Knowing What When and How to Appeal

Denise Wilson MS, RN Director, Audit & Appeal Services

Learning Objectives

- Construct winning appeal letter templates for DRG validation and Medical Necessity appeals.
- Use payment and reimbursement guidelines, evidence-based clinical practice guidelines, and judicial law citations in appeal letter templates.
- Drive your reviewers to a decision in your favor by building a road map for your case.
- Keep your reviewers happy by following their instructions and making their life easier.
- Become a winning appeals writer by following all the leads and doing the research.

Planning for Appeal

- Create a Decision Tree for determining cases to appeal – technical issues
- Develop a workflow process – who, what, when – for making the decision to appeal – coding or clinical issues
- Define an appeal methodology – timing is everything

Building the Foundation for Appeal

- Review the decision letters (results letter and demand letter) in detail
- Decision letters include the regulations used in the decision to deny, the reason for denial, instructions for appeal, required forms or information, timelines, and addresses
- Begin developing a library of appeal letter templates and documents for appeal

Building the Foundation for Appeal

Review the Regulations Used in the Decision to Deny (Following all the Leads)

Excerpt from a Review Results Letter (HDI)

Based on the medical documentation reviewed for the selected claim(s), HDI found that some of the services you submitted were not reasonable and necessary as required by §1861 of the Act, or did not meet the Medicare coverage requirements as required in §1862 of the Act outlined in the attached Audit Detail page. Along with our claims payment determination, we have made limitations on liability decisions for denials of those services subject to provisions of §1879 of the Act. Those claims for which we determined that you knew, or should have known, that the services were noncovered have been included in the results of this review. In addition, we have made decisions as to whether or not you are without fault for the overpayment under the provisions of §1870 of the Act. Those claims for which you are not without fault have been included in the results of this review. Detailed information regarding each claim and the findings identified during the review are attached to this letter.

Download and save these sections of the SSA in your Appeals Documents library.

http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm
Title XVIII Health Insurance for the Aged and Disabled

Building the Foundation for Appeal

Review the Reason for Denial

Excerpt from a Review Results Letter (DCS)

Audit Determination Rationale:

The patient was an 83 year old male admitted through the Emergency Room on 1/02/08. On admission to the hospital, the patient was assigned code 518.81 (Respiratory Failure). This principal diagnosis was not supported based on the initial treatment, procedures ordered on admission and the lack of sufficient documentation throughout the medical record. The thrust of care and treatment was centered on and directed toward the exacerbation of chronic obstructive bronchitis. The principal diagnosis of 518.81 (Respiratory Failure) was changed to 491.21 (Obstructive Chronic Bronchitis with Acute Exacerbation). The result of the re-sequencing of coding, changes the MS-DRG from 189 (Pulmonary Edema and Respiratory Failure) to MS-DRG 190 (Chronic Obstructive Pulmonary Disease with MCC). The changes are based on the Official Guidelines for Coding and Reporting October 1, 2007. The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital for care. References: Official Guidelines for Coding and Reporting October 1, 2007.

Include the ICD-9-CM Official Guidelines for Coding and Reporting for these claims dates of service in your Appeals Documents Library.

Building the Foundation for Appeal

Review and Follow the Instructions for Appeal

First Opportunity: To avoid the recoupment, the appeal request must be filed within 30 days of this letter. We request that you clearly indicate on your appeal request that this is a RAC **overpayment** appeal and you are requesting a redetermination. Send your appeal request with a copy of this entire letter to:

Medicare Appeals
Highmark Medicare Services
PO Box 89XXXX
Camp Hill, PA 17089-XXXX
Substitute the XXX with the appropriate PO Box number and 4-digit zip from the table below:

State	PO Box Number / 4 Digit Zip
Pennsylvania Part A Institutional	0385
Maryland/ District of Columbia Metropolitan Area Part A Institutional	0385

Include the words 'RAC overpayment appeal' and 'request for redetermination' in your appeal letter.

Building the Foundation for Appeal

Review and Follow the Instructions for Appeal

NORIDIAN®
Administrative Services LLC

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Redetermination/Reopening Form **Medicare Part A**

When to request a redetermination - A redetermination should be requested when there is dissatisfaction with the original determination. A redetermination is the first level of the appeals process and is an independent re-examination of an initial claim determination. A claim must be appealed within 120 days from the date of receipt of the Medicare Summary Notice (MSN) or Remittance Advice (RA).

Helpful Hints:

1) ONE REQUEST FORM PER BENEFICIARY AND ISSUE
2) For claim status/tracer questions, use the IVR by dialing (866) 497-7857.
3) Provider Address or Assignment changes, please contact Provider Enrollment
4) **Do not use this form for Medicare Secondary Payer (MSP) or General Written Inquiries.**
5) If you have received a redetermination decision regarding this issue, do not submit this form. You must request a reconsideration from the QIC. A reconsideration form can be found on our website at www.noridianmedicare.com.
6) When submitting a Redetermination, please attach the required documentation, which may include office notes, operative reports, trip reports, etc. Reasonable and necessary denials must include a copy of the ABN signed by the beneficiary if available. Please also attach a corrected UB04 form.

Building the Foundation for Appeal

Use the Appropriate Forms or No Form

Medicare Claims Processing Manual; Chapter 29 – Appeals of Claims Decisions ; 310.1 – Filing a Request for Redetermination

- a. A completed Form CMS-20027 constitutes a request for redetermination. The contractor supplies these forms upon request by an appellant. "Completed" means that all applicable spaces are filled out and all necessary attachments are included with the request.
- b. A written request not on Form CMS-20027. At a minimum, the request shall contain the following information:
  - 1. Beneficiary name;
  - 2. Medicare health insurance claim (HIC) number;
  - 3. The specific service(s) and/or item(s) for which the redetermination is being requested;
  - 4. The specific date(s) of the service; and
  - 5. The name and signature of the party or the representative of the party.

http://www.cms.gov/manuals/downloads/clm104c29.pdf

http://www.cms.gov/CMSForms/CMSForms/list.asp

Creating the Structure for Appeal

Set the Stage

Dear Reviewer,

This is an appeal for review of the denied Medicare claim for inpatient services at Memorial Hospital, for the beneficiary named below, for the dates of service of 01/02/2008 through 01/05/2008. The following is a summary of the pertinent information of the decision by DCS as well as a substantiation of the ICD-9 codes that support the need for services as provided and billed based upon the proper MS-DRG assignment of 189.

Beneficiary Name	Abraham Lincoln	**HIC Number:**	999999999	**Case ID Number:**	0942
Claim Dates Of Service	01/02/2008-01/05/2008	**Provider Number:**	1099999	**Medical Record Number:**	999000
Reason(s) for Denial by RAC	Revised DRG to 190 (from 189) based on change of principal diagnosis			**Patient DOB**	08/13/1924
Diagnosis	Acute Respiratory Failure			**Gender**	Male
Comorbidities/Complicating Factors	COPD, Lower Sacrum Decubitus, Depression, Cardiomyopathy			**Discharge Status**	Routine / Home 01

Creating the Structure for Appeal

Set the Stage

DCS Denial

Audit Determination Rationale:

The patient was an 83 year old male admitted through the Emergency Room on 1/02/08. On admission to the hospital, the patient was assigned code 518.81 (Respiratory Failure). This principal diagnosis was not supported based on the initial treatment, procedures ordered on admission and the lack of sufficient documentation throughout the medical record. The thrust of care and treatment was centered on and directed toward the exacerbation of chronic obstructive bronchitis. The principal diagnosis of 518.81 (Respiratory Failure) was changed to 491.21 (Obstructive Chronic Bronchitis with Acute Exacerbation). The result of the re-sequencing of coding, changes the MS-DRG from 189 (Pulmonary Edema and Respiratory Failure) to MS-DRG 190 (Chronic Obstructive Pulmonary Disease with MCC). The changes are based on the Official Guidelines for Coding and Reporting October 1, 2007. The principal diagnosis is the condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital for care. References: Official Guidelines for Coding and Reporting October 1, 2007.

Justification for Appeal

The arguments presented below justify the ICD-9 code selection that affect MS-DRG 189.

Creating the Structure for Appeal

Paint the Picture

{Admission Symptoms/Functional Limitations}

Upon admission to Memorial Hospital, Mr. Lincoln presented with complaints of severe fatigue, shortness of breath, and leg swelling. Mr. Lincoln's oxygen (O_2) saturation was in the range of 75 to 78% on room air; increasing to 92% on O_2 at 2 liters per nasal cannula (NC). The patient also had 2+ edema of the lower extremities. This patient had a history of COPD, depression, and cardiomyopathy.

Include:

- Admission Symptoms for Medical Necessity or DRG Validation
- Functional Limitations for therapy services (PT, OT, Speech, Behavioral Health, Rehab)
- Comorbidities

Creating the Structure for Appeal

Provide a Roadmap

Justification of Medical Necessity

The arguments presented below justify the medical necessity of the procedure performed. Just as importantly, the arguments justify that the hospital services provided are "generally accepted by the professional community as being safe and effective treatment" for this patient's diagnosis and symptom presentation.

Signs and Symptoms or Complications	Where Documented	Skilled Intervention(s)	Expected or Realized Outcome of Intervention	Source of Recommendation
Patient was found to be in a 2nd degree AV block, likely related to AV nodal medication	Discharge Summary; 6/12/2009; p. 5 of MR	Implantation of Dual Chamber Pacemaker; 6/11/2009; p. 104 of MR	Expected Outcome: Reduction of atrial fibrillation in a patient paced for Sinus Node Dysfunction (SND) or AV block	ACC/AHA/HRS 2008 Guidelines for Device-Based Therapy of Cardiac Rhythm Abnormalities; p. e24
Admission Diagnosis: 2nd degree AV Heart Block	Admission Orders; 6/9/2009; p. 34 of MR		Expected Outcome: Reduction in atrial fibrillation, reduction in heart failure symptoms,	Ventricular Pacing or Dual-Chamber Pacing For Sinus-Node Dysfunction (MOST Trial); p. 1861

- **Number the pages of your medical record**
- **Point the reviewer to the specific page**
- **Flag or highlight the documentation within the medical record**

Creating the Structure for Appeal

Use the Best Evidence (Doing the Research)

- Supporting Documentation from Regulations
- Limitation on Liability; Social Security Act § SEC. 1879. [42 U.S.C. 1395pp]
- Code of Federal Regulations (CFR); 42 CFR 400 and following
- CMS Internet Only Manuals (IOM)
- NCD, LCD
- ICD-9-CM Coding Manual (for dates of service on claim)
- ICD-9-CM Addendums and coding clinics
- Evidence Based Guidelines; Position Statements

Creating the Structure for Appeal

CMS Internet Only Manuals (IOM)

- 100-02 Medicare Benefit Policy Manual Chapter 1 – Inpatient Hospital Services Covered Under Part A
- 10 – Covered Inpatient Hospital Services Covered Under Part A
  - Definition of Inpatient
  - Physician's responsibility on deciding on Inpatient admission
- 100-02 Medicare Benefit Policy Manual Chapter 6 – Hospital Services Covered Under Part B
- 20.6 – Outpatient Observation Services
  - Definition of Observation Services
  - Coverage of Outpatient Observation Services
- *http://www.cms.gov/Manuals/IOM/list.asp*

Creating the Structure for Appeal

CMS Internet Only Manuals (IOM)

- 100-08 CMS Medicare Program Integrity Manual Chapter 6 – Intermediary MR Guidelines for Specific Services
- Section 6.5.2 – Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims
  - Determining Medical Necessity and Appropriateness of Admission
  - "pre-existing medical problems or extenuating circumstances"
  - "the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting"
- Section 6.5.3 – DRG Validation Review
- *http://www.cms.gov/Manuals/IOM/list.asp*

Creating the Structure for Appeal

Limitation on Liability; Social Security Act § SEC. 1879. [42 U.S.C. 1395pp]

(a) Basic rule. A provider, practitioner, or supplier that furnished services which constitute custodial care under Sec. 411.15(g) or that are not reasonable and necessary under Sec. 411.15(k) is considered to have known that the services were not covered if any one of the conditions specified in paragraphs (b) through (e) of this section is met.

(e) Knowledge based on experience, actual notice, or constructive notice. It is clear that the provider, practitioner, or supplier could have been expected to have known that the services were excluded from coverage on the basis of the following:

(1) Its receipt of HCFA notices…

(2) Federal Register publications…

(3) Its knowledge of what are considered acceptable standards of practice by the local medical community.

http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm

Creating the Structure for Appeal

HCFA Ruling 95-1 states:

"Medicare contractors, in determining **what "acceptable standards of practice" exist within the local medical community**, rely on published medical literature, a consensus of expert medical opinion, and consultations with their medical staff, medical associations, including local medical societies, and other health experts. "Published medical literature" refers generally to scientific data or research studies that have been published in peer-reviewed medical journals or other specialty journals that are well recognized by the medical profession, such as the "New England Journal of Medicine" and the "Journal of the American Medical Association." By way of example, consensus of expert medical opinion might include recommendations that are derived from technology assessment processes conducted by organizations such as the Blue Cross and Blue Shield Association or the American College of Physicians, or findings published by the Institute of Medicine."

https://www.cms.gov/Rulings/downloads/hcfar951.pdf

Researching CMS Regulations

National Coverage Determinations

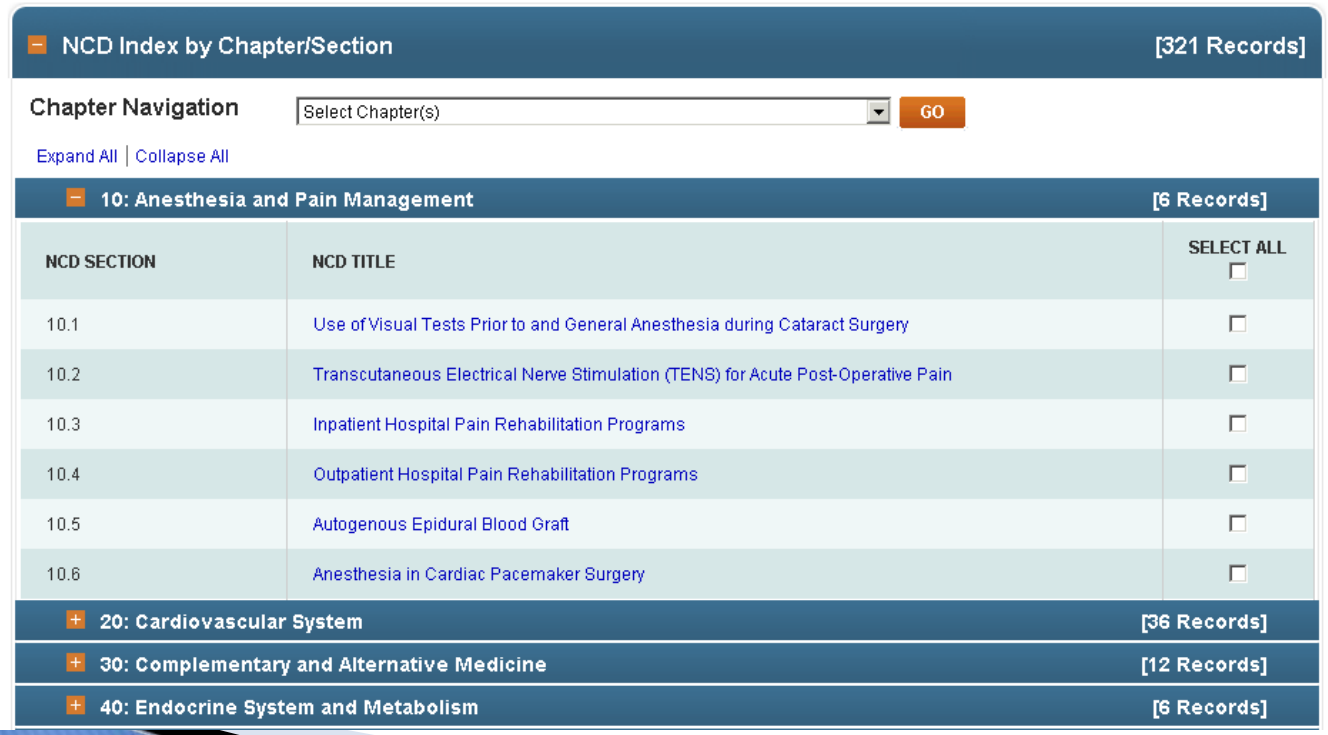
- Published by CMS
- Applies to all CMS providers/beneficiaries
- CMS Internet Only Manuals (IOM); 100-03 Medicare National Coverage Determinations (NCD)

http://www.cms.gov/MCD/overview.asp

Researching CMS Regulations

National Coverage Determinations

- *http://www.cms.gov/MCD/overview.asp*
  - Indexes > NCDs by Chapter/Section



NCD Index by Chapter/Section [321 Records]

Chapter Navigation: Select Chapter(s) GO

Expand All | Collapse All

10: Anesthesia and Pain Management [6 Records]

NCD SECTION	NCD TITLE	SELECT ALL
10.1	Use of Visual Tests Prior to and General Anesthesia during Cataract Surgery	
10.2	Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain	
10.3	Inpatient Hospital Pain Rehabilitation Programs	
10.4	Outpatient Hospital Pain Rehabilitation Programs	
10.5	Autogenous Epidural Blood Graft	
10.6	Anesthesia in Cardiac Pacemaker Surgery	

20: Cardiovascular System [36 Records]

30: Complementary and Alternative Medicine [12 Records]

40: Endocrine System and Metabolism [6 Records]

Researching CMS Regulations

National Coverage Determination

REGULATORY GUIDELINES

National Coverage Determination – Centers for Medicare and Medicaid Services

NCD for Cardiac Pacemakers (20.8)

Publication Number 100-3; Manual Section Number 20.8; Version Number 2

Effective Date of this Version 4/30/2004; Implementation Date 4/30/2004

Group I: Single-Chamber Cardiac Pacemakers (Effective March 16, 1983)

A. Nationally Covered Indications

Sinus node dysfunction with or without tachyarrhythmias or AV conduction block (i.e., the bradycardia-tachycardia syndrome, sino-atrial block, sinus arrest) when accompanied by significant symptoms (e.g., syncope, seizures, congestive heart failure, dizziness or confusion).

Dual-chamber pacemakers may also be covered for the conditions, as listed in Group I. A., if the medical necessity is sufficiently justified through adequate claims development. Expert physicians differ in their judgments about what constitutes appropriate criteria for dual-chamber pacemaker use. The judgment that such a pacemaker is warranted in the patient meeting accepted criteria must be based upon the individual needs and characteristics of that patient, weighing the magnitude and likelihood of anticipated benefits against the magnitude and likelihood of disadvantages to the patient.

TIP: Insert the NCD or LCD into the Appeal Letter Template, then make the appropriate edits from there.

Researching CMS Regulations

Local Coverage Determinations

- Developed and published by MACs/FIs
- Applies to providers/beneficiaries residing in the MAC/FI region
- Not allowed to be more restrictive than CMS regulations
- ALJs do not have to abide by LCD regulations

http://edocket.access.gpo.gov/cfr_2008/octqtr/pdf/42cfr405.1062.pdf

Researching CMS Regulations

Local Coverage Determinations

Use the LCD index on CMS website—usually more current than listing on FI or MAC websites

http://www.cms.hhs.gov/MCD/overview.asp

Coding Guidelines

RAC SOW p. 21

"When making coverage and coding determinations, if no written Medicare policy, Medicare article, or Medicare-sanctioned coding guideline exists, the RAC shall not use automated review. Examples of Medicare-sanctioned coding guidelines include: CPT statements, CPT Assistant statements, and Coding Clinic statements."

https://www.cms.gov/Recovery-Audit-Program/Downloads/090111RACFinSOW.pdf

Researching SSA Regulations

Limitation on Liability § 1879 of the Act

Excerpt from Focused Review Denial (NGS)

Who is Responsible for the Bill?

After reaching a decision that the service/item will not be covered by Medicare, we must decide who is liable for the denied service/item. The instructions contained in Section 1879 of the Social Security Act require two steps. First, we must decide if the beneficiary either knew or could reasonably be expected to know that the service/item would not be covered under 1861(a)(1) or 1861 (a)(9) of the Social Security Act. Next, we must decide if the provider either knew or could reasonably be expected to know that the service/item would not be covered under 1861(a)(1) or 1861 (a)(9) of the Social Security Act.

By following these instructions, we have decided that the provider either knew or could be reasonably expected to know that the service/item would not be covered at the level billed. 42 Code of Federal Regulations (CFR) 411.406 states that providers are presumed to have knowledge of published Medicare rules and regulations, CMS rulings, Medicare coverage policies in contractor bulletins or websites and acceptable standards of medical care in the community. The provider has received notices and directives (such as bulletins, Change Requests, Medicare Memos, and Local Coverage Determinations) from CMS and this contractor. These have included instructions on how to access the Medicare Internet-Only Manuals (IOMs).

http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr411.406.pdf

Researching Acceptable Standards of Practice

LCD from Highmark Medicare Services

Utilization Guidelines

In accordance with CMS Ruling 95-1 (V), utilization of these services should be consistent with locally acceptable standards of practice.

Sources of Information and Basis for Decision

Highmark Medicare Services is not responsible for the continued viability of websites listed.

Agency for Healthcare Research and Quality. Usual care in the Management of Chronic Wounds: A review of the Recent Literature. 03/08/2005 Technology Assessment. Available at: http://www.cms.hhs.gov/mcd/viewtechassess.asp?where=index&tid=37. Accessed on 05/14/2007.

Agency for Healthcare Research and Quality. Wound-Healing Technologies: Low-Level Laser and Vacuum-Assisted Closures. Evidence Report/Technology Assessment: Number 111. Available at: http://www.ahrq.gov/clinic/epcsums/woundsum.htm

American Physical Therapy Association, Guide to Physical Therapist Practice, Second Edition, 2001.

Bell AL, Cavorsi J. Noncontact Ultrasound Therapy for Adjunctive Treatment of Nonhealing Wounds: Retrospective Analysis. *Physical Therapy* 2008; 88(12):1517-1524.

Bryant RA and Nix DP. Principles of Wound Management. In: Bryant RA and Nix DP, *Acute & Chronic Wounds: Current Management Concepts*. 3rd ed. St. Louis, MO:Mosby; 2007: Chapter 19.

Bryant RA and Nix DP. Wound Debridement. In: Bryant RA and Nix DP, *Acute & Chronic Wounds: Current Management Concepts*. 3rd ed. St. Louis, MO:Mosby; 2007: Chapter 10

Ennis WJ, Valdes W, Gainer M, et al. Evaluation of Clinical Effectiveness of MIST Ultrasound Therapy for the Healing of Chronic Wounds. *Adv Skin Wound Care* 2006;19(8):437-446.

Researching Acceptable Standards of Practice

NCD for Cardiac Pacemakers (20.8)

- Second reconsideration for Cardiac Pacemakers (CAG-00063R2)
  - Decision Memo

1 Bennett, J. Claude, Goldman, Lee. Cecil Textbook of Medicine. 2000; 1: 249.

2 Silverman BG, Gross TP, Kaczmareki, Hamilton P and Hamburger. The epidemiology of pacemaker implantation in the United States. *Public Health Reports* 1995;110(1):42-46 and Daley WR, Kaczmarek RG. The epidemiology of cardiac pacemakers in the older US population. *Journal of the American Geriatrics Society* 1998;46(8):1016-1019.

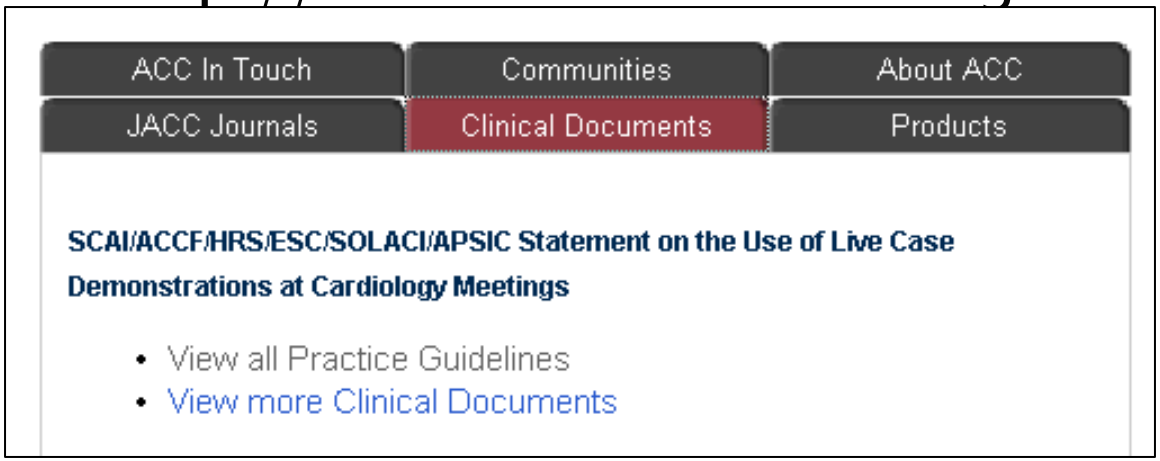
3 See Cardiac Pacemaker Decision Memorandum (CAG 00063N) and Pavia S, Wildoff B. The management of surgical complications of pacemaker and implantable cardioverter-defibrillators. *Current Opinion in Cardiology* 2001;16(1):66-71.

4 Yamamura KH, Kloosterman EM, Alba J et al. Analysis of charges and complications of permanent pacemaker implantation in the cardiac catheterization laboratory versus the operating room. *Pacing and Clinical Electrophysiology* 1999;22(12):1820-1824.

Researching Acceptable Standards of Practice

Evidence Based Guidelines; Position Statements

- Professional Associations
  - American College of Cardiology
  - http://www.cardiosource.org



TIP: Insert the EBG or PS into the Appeal Letter Template, then make the appropriate edits from there.

Links

- Code of Federal Regulations (CFR)
  - *http://www.gpoaccess.gov/cfr/index.html*
- Limitation on Liability; Social Security Act § SEC. 1879. [42 U.S.C. 1395pp]
  - *http://www.ssa.gov/OP_Home/ssact/title18/1879.htm*
- CMS Internet Only Manuals (IOM)
  - *http://www.cms.hhs.gov/*
- NCDs (IOM 100-03)
  - *http://www.cms.gov/Manuals/IOM/list.asp*
- LCDs
  - *http://www.cms.hhs.gov/MCD/overview.asp*

Q&A

Questions?
Email me at:
dwilson@intersecthealthcare.com
410-252-4343 ext 16
www.intersecthealthcare.com