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Crafting a Winning Appeal Letter

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Learning Objectives

Understand strategies for crafting a winning appeal letter:

- How to craft a persuasive appeal narrative
- How to use CMS regulations to your advantage in a winning appeal letter
- How to incorporate evidence based medicine and the standard of practice in a winning appeal letter

Elements of the Appeal Letter

Required Elements

Per CMS Guidelines

Narrative

A compelling true story of the relevant hospital course

CMS Guidelines

CMS Medicare Benefit Policy Manual 100-02

National Coverage Determination (NCD)

Local Coverage Determination (LCD)

Elements of the Appeal Letter

Evidence Based Guidelines

Acceptable standards of medical care in the community

Regulatory Arguments

Limitation on Liability

Treating or attending physician "rule"

Required Elements

CMS Internet-Only Manuals (IOMs)
100-04 Medicare Claims Processing Manual
Chapter 29 – Appeals of Claims Decisions

5 elements for L1 appeal:

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.

Required Elements

Beneficiary Name	John Doe	**HIC Number:**	XXXXXXXXXA
Claim Dates of Service	02/10/2012 - 02/11/2012		
Reason(s) for Denial	Not Medically Necessary		
Principal Diagnosis	Acute congestive heart failure		
Comorbidities/Complicating Factors	Chronic Obstructive Pulmonary Disease Hypertension		
Procedures	Echocardiogram Chest x-ray Electrocardiogram		
Social Factors	Speaks only Cantonese 5 pack year history of smoking Rarely goes to the doctor Very poor dentition		

Narrative

«PAT_Full_Name» *was a [blind, wheelchair bound, developmentally delayed, brain-injured,] ___ year-old [disabled/widowed] [lady/gentleman] who lived [alone, in a NH, ALF, etc.] with a medical history of _____ [list all the patient's comorbid conditions, as well as any/all complicating factors], and family history of _____ [list pertinent family history, if applicable]. Of note,* «PAT_Full_Name» *routinely took [# of medications & any allergies with allergic response if severe].*

«PAT_Full_Name» *presented to the hospital Emergency Department via [ambulance (if applicable)] after experiencing [description of acute symptoms. Avoid the word complaining].* «PAT_Full_Name» *was [admitted as an inpatient/initially placed in observation] on the [Telemetry/Medical-Surgical/Observation] unit.*

Narrative

Tell a compelling true story of the relevant hospital course – this patient's experience from just prior to presentation to post discharge plan

Support that the patient was severely ill enough, at a high risk of death or further disability, required intensive medical care, services, testing, and monitoring

Include the specialty/interdisciplinary consultations ordered along with their findings.

Cite all relevant abnormal findings.

Narrative

Avoid using words like some, a little, minor, etc., while incorporating words like significant, severe, abnormal, elevated, decreased, as long as that is supported in the medical record.

Note if the patient received > 24 hours of hospital care counting from the time the patient arrives in the ED until the patient is wheeled out the door.

Justify severity of illness and intensity of services.

Case Study #1 CHF

John Doe was a 78 year-old gentleman who had a five pack year history of smoking, but quit several years prior to presentation. He was a very poor historian and stated that he rarely went to the doctor. He denied any medical history, but the physician was later able to document chronic obstructive pulmonary disease and hypertension. He was only able to speak Cantonese, and had to have an interpreter present to communicate with the medical staff.

Tips: *Refer to the patient by their name, lady/gentleman, he/she*

Include any information that helps paint the picture of the lady/gentleman

Case Study #1 CHF

John Doe presented to the hospital Emergency Department after suffering from congestion, shortness of breath and bilateral lower extremity edema that had been progressively worsening over the previous three weeks. He had been evaluated by his primary care physician, who diagnosed him with bronchitis and gave him multiple inhalers, which Mr. Doe said, made his palpitations and shortness of breath worse. He had experienced palpitations and a productive cough with white sputum for one week and described a sensation like "my heart is freezing."

TIPS: *Patient suffer and experience their symptoms which they describe in their own words.*

Patients fail outpatient treatment.

Case Study #1 CHF

Upon examination, Mr. Doe was noted to have elevated JVP (jugular venous pressure) and fine bibasilar crackles in the lungs. He was hypotensive with a blood pressure as low as 93/78 and he was tachycardic with a heart rate at 105. He was running a fever of 38.7 Celsius (equivalent to 101.7 Fahrenheit). He was tachypneic with a respiratory rate of 24. Mr. Doe was also suffering from 2 + bilateral lower extremity edema.

TIPS: *Keep the narrative in chronological order:*

Presentation

Examination

Study Results

Treatments

Decision Making

Disposition

Case Study #1 CHF

A chest x-ray showed cardiomegaly and moderate pulmonary edema. Laboratory studies showed a very elevated brain natriuretic peptide of 2395 (H) [0-100]. Mr. Doe's potassium level was 3.3 (L) [3.6-5.1], sodium level was 130 (L) [136-144], creatinine was 1.3 (H) [.7-1.2], glomerular filtration rate 53 (L) [>60], and his troponin was elevated at 0.08 (H) [0-0.04]. The physician noted that the elevated troponin was likely secondary to volume overload from the congestive heart failure. Mr. Doe received a continuous albuterol nebulizer treatment in the emergency department as well as intravenous Lasix 40 mg. The physician's impression was "acute dyspnea and new onset acute congestive heart failure."

TIPS: *Include normal lab values to emphasize the abnormality of the results*

Case Study #1 CHF

There was concern for an infectious process because of the fever. A urinalysis was ordered and the plan was to do a culture if it was indicative of a urinary tract infection. The physician felt that the low sodium level was likely secondary to hypervolemia due to the acute congestive heart failure. The physician documented "**new acute decompensated congestive heart failure exacerbation, likely systolic**" and "given his physical exam with the xanthomas, I suspect he has underlying hyperlipidemia and possibly hypertension at least." The patient was admitted as an inpatient to the Intermediate monitored (step down) unit.

TIPS: *Use bolding and/or underlining **sparingly** to emphasize severity of signs or symptoms or concerns for risk of harm*

Case Study #1 CHF

Admission orders included low sodium diet, free water restriction, strict I&O, daily weights, echocardiogram, EKG, cardiology consult, dietary consult, blood culture, serial cardiac enzymes, Lasix 20 mg IV twice a day, Lasix 40 mg IV daily, potassium 40 mEq orally every 2 hours for 3 doses, potassium chloride 20 mEq twice a day, potassium 80 mEq orally x 1, oral Carvedilol (for afterload reduction), oral lisinopril (for afterload reduction), magnesium sulfate 1 gram IV x 2 doses, oral Lipitor, oral aspirin, Tamiflu orally twice a day, oral captopril every 8 hours, Lovenox 40 mg subcutaneously daily, sequential compression device, bedrest with bathroom privileges, pulse oximetry every shift, and oxygen- titrated to keep oxygen saturation greater than or equal to 92%.

TIPS: *How sick was this guy? How intense were these services?*

Case Study #1 CHF

An echocardiogram showed pulmonary hypertension, severely dilated left atrium, severely enlarged left ventricle, and a severely decreased ejection fraction of 20-25% (L) [55-70%] with grade 2 diastolic dysfunction. His cardiac output was 3.41 (L) [normal male at rest is 5.6]. He had several episodes of unsustained ventricular tachycardia on telemetry. A cardiologist was consulted and his impression was: acute congestive heart failure secondary to dilated cardiomyopathy with poor left ventricular systolic function. The cardiologist wanted to do an adenosine perfusion scan, but Mr. Doe refused it.

TIPS: *Although this test was done after the decision to admit, it supports the physician's assessment of the severity of illness for this gentleman*

Case Study #1 CHF

Fortunately, Mr. Doe's condition improved over the course of his hospitalization, despite the fact that he was non-compliant at times and occasionally refused to follow the physician's plan of care.

Mr. Doe was discharged, after an acute inpatient stay of approximately **42 hours**, on new medications, including aspirin, atorvastatin, carvedilol, lasix, lisinopril and potassium chloride. He was to follow up as an out-patient for a stress echo one week after discharge. Home health visits were ordered for newly diagnosed congestive heart failure.

TIPS: *This gentleman was so sick he needed six new medications and follow-up care*

Case Study #1 CHF

Justification by CMS Guideline

X	**The severity of the signs and symptoms exhibited by the patient warrant possible need for inpatient admission.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	Emergency Department Record pp 4-5; History and Physical pp. 12-15; Personal History and Physical Examination pp. 5-7; Consultation pp. 18-19
X	**The medical predictability of something adverse happening to the patient warrants possible need for inpatient admission.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	History and Physical pp. 12-15

TIPS: *Severity of Signs and Symptoms: Think EMT Records, ED Records, Office Visit Notes, History and Physical, Consult Notes Medical Predictability of Adverse Events: Think Evidence Based Medicine – Physician Decision Making*

Case Study #1 CHF

Justification by CMS Guideline

	The need for diagnostic studies warrants possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	The availability of diagnostic procedures at the time when and at the location where the patient presents warrants possible need for inpatient admission. CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.

TIPS: *When does this come into play? What about "the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting."*

Case Study #1 CHF

Justification by CMS Guideline

X	**This patient was expected to need hospital care for 24 hours or more.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	History and Physical pp. 12-15

TIPS: *What was the plan of treatment in the physician's History and Physical? What physician orders were placed?*
IV Lasix 40 mg every 8 hours X 3 then start PO Lasix 40 mg daily – Helpful!
EKG in AM – Not so much!

Case Study #1 CHF

Justification by CMS Guideline

X	**There are pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.** CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.
	History and Physical pp. 12-15; Personal History and Physical Examination pp. 5-7; Consultation pp. 18-19
	The beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.

TIPS: *Social factors, noncompliant with medications, language barriers, failing outpatient therapy, CHF vs. COPD vs. Pneumonia.*

Case Study #1 CHF

Justification by Evidence Based Guidelines

Source/Reference	**Acute Decompensated Heart Failure. Journal of Cardiac Failure. Vol. 16 No. 6 2010. As found on: http://www.onlinejcf.com/article/S1071-9164(10)00227-7/fulltext**
Evidence Based Guideline/Practice Guideline Recommendation	Hospitalization is Appropriate in ADHF with: [p. e137] Hypotension Worsening renal function Dyspnea at rest/resting tachypnea/oxygen saturation <90% Hemodynamically significant arrhythmia Acute coronary syndromes Worsened congestion even without dyspnea Signs and symptoms of pulmonary or systemic congestion, even in the absence of weight gain Major electrolyte disturbance Pneumonia **Previously undiagnosed HF with signs and symptoms of systemic or pulmonary congestion**

TIPS: *Underline and/or bold elements that are specific to this case*

Case Study #1 CHF

Justification by Evidence Based Guidelines

Source/Reference	**Acute Decompensated Heart Failure. Journal of Cardiac Failure. Vol. 16 No. 6 2010. As found on: http://www.onlinejcf.com/article/S1071-9164(10)00227-7/fulltext**
Evidence Based Guideline/Practice Guideline Recommendation	•"Several additional days of hospitalization are often necessary to return the patient to a volume status that makes discharge acceptable." [p. e137] •Diuretics may induce symptomatic hypotension, worsening renal function, or arrhythmias [p. e140] •Monitor serum potassium and magnesium levels at least daily- "more frequent monitoring may be necessary when diuresis is rapid." [p. e140]

TIPS: *Is this reflected in the record? Vital signs, labs, telemetry strips, physician's orders*

Case Study #1 CHF

Justification by Evidence Based Guidelines

Source/Reference	**Acute Decompensated Heart Failure. Journal of Cardiac Failure. Vol. 16 No. 6 2010. As found on: http://www.onlinejcf.com/article/S1071-9164(10)00227-7/fulltext**
Evidence Based Guideline/Practice Guideline Recommendation	Discharge Criteria for Patients With HF [p. e151] •Address exacerbating factors •Near optimal volume status •Transition from intravenous to oral diuretic •Complete patient and family education •Document left ventricular ejection fraction [LVEF] •Begin smoking cessation counseling •Near optimal pharmacologic therapy achieved •Follow-up clinic visit scheduled •Oral medication regimen stable for 24 hours •No intravenous vasodilator or inotropic agent for 24 hours •Ambulation before •Plans for post discharge management (scale present in home, visiting nurse or telephone follow up generally no longer than 3 days after discharge) •Referral for disease management

TIPS: *When was this gentleman safe for discharge?*

Case Study #1 CHF

Justification by Evidence Based Guidelines

Source/Reference	**National Guideline Clearinghouse. (Revised 2011). Heart failure in adults. As found on: *http://www.guideline.gov/content.aspx?id*= 34840&search=congestive+heart+failure**
Evidence Based Guideline/Practice Guideline Recommendation	Unstable Signs and Symptoms/Emergent Management •Dyspnea at rest/orthopnea (change from baseline), sudden onset of shortness of breath (SOB), worsening SOB, exertional dyspnea, gasping •Chest pain •Systolic blood pressure (BP) <90 and symptomatic **Admission Recommendations** **"Consider hospitalization in the presence or suspicion of heart failure with any of the following findings:"** •Evidence of acute myocardial ischemia or infarction •Pulmonary edema or severe respiratory distress •Management of clinically significant arrhythmias •Generalized edema (Anasarca) •Inadequate social support for safe outpatient management

TIPS: *A little more restrictive guidelines, but still applicable*

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Case Study #1 CHF

Justification by Evidence Based Guidelines

Source/Reference	**Cleveland Clinic. (2012). Understanding Your Ejection Fraction. As previously cited in: As found on: Ejection Fraction Heart Failure Measurement, Heart.org. http://my.clevelandclinic.org/heart/disorders/heartfailure/ejectionfraction.aspx**
Evidence Based Guideline/Practice Guideline Recommendation	• Normal ejection fraction is 55-70%. [p. 1] • The ejection fraction may be low when the heart muscle is damaged. [p. 1] • An EF of < 40% may confirm heart failure…. **an EF of < 35% increases the risk of life- threatening heartbeats that can cause cardiac death**. [p. 1]

TIPS: *Speaks to "medical predictability of something adverse happening to the patient". Risk!*

Case Study #1 CHF

Regulatory Arguments

1) Limitation on Liability

- "the provider or beneficiary of services "did not know, and could not reasonably have been expected to know, that payment would not be made for such items or services under such part A or part B"

Case Study #1 CHF

- “criteria for determining that a provider, practitioner, or supplier knew that services were excluded from coverage as custodial care or as not reasonable and necessary are as follows:

  (a) Basic rule. A provider, practitioner, or supplier is considered to have known if any one of the conditions of this section is met.

  (b) Notice from the PRO, intermediary or carrier.

  (c) Notice from the utilization review committee or the beneficiary's attending physician.

  (d) Notice from the provider, practitioner, or supplier to the beneficiary.

(e) Knowledge based on experience, actual notice, or constructive notice.”

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"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, including manual issuances, bulletins, or other written guides or directives from intermediaries, carriers, or PROs, including notification of PRO screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue and of medical procedures subject to preadmission review by a PRO.

(2) Federal Register publications containing notice of national coverage decisions or of other specifications regarding noncoverage of an item or service.

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

Case Study #1 CHF

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Case Study #1 CHF

2) Treating or Attending Physician Rule

The treating or attending physician rule as applied in the Fourth Circuit requires that the treating physician's opinion "be given great weight and may only be disregarded if there is persuasive contradictory evidence" in the record.

The rationale for this rule is that the treating physician's opinion "reflects an expert judgment based on a continuing observation of the patient's condition over a prolonged period of time."

Although the "treating or attending physician rule" is typically applied in Social Security disability cases the rule has been applied in the context of Medicare reimbursement.

http://www.ssa.gov/OP_Home/cfr20/404/404-1527.htm

Case Study #2 TIA

Beneficiary Name	Jane Doe	**HIC Number:**	XXXXXXXXXA
Claim Dates of Service	08/23/2011 - 08/26/2011		
Reason(s) for Denial	Outpatient services in the hospital billed as acute hospitalization.		
Principal Diagnosis	Unspecified Cerebral Transient Ischemia		
Comorbidities/Complicating Factors	Hyposmolality and/or hyponatremia Essential hypertension, unspecified benign or malignant Persistent mental disorders due to conditions classified elsewhere Unspecified acquired hypothyroidism Unspecified atherosclerosis of native arteries of extremities Personal history of transient ischemic attack (TIA), and cerebral infarction without residual Status post cardiac pacemaker in situ		
Social Factors	Resides at a board-and care home.		

Case Study #2 TIA

Jane Doe was a 91 year-old lady who lived in a board-and-care home with a medical history of dementia, TIA's, CAD, hypertension, hypothyroidism, peripheral vascular disease, chronic hyponatremia, and had a pacemaker. Of note, Ms. Doe routinely took eight medications to manage her multiple medical problems.

Ms. Doe presented to the hospital Emergency Department with her family, after experiencing confusion and leaning towards the right side during observed ambulation. Ms. Doe had also been suffering from confusion for three days, increased weakness for one week, trouble ambulating, and shortness of breath. Given that Ms. Doe had multiple episodes of TIA's in the past, the family felt it prudent to take her to the ED .

Case Study #2 TIA

Upon examination, she was hypertensive with a blood pressure of 140/54 and she was confused. She was short of breath, had decreased breath sounds, wheezes, and crackles in her lung fields. She had edema in her both lower extremities. She was hyponatremic.

Her abnormal labs upon admission were:

Sodium 126 (L) [136-145], Chloride 94 (L) [98-107]

WBC 12.0 (H) [5.0-10.0]

RBC 3.23 (L) [4.4-5.9], Hematocrit 35.1 (L) [37-47]

BUN 29 (H) [7-18]

SGOT 67 (H) [15-37], SGPT 108 (H) [10-40], Lactic Acid 2.5 (H) [0.4-2.0].

Case Study #2 TIA

A Foley catheter was inserted and she was given 40 mg Lasix intravenously. Her blood pressure remained elevated at 135/59 and 132/62 during her ER stay. The chest x-ray showed that her heart was enlarged.

Her last hospitalization was six months previously, where she was admitted for TIA, despite therapeutic INR's. She was incontinent of bowel and bladder. She was noted to have a possible urinary tract infection and the ER physician noted similar symptoms with a UTI in the past. She was given a dose of IV Levaquin in the ER, while awaiting culture and sensitivity. Her admitting diagnoses were UTI, urosepsis, hyponatremia, and possible CVA.

TIPS: *Remember pre-existing medical conditions or extenuating circumstances?*

Case Study #2 TIA

At the time when the inpatient admission decision was made, she needed assistance with ADL's, was walking minimally, had auditory and visual impairment, and was mobile with use of a wheelchair. She was ordered to stay on bedrest, vital signs were ordered every two hours, and oxygen 2-6 liters was ordered to keep her oxygen saturation above 95%. Physical therapy and occupational therapy evaluations were ordered for her unsteady gait and weakness. Lasix 40mg IV was to continue daily. Lastly, the physician ordered a dysphagia screen to evaluate her safety in swallowing. She was not allowed to eat until the evaluation was completed.

TIPS: *Remember intensity of services, patient safety?*

Case Study #2 TIA

The physical therapy evaluation noted that the Ms. Doe was "too sleepy" during the evaluation and was not transferred to the chair due to lethargy, recommending that she not be transferred to a chair at that time and remain on bedrest. She needed cues to keep her eyes open and could only sit up on the side of the bed for no more than 5 seconds x 2. She needed moderate assistance with two people from sitting to standing and standing to sitting. She was unable to take a step to ambulate with a walker and was unable to shift from leg to leg. She required extensive care for ambulation and mobility and needed moderate to max assist in ADL's. OT noted that her strength was 4/5, that she had poor retention of information, and that she had poor activity tolerance and endurance.

TIPS: *Remember intensity of services, patient safety?*

Case Study #2 TIA

The discharge plan was to have her transferred to a skilled nursing facility until PT/OT determined that it was safe for her to go back to her board-and-care home.

TIPS: *Change in level of care/independence post discharge speaks volumes for severity of illness and patient safety*

Case Study #2 TIA

Justification by CMS Guideline

X	**The severity of the signs and symptoms exhibited by the patient warrant possible need for inpatient admission.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	Emergency Department Record pp 4-5; History and Physical pp. 12-15; Consultation pp. 18-19
X	**The medical predictability of something adverse happening to the patient warrants possible need for inpatient admission.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	History and Physical pp. 12-15; Consultation pp. 18-19

TIPS: *Will be supported by Evidence Based Medicine further down in appeal letter*

Case Study #2 TIA

Justification by CMS Guideline

X	**This patient was expected to need hospital care for 24 hours or more.** CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A.
	History and Physical pp. 12-15

TIPS: *Remember to look at Plan of Treatment under the Physician's History and Physical and Physician's Orders*

Case Study #2 TIA

Justification by CMS Guideline

X	**There are pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary.** CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.
	History and Physical pp. 12-15; Personal History and Physical Examination pp. 5-7; Consultation pp. 18-19
X	**The beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.** CMS Medicare Program Integrity Manual 100-08; Chapter 6; Section 6.5.2 - Medical Review of Acute Inpatient Prospective Payment System (IPPS) Hospital or Long-term Care Hospital (LTCH) Claims.
	PT Evaluation, p. 37

TIPS: *Physical Therapy provided excellent documentation of the concern for the safety of Ms. Doe*

Case Study #2 TIA

Source/Reference	**AHA/ASA Guideline. Definition and Evaluation of Transient Ischemic Attack (*Stroke*. 2009;40:2276-2293.)**
Evidence Based Guideline/Practice Guideline Recommendation	Patients with TIAs are at high risk of early stroke Diagnostic recommendations include: TIA patients should undergo neuroimaging evaluation within 24 hours of symptom onset Noninvasive imaging of the cervical vessels should be performed and noninvasive imaging of intracranial vessels is reasonable Electrocardiography should occur as soon as possible after TIA and prolonged cardiac monitoring and echocardiography are reasonable in patients in whom the vascular etiology is not yet identified It is reasonable to hospitalize patients with TIA if they present within 72 hours and have an ABCD2 score more than 3, indicating high risk of early recurrence, or the evaluation cannot be rapidly completed on an outpatient basis.

Case Study #2 TIA

Source/Reference	**AHA/ASA Guideline. Definition and Evaluation of Transient Ischemic Attack (*Stroke*. 2009;40:2276-2293.)**
Evidence Based Guideline/Practice Guideline Recommendation	"Patients with TIA score points (indicated in parentheses) for each of the following factors: age > 60 years (1); blood pressure > 140/90 mm Hg on first evaluation (1); clinical symptoms of focal weakness with the spell (2) or speech impairment without weakness (1); duration 60 minutes (2) or 10 to 59 minutes (1); and diabetes (1). In combined validation cohorts, the 2-day risk of stroke was 0% for scores of 0 or 1, 1.3% for 2 or 3, 4.1% for 4 or 5, and 8.1% for 6 or 7." **NOTE: Ms. Doe's ABCD2 score was 6:** age > 60 years (1); blood pressure > 140/90 mm Hg on first evaluation (1); clinical symptoms of focal weakness with the spell (2); duration 60 minutes (2) (Emergency Department Note, p.6)

TIPS: *Even if ABCD2 score was not used or documented in the record, you can still use it/cite it! "Acceptable Standard of Care"*

Case Study #2 TIA

Source/Reference	**A-Salman J, Kemp D, and Randall D. (2002). Hyponatremia. Western Journal of Medicine. Volume 176:173-176. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071707/pdf/wjm17600173.pdf**
Evidence Based Guideline/Practice Guideline Recommendation/Quote	Symptomatic hyponatremia requires treatment, usually by hypertonic sodium chloride infusion. Correction should be limited to about 25 mmol/L during the initial 24 to 48 hours. Nausea and malaise are the earliest findings and may be seen when the plasma sodium concentration falls below 125 to 130 mmol/L. This may be followed by headache, lethargy, obtundation, and eventually seizure, coma, and respiratory arrest if the plasma sodium concentration falls below 115 to 120 mmol/L.

TIPS: *Use additional Standards of Care as they apply*

Summary

- Be persuasive in your appeal narrative. Bring the patient to life. Add emphasis where it is warranted.
- Frame your arguments against the CMS regulations to your advantage. Definition of inpatient for level of care; NCDs and/or LCDs for medical necessity of procedures.
- Incorporate evidence based medicine and the standard of practice. When is it appropriate to admit? What is the risk to the patient?

Q & A

Thank you!

Questions?
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