box 14601
Lexington, KY 40512-4601

[redacted]

Provider Request ID: [redacted]

[redacted]

RE: Postpayment Medical Record Review Initial Findings Letter

Dear Health Care Professional:

Humana Provider Payment Integrity ("PPI") has recently completed a review of medical records submitted by your facility in response to a Comprehensive review. The results of the review show that Humana has made an overpayment to your facility. The details of the review results are provided in the enclosed review findings summary.

- Humana will send a refund request letter stating the amount of overpayment ("Refund Request") within 30 days of this letter.
- We will recoup the overpayment if we have not received the attached PPI Dispute Request Form and all relevant documents within 45 days of the date of the refund request.
- All Dispute materials should be mailed to:

  Humana Provider Payment Integrity Disputes
  P.O. Box 14279
  Lexington, KY 40512-4279

- You also may fax dispute materials to 1-888-815-8912

For additional information regarding Humana PPI reviews or the dispute process, visit Humana.com/providers, select the "Claim resources" link under "Key Resources," then choose the "Provider Payment Integrity Policies" link at the bottom.

If you have any questions or need further assistance, please leave us a message at 1-800-438-7885; this line is available 24 hours a day, seven days a week. Please be prepared with the following information: health care professional's name, tax identification number (TIN), phone and fax numbers, patient's name, member ID, claim number and date of service

Humana®

Review Findings Summary

Provider Request ID (Humana Use Only):	[redacted]
Member Name:	[redacted]
Member Identification Number:	[redacted]
Member Date of Birth:	[redacted]
Service Date(s):	[redacted]
Claim Number:	[redacted]
Letter Request ID:	[redacted]
Legal Entity:	Humana Insurance Company

PROVIDER DRG ASSIGNMENT: 190

Principal Diagnosis Code & POA: J441 Y
Secondary Diagnosis Code(s) & POA: J9621 Y Z9981 Y I10 1 E785 Y Z720 Y Z8711 1 Z9119 1 I4510 1

Principal Procedure Code:
Secondary Procedure Code:

Discharge Disposition: 06

REVISED DRG ASSIGNMENT: 191

Principal Diagnosis Code & POA: J441 Y
Secondary Diagnosis Code(s) & POA: J9611 1 Z9981 1 I10 1 E785 Y Z720 1 Z8711 1 Z9119 1 I4510 1

Principal Procedure Code:
Secondary Procedure Code:

Discharge Disposition: 06

Review Determination Rationale:

The patient is a 71 year old male who was admitted on [redacted]. The provider coded J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) as a secondary diagnosis; however, there is not sufficient clinical evidence to support the diagnosis of acute respiratory failure and therefore this code has been replaced with J96.11 (Chronic Respiratory Failure with Hypoxia). This changed the MS-DRG from 190 (Chronic Obstructive Pulmonary Disease with MCC) to MS-DRG 191 (Chronic Obstructive Pulmonary Disease with CC).

Clinical Review Supporting Documentation:

A Clinical Validation review was completed by a licensed, board-certified physician on the billed

diagnosis of Acute Respiratory Failure based on specific criteria supported by ACP Hospitalist and MedScape (full reference below).

The patient is a 71 year old male who presented with shortness of breath. EMS found the patient with an oxygen saturation of 85 percent on room air and was placed on non-rebreather mask and was and given a nebulizer treatment en route to this facility. The patient's vital signs on arrival showed pulse rate 100, respirations 34 breaths per minute, blood pressure 196/77 and oxygen saturation 99 percent on room air. The patient was removed from oxygen, but was later placed on two liters secondary to tachypnea. His lungs were positive for wheezing. The patient at baseline required use of supplemental oxygen. The patient was admitted with chronic obstructive pulmonary disease exacerbation with acute hypoxemic respiratory failure, now improved. An arterial blood gas drawn on 2 liters of oxygen showed a pH of 7.32 (7.35-7.45), pCO2 71 (35-45), pO2 72 (80-100) and oxygen saturation 93.0 percent (95-100).

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 Respiratory Failure:

1. Respiratory distress, tachypnea, dyspnea, shortness of breath and/ or wheezing AND
2. At least 1 of the following:

Partial pressure of oxygen (pO2) less than 60mm Hg or SpO2 of less than 91 percent on room air in a patient without chronic respiratory failure, OR
Partial pressure of carbon dioxide (pCO2) greater than 50 with pH less than 7.35, OR
P/F ratio (pO2 / FIO2) less than 300, (do not use the P/F ratio to diagnose acute-on-chronic respiratory failure since it is typically less than 300 in these patients at baseline) OR
PO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known- for patient with chronic respiratory failure), OR
A need for mechanical ventilation (non-invasive bi-level positive pressure ventilation or mechanical ventilation)

The above denial is based on lack of supporting clinical evidence from the medical record provided which has been reviewed by a licensed board-certified physician. This denial is not based on coding guidelines. The entirety of the clinical assessment and the documentation submitted has been taken into consideration.

If documentation can be provided to meet the criteria outlined above, please submit with dispute as additional documentation.

Guideline reference:
ACP Hospitalist, Revisiting Respiratory Failure, Parts 1 and 2, R Pinson October and November 2013 and Medscape.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Review Determination Rationale:

The patient is a 71 year old male who was admitted on [redacted]. The provider coded J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) as a secondary diagnosis; however, there is not sufficient clinical evidence to support the diagnosis of acute respiratory failure and therefore this code has been replaced with J96.11 (Chronic Respiratory Failure with Hypoxia). This changed the MS-DRG from 190 (Chronic Obstructive Pulmonary Disease with MCC) to MS-DRG 191 (Chronic Obstructive Pulmonary Disease with CC).

The patient is a 71 year old male who presented with shortness of breath. EMS found the patient with an oxygen saturation of 85 percent on room air and was placed on non-rebreather mask and was and given a nebulizer treatment en route to this facility. The patient's vital signs on arrival showed pulse rate 100, respirations 34 breaths per minute, blood pressure 196/77 and oxygen saturation 99 percent on room air. The patient was removed from oxygen, but was later placed on two liters secondary to tachypnea. His lungs were positive for wheezing. The patient at baseline required use of supplemental oxygen. The patient was admitted with chronic obstructive pulmonary disease exacerbation with acute hypoxemic respiratory failure, now improved. An arterial blood gas drawn on 2 liters of oxygen showed a pH of 7.32 (7.35-7.45), pCO2 71 (35-45), pO2 72 (80-100) and oxygen saturation 93.0 percent (95-100).

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 Respiratory Failure:

1. Respiratory distress, tachypnea, dyspnea, shortness of breath and/ or wheezing AND
2. At least 1 of the following:

Partial pressure of oxygen (pO2) less than 60mm Hg or SpO2 of less than 91 percent on room air in a patient without chronic respiratory failure, OR
Partial pressure of carbon dioxide (pCO2) greater than 50 with pH less than 7.35, OR
P/F ratio (pO2 / FIO2) less than 300, (do not use the P/F ratio to diagnose acute-on-chronic respiratory failure since it is typically less than 300 in these patients at baseline) OR
PO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known- for patient with chronic respiratory failure), OR
A need for mechanical ventilation (non-invasive bi-level positive pressure ventilation or mechanical ventilation)

[redacted]

[redacted]

[redacted]

Upon review by our facility and by our clinical documentation improvement specialist, [redacted], BSN, RN, we respectfully disagree with the recommendation that secondary diagnosis J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) be removed and replaced with J96.11 (Chronic Respiratory Failure with Hypoxia) resulting in a DRG of 190 to 191. Per the thorough review performed by Ms. [redacted] our reason for disagreement is based on the following review of the clinical documentation that the medical record (which Humana already has in possession), which clearly supports the assignment of the secondary diagnosis of J96.21. Our findings are as follows:

Throughout chart documented SOB, labored breathing, wheezing, SOB with exertion, Dyspnea on exertion, labored breathing, PT note states "Pt semi reclined in bed has O2 at 2LNC, Pt gulps for air at regular intervals using accessory muscles for respiration", "O2 at 2L NC, at end of exercise falls to 85%".

Patient admitted with COPD exacerbation with acute hypoxemic respiratory failure. Patient on home oxygen.

ABG on 09/28 at 8:04 showed pCO2 71 (criteria greater than 50), pH of 7.32 (criteria of less than 7.35).

For the aforementioned rationale and reasoning, we respectfully disagree with the original determination and further request restoration of our original billed DRG of 190. Should you have any questions or need anything other than what we have provided, please contact me directly at [redacted]. If possible, please submit your response via facsimile to [redacted] to my attention or via hard copy to the following address below:

[redacted]

[redacted]

Jennifer L Bartlett

[redacted]

[redacted]

Humana.
Toll Free: 866-427-7478
P.O. Box 14601
Lexington KY 40512-4601

[redacted]

[redacted] 2651

RE: Level 1 Medical Record Review Dispute Determination

Dear Health Care Professional:

This letter serves as notice of your Level 1 dispute determination regarding the claim referenced below.

A Medical Professional completed the Level 1 dispute review of the documentation you submitted with your request. Based on the submitted documentation, the original determination is upheld.

Insurance company:	Humana
Legal entity:	HUMANA HEALTH PLAN, INC.
Review conducted by:	Performant
Patient name:	[redacted]
Member identification number:	[redacted]
Patient date of birth:	[redacted]
Service date(s):	[redacted]
Claim number:	[redacted]
Review type:	Clinical Validation

The results of this review are outlined below:

After review of the original and additional documentation provided, it has been determined J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) as the secondary diagnosis is not supported. The original determination has been upheld. In this case, the patient was a 71-year-old male who presented to the hospital with a chief complaint of shortness of breath. Prior to presentation, EMS reported a SpO2 of 85 percent on room air. The patient was placed on a non-rebreather mask and was and given a nebulizer treatment en route to the hospital. The patient carried a previous medical history which included chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, coronary artery disease, hypertension, and shortness of breath. At baseline, the patient required supplemental oxygen via nasal cannula. Initial hospital vitals signs showed a pulse rate 100, respirations 34 breaths per minute, blood pressure 196/77 and oxygen saturation 99 percent on room air. Supplemental oxygen was discontinued but later reapplied at two liters secondary to tachypnea. Physical examination noted a respiratory status positive for wheezing. Laboratory studies noted an arterial blood gas drawn on 2 liters of oxygen showing a pH of 7.32 (7.35-7.45), pCO2 71 (35-45), pO2 72 (80-100) and oxygen saturation 93.0 percent (95-100). The patient received aggressive pulmonary toiletry with gradual responsiveness to medications. The record failed to demonstrate a PO2 decrease or pCO2 increase by 10 mm Hg from baseline in the patient with chronic respiratory failure. Humana requires the medical record meet the following guideline for Acute Respiratory Failure:1. Respiratory distress, tachypnea, dyspnea, shortness of breath and/ or wheezing AND2. At least 1 of the following:Partial pressure of oxygen (pO2) less

than 60mm Hg or SpO2 of less than 91 percent on room air in apatient without chronic respiratory failure, ORPartial pressure of carbon dioxide (pCO2) greater than 50 with pH less than 7.35, ORP/F ratio (pO2 / FIO2) less than 300, (do not use the P/F ratio to diagnose acute-on-chronic respiratoryfailure since it is typically less than 300 in these patients at baseline) ORPO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known- for patient with chronicrespiratory failure), ORA need for mechanical ventilation (non-invasive bi-level positive pressure ventilation or mechanicalventilation)Guideline reference:ACP Hospitalist, Revisiting Respiratory Failure, Parts 1 and 2, R Pinson October and November 2013 and Medscape.

If you would like to submit a Level 2 dispute, it must be received within 60 calendar days from the date of the Level 1 dispute determination letter. Please send a letter detailing the reason for the dispute, along with any supporting documentation via fax to 1-888-815-8912 or mail to the following address:

Humana Provider Payment Integrity Disputes
P.O. Box 14279
Lexington, KY 40512-4279

If you have additional questions or need further assistance, please reference the Humana Provider Payment Integrity dispute policy on Humana.com at **humana.com/ppidispute,** or please leave us a message at 1-800-438-7885; this line is available 24 hours a day, seven days a week. Please be prepared with the following information: health care professional's name, health care professional tax identification number (TIN), phone and fax numbers, patient's name, member ID, claim number and date of service for the claim.

Sincerelv.

Gayle Kennedy

Gayle Kennedy
Provider Payment Integrity

Enclosure: PPI Medical Record Review Dispute Request Form

[redacted]

[redacted]

[redacted]

Humana Provider Payment Integrity Disputes
P.O. Box 14279
Lexington, KY 40512-4279
VIA FACSIMILE: (888)-815-8912

RE:	**Appeal of DRG Validation Audit/Change**
Hospital Account #:	[redacted]
Patient Name:	[redacted]
Length of Stay:	**4 Days**
Date of Service:	[redacted]
Facility:	[redacted]
Insurance #:	[redacted]
Date of Birth:	[redacted]
Billed DRG:	190 CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC

To whom it may concern:

Humana audited the referenced account and in a review result letter dated [redacted] recommended that secondary diagnosis J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) be removed and replaced with J96.11 (Chronic Respiratory Failure with Hypoxia) resulting in a DRG change of 190 to 191. On [redacted], we submitted a Level 1 appeal to which Humana has responded and advised that they are upholding their original determination. A letter dated [redacted] states as follows:

The results of this review are outlined below:

After review of the original and additional documentation provided, it has been determined J96.21 (Acute and Chronic Respiratory Failure with Hypoxia) as the secondary diagnosis is not supported. The original determination has been upheld. In this case, the patient was a 71-year-old male who presented to the hospital with a chief complaint of shortness of breath. Prior to presentation, EMS reported a SpO2 of 85 percent on room air. The patient was placed on a non-rebreather mask and was and given a nebulizer treatment en route to the hospital. The patient carried a previous medical history which included chronic obstructive pulmonary disease, chronic respiratory failure with hypercapnia, coronary artery disease, hypertension, and shortness of breath. At baseline, the patient required supplemental oxygen via nasal cannula. Initial hospital vitals signs showed a pulse rate 100, respirations 34 breaths per minute, blood pressure 196/77 and oxygen saturation 99 percent on room air. Supplemental oxygen was discontinued but later reapplied at two liters secondary to tachypnea. Physical examination noted a respiratory status positive for wheezing. Laboratory studies noted an arterial blood gas drawn on 2 liters of oxygen showing a pH of 7.32 (7.35-7.45), pCO2 71 (35-45), pO2 72 (80-100) and oxygen saturation 93.0 percent (95-100). The patient received aggressive pulmonary toiletry with gradual responsiveness to medications. The record failed to demonstrate a PO2 decrease or pCO2 increase by 10 mm Hg from baseline in the patient with chronic respiratory failure. Humana requires the medical record meet the following guideline for Acute Respiratory Failure:1. Respiratory distress, tachypnea, dyspnea, shortness of breath and/ or wheezing AND2. At least 1 of the following:Partial pressure of oxygen (pO2) less

DEPARTMENT OF CLINICAL APPEALS AND DENIALS
Infirmary Health
P O Box 2651 Mobile, AL 36652-2651
Phone: (251) 435-2097 / Fax: (251) 435-5154
Email: Jennifer.Bartlett@InfirmaryHealth.org

[redacted]

than 60mm Hg or SpO2 of less than 91 percent on room air in apatient without chronic respiratory failure, ORPartial pressure of carbon dioxide (pCO2) greater than 50 with pH less than 7.35, ORP/F ratio (pO2 / FIO2) less than 300, (do not use the P/F ratio to diagnose acute-on-chronic respiratoryfailure since it is typically less than 300 in these patients at baseline) ORPO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known- for patient with chronicrespiratory failure), ORA need for mechanical ventilation (non-invasive bi-level positive pressure ventilation or mechanicalventilation)Guideline reference:ACP Hospitalist, Revisiting Respiratory Failure, Parts 1 and 2, R Pinson October and November 2013 and Medscape.

Upon review by our facility and by our clinical documentation improvement specialist, [redacted], BSN, RN, we respectfully disagree with the original audit determination and maintain that Humana's requirements for assignment of Acute Respiratory Failure are documented in the patient's medical records. Our findings are as follows:

Required by Humana to meet Acute Respiratory Failure				
Vital Signs/Measurements	**Date(s)**		**Exhibit Page(s)**	
Repiratory Distress	9/28/2018		1, 2	
Tachypnea	9/28/2018		2	
Dyspnea	9/28/2018		All	
Shortness of Breath and/or Wheezing	9/28/2018		All	
AND at least 1 of the following:				
Vital Signs/Measurements	**Date(s)**	**Results**	**Exhibit Page(s)**	**Humana Range Values**
pO2				< 60 mmHg
SpO2				< 91% on room air *(Pt w/out CRF)*
OR:				
Vital Signs/Measurements	**Date(s)**	**Results**	**Exhibit Page(s)**	**Humana Range Values**
pCO2	9/28/2018 8:04:00 AM	**71 mmHg**	5	>50 mmHg
pH	9/28/2018 8:04:00 AM	**7.32**	5	<7.35
pO2/FI02				<300
PO2				decrease by 10mmHg from baseline
pCO2				increase by 10mmHg from baseline
OR:				
				Need for mechanical ventilation

For the aforementioned rationale and reasoning, we respectfully disagree with the original determination and further request restoration of our original billed DRG of 190. Should you have any questions or need anything other than what we have provided, please contact me directly at [redacted]. If possible, please submit your response via facsimile to [redacted] to my attention or via hard copy to the following address below:

[redacted]

[redacted]

[redacted] Description: 71 year old male

[redacted]

[redacted]

Patient brought into ED via EMS with c/c of SOB that started this morning. Patient has PMH of COPD, cardiac disease and home oxygen therapy. EMS reports that pt was initially 85% sats on RA. Placed on NRB and increased to 98%. BG per EMS was 127. Nebulizer treatment en route x1. On arrival, pt was 99% on RA. Placed on 2L NC r/t labored breathing. Patient is awake, alert, oriented. Denies any CP or other pain at this time. Had a fall this morning per pt. Denies any LOC or hitting his head. No obvious injuries noted. BBS are diminished.

Electronically signed by [redacted], RN at [redacted]

ED to Hosp-Admission (Discharged) [redacted]

[redacted]

Humana.
Toll Free: 866-427-7478
P.O. Box 14601
Lexington KY 40512-4601

[redacted]

[redacted]

RE: Level 2 Medical Record Review Dispute Determination

Dear Health Care Professional:

This letter serves as notice of your Level 2 dispute determination regarding the claim referenced below.

A Medical Professional completed the Level 2 dispute review of the documentation you submitted with your request. Based on the submitted documentation, the prior determination is overturned.

Same documentation submitted on the Level 1

Insurance company:	Humana
Legal entity:	HUMANA HEALTH PLAN, INC.
Review conducted by:	Internal Coder Team
Patient name:	[redacted]
Member identification number:	[redacted]
Patient date of birth:	[redacted]
Service date(s):	[redacted]
Claim number:	[redacted]
Review type:	Clinical Validation

The results of this review are outlined below:

A Clinical Validation review was completed by a licensed, board-certified physician on the billed diagnosis of Acute Respiratory Failure based on specific criteria supported by ACP Hospitalist and MedScape (full reference below). Based on this review, the diagnosis of acute respiratory failure was able to be validated. Humana requires the medical record meet the following guideline for Acute Respiratory Failure:Respiratory distress, tachypnea, dyspnea, shortness of breath and/ or wheezing AND At least 1 of the following:oPartial pressure of oxygen (pO2) less than 60mmHg or SaO2 of less than 91% on room air in a patient without chronic respiratory failure, OR oPartial pressure of carbon dioxide (pCO) greater than 50 with pH less than 7.35, ORoP/F ratio (pO2 / FIO2) less than 300, (do not use the P/F ratio to diagnose acute-on-chronic respiratory failure since it is typically <300 in these patients at baseline) ORopO2 decrease or pCO2 increase by 10 mm Hg from baseline (if known- for patient with chronic respiratory failure), ORoA need for mechanical ventilation (non-invasive bi-level positive pressure ventilation or mechanical ventilation) Medical record provided included documentation of shortness of breath, wheezing, pCO2 > 50 and pH < 7.35 to support a diagnosis of acute respiratory failure.Humana conducts clinical review validation audits on the diagnosis of acute respiratory failure based on specific criteria supported by ACP Hospitalist, Revisiting Respiratory Failure, Parts 1 and 2, R Pinson October & November 2013 and Medscape, Respiratory Failure, Last Medscape update March 2016.

Humana Provider Payment Integrity Disputes

[redacted]

P.O. Box 14279
Lexington, KY 40512-4279

If you have additional questions or need further assistance, please reference the Humana Provider Payment Integrity dispute policy on Humana.com at **humana.com/ppidispute,** or please leave us a message at 1-800-438-7885; this line is available 24 hours a day, seven days a week. Please be prepared with the following information: health care professional's name, health care professional tax identification number (TIN), phone and fax numbers, patient's name, member ID, claim number and date of service for the claim.

Sincerely,

Gayle Kennedy

Gayle Kennedy
Provider Payment Integrity