**Please return all correspondence to:**

«TableStart:PATIENTINFO»«Facility\_Description»

NPI: «Facility\_NPI»

Tax ID: «Facility\_Tax\_ID»

PTAN: «PTAN»

«TableEnd:PATIENTINFO»

November 19, 2013

«TableStart:PAYERINFO»

«PAY\_Payer\_Address1»

«PAY\_Payer\_City», «PAY\_Payer\_State» «PAY\_Payer\_Zip\_Code»

«TableEnd:PAYERINFO»

«TableStart:PATIENTINFO»«Salutation\_Recipient»:

This is a request for «Appeal\_Description» on «PAT\_Full\_Name»’s denied Medicare claim for inpatient services at «Facility»*.* The following is a summary of the denial from «Prior\_Reviewing\_Agency», as well as substantiation of the medical necessity that supports the need for services as provided and billed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Beneficiary Name** | «PAT\_Full\_Name» | **HIC Number:** | «HICN» |
| **Claim Dates of Service** | «Svc\_From» - «Svc\_To» |
| **Reason(s) for Denial** |  |
| **Principal Diagnosis** |  |
| **Comorbidities/Complicating Factors** |  |
| **Procedures** |  |
| **Social Factors** |  |

**Justification for Appeal**

«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.*

**Justification of Treatment and Setting by CMS Guidelines**

|  |  |
| --- | --- |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |
|  | **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.  |
| *Please cite title of document and page numbers that support this guideline (if applicable).* |
|  |  |

Source:

**LCD L27548 – Acute Care: Inpatient, Observation and Treatment Room Services**

**Indications and Limitations of Coverage and/or Medical Necessity**

*Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.*

“The determination of an inpatient or outpatient status for any given patient is specifically reserved to the **admitting** **physician**. The decision must be based on the physician's expectation of the care that the patient will require. The general rule is that the physician should order an inpatient admission for patients who are expected to need hospital care for 24 hours or longer and treat other patients on an outpatient basis. An inpatient admission is not covered when the care can be provided in a less intensive setting without significantly and indirectly threatening the patient's safety or health. Although in many institutions there is no difference between the actual medical services provided in inpatient and outpatient observation settings, in such cases the designation still serves to assign patients to an appropriate billing category.

A person is considered an inpatient if he is formally admitted based on the physician's expectation of a need for an appropriate inpatient stay. If the patient dies, is transferred, leaves AMA or recovers in a shorter period of time, an inpatient admission is still appropriate. The justification for the admission, then, is based on the information available at the time of admission. Subsequent information may support a physician's "hunch" that the patient needed inpatient care, but never serves to refute that original determination.”

**CMS Medicare Benefit Policy Manual 100-02; Chapter 1; Section 10 - Covered Inpatient Hospital Services Covered Under Part A**

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, 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. Factors to be considered when making the decision to admit include such things as:

* The severity of the signs and symptoms exhibited by the patient;
* The medical predictability of something adverse happening to the patient;
* The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
* The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or non-covered solely on the basis of the length of time the patient actually spends in the hospital.

Auditing entities should “consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They should not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was 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**

A. Determining Medical Necessity and Appropriateness of Admission

The reviewer shall consider, in his/her review of the medical record, any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. When such factors affect the beneficiary's health, consider them in determining whether inpatient hospitalization was appropriate.

Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting. Without accompanying medical conditions, factors that would only cause the beneficiary inconvenience in terms of time and money needed to care for the beneficiary at home or for travel to a physician's office, or that may cause the beneficiary to worry, do not justify a continued hospital stay. See Pub. 100-02, chapter 1, §10 for further detail on what constitutes an appropriate inpatient admission.

**Acceptable Standards of Medical Care in the Community**

Department of Health and Human Services, Health Care Financing Administration (1995, December). HCFA Ruling 95-1. Retrieved from <http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/HCFAR951.pdf>.

V. ACCEPTABLE STANDARDS OF PRACTICE--APPLICATION

“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.”

**Justification of Treatment and Setting by Evidence Based Guidelines**

***Below are popular justifications related to standard of care and/ or risk for adverse events relevant to this DRG. Please note that all citations may not be relevant to your patient. Inapplicable material should be deleted.***

|  |  |
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| **Source/Reference**  | **AHA/ASA Guideline. Guidelines for Prevention of Stroke in Patients With Ischemic Stroke or Transient Ischemic Attack. *Stroke.* 2006;37:577-617** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * There is an association between blood pressures (BPs) and the risk of ischemic stroke. [p. 578]
* Diabetes is a risk factor for stroke/poor outcome [p. 580]
* The elderly are at a greater risk of stroke and have highest risk from oral anticoagulants and carotid endarterectomy [p. 604]
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| **Source/Reference**  | **American Heart Association/American Stroke Council. Guidelines for the Early Management of Adults With Ischemic Stroke. *Stroke* 2007, 38:1655-1711: originally published online April 12, 2007. As found on: http://stroke.ahajournals.org/content/38/5/1655.long** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Patients with stroke symptoms should be evaluated with same priority as patients with myocardial infarction/serious trauma, regardless of the severity of the deficits. [p. 1663]
* The time of stroke onset is when patients were at their previous baseline. [p. 1663]
* Patients unable to provide this information or who awaken with stroke symptoms: the time of onset is when last symptom free [pp. 1663-1664]
* For patients who had neurological symptoms that resolved, the clock is reset [p. 1664]
* 25% of patients have neurological worsening during the first 24 to 48 hours after stroke. “It is difficult to predict which patients will deteriorate.” [p. 1687]
* Admission to the hospital or a specialized stroke care unit is a recognized standard of care [pp. 1687-1688]
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| **Source/Reference**  | **American Heart Association. Definition and Evaluation of Transient Ischemic Attack. *Stroke* 2009;40;2276-2293. As found on: http://stroke.ahajournals.org/content/40/6/2276.full.pdf+html** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * “… it is reasonable to hospitalize patients with TIA if they present within 72 hours and have an ABCD2 score >3” [p. 2276]
* TIA incidence markedly increases with age [p. 2277]
* “… many ischemic episodes with symptoms lasting <24 hours also are associated with new infarction.” [p. 2279]
* TIA score points: age 60 (1); initial blood pressure > 140/90 (1); focal weakness (2) or speech impairment without weakness (1); duration 60 minutes (2) or 10 to 59 minutes (1); and diabetes (1). [p. 2282]
* 54% of patients with TIA were admitted to the hospital [p. 2282]
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| **Source/Reference** | **Huff JS, Wyatt W. Decker WW, Quinn JV, et al. (2007) American College of Emergency Physicians, Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department with Syncope.** **As found on: www.acep.org/WorkArea/DownloadAsset.aspx?id=8828** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * “Admit patients with syncope and evidence of heart failure or structural heart disease.” [p. 435]
* Admit patients with syncope and high-risk factors for an adverse outcome. [p. 435]
* The primary reason for admitting patients with syncope as an inpatient is related to risk for cardiac dysrhythmia/sudden death that might be detected and treated. [p. 435]

**Factors for high-risk for adverse outcome [p. 436]*** Older age/associated comorbidities\*
* Abnormal ECG†
* Hct 30
* History/presence of heart failure, coronary artery disease, or structural heart disease
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| **Source/Reference**  | **Prisant ML, & Moser M. Hypertension in the Elderly:**  **Can We Improve Results of Therapy? *Arch Intern Med.* 2000;160(3):283-289. As found on: http://archinte.jamanetwork.com/article.aspx?articleid=485230** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Uncontrolled blood pressure leads to “debilitating complications of stroke, heart failure, angina, and renal failure” [p. 283]
* For the US population > 60 years: stage 1 hypertension (140-159/90-99 mm Hg), stage 2 (160-179/100-109), and stage 3 (≥180/110 ) [p. 283]
* Organ damage from hypertension includes left ventricular hypertrophy, angina or myocardial infarction, coronary revascularization, and congestive heart failure, stroke or transient ischemic attack, nephropathy, peripheral arterial disease, and retinopathy. [p. 286]
* Risk group A: elevated BP; Risk group B: 1 risk factor (not diabetes mellitus) and hypertension; Risk group C: high risk for organ damage, cardiovascular disease, or diabetes alone, or 2 or more risk factors. “Older persons are more likely to fall into risk group C…” [p. 286]
* Treatment of hypertension in the elderly requires consideration of drug metabolism, and physiological considerations (postural hypotension, decreased in cardiac output, renal function, and mental capacity) [p. 288]
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| **Source/Reference**  | **Vidt, DG. (2001). Emergency Room Management of Hypertensive Urgencies and Emergencies. Medscape Nurses. As found on:** <http://www.medscape.com/viewarticle/407727> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Hypertensive emergencies are severe elevations in blood pressure complicated by evidence of progressive organ dysfunction and warrant admission to an intensive care unit [p. 1]
* Organ dysfunction can manifest as coronary ischemia, disordered cerebral function, a cerebrovascular event, pulmonary edema, or renal failure. [p. 1]
* “Hypertensive urgencies are severe elevations in blood pressure without evidence of progressive target organ dysfunction” [p. 1]
* Rapid reduction in blood pressure can cause deterioration in renal function, ischemic, cardiac, or cerebral events, and blindness. [p. 1]
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| **Source/Reference** | **Jyrkka J, et al. (2009). Polypharmacy status as an indicator of mortality in an elderly population [Abstract].** [**Drugs Aging.**](http://www.ncbi.nlm.nih.gov/pubmed/19929031) **26(12):1039-48. As found on p. 1039:** <http://www.ncbi.nlm.nih.gov/pubmed/19929031> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Polypharmacy is six to nine drugs
* Excessive polypharmacy is ten or more drugs
* The mortality rate was 37% in the first phase [elderly persons aged>or=75 years] and 40% in the second phase [second phase aged>or=80 years].
* Excessive polypharmacy is an indicator for mortality in the elderly
* Age, male sex and Activities of Daily Living dependency were associated with mortality in both phases
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| **Source/Reference**  | **National Stroke Association. Transient Ischemic Attack (TIA): Prognosis and Key Management Considerations. As found on:** <http://www.stroke.org/site/DocServer/NSA_ABCD2_tool.pdf?docID=5981> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Hospitalization is appropriate with an ABCD2 score of 0-3 plus another indication, and scores of 4-7 [p. 1]
* Higher ABCD2 scores are associated with greater risk of stroke up to 90 days after a TIA [p. 1]
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| **Source/Reference**  | **Reviewed by Jung, L. (2006) Headache: Geriatric Headaches. *WebMD Medical Reference from WebMD Scientific American Medicine.* As found on: http://www.webmd.com/migraines-headaches/geriatric-headaches?** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * New-onset headaches in persons older than 65 years have a risk of serious secondary disorders [p. 1]
* “Headaches commonly accompany stroke.” [p. 1]
* Patients with prior recurrent throbbing headaches were more likely to have headaches associated with stroke. [p. 1]
* Subarachnoid hemorrhage may present with a patient reporting “the worst headache of their life” [p. 1]
* “…30% of all persons older than 65 years fall at least once a year” and 90% of patients with head trauma report headaches [p. 2]
* “About 50% of patients with chronic subdural hematomas will have altered mental status.” [p. 2]
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| **Source/Reference**  | **Falciglia M, Freyberg RW, Almenoff PL, D’Alessio DA, et al. (2009). Hyperglycemia-Related Mortality in Critically Ill Patients Varies with Admission Diagnosis. Crit Care Med. 37(12): 3001–3009.** **As found on:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2905804/> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * “Hyperglycemia was associated with increased mortality independent of illness severity.” [p. 3001]
* Mortality related to hyperglycemia had a clear association with acute myocardial infarction, arrhythmia, unstable angina, and pulmonary embolism. [pp. 3001-3002]
* “Hyperglycemia was associated with increased mortality independent of ICU type, length of stay and diabetes.” [p. 3002]
 |
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| **Source/Reference** | **Umpierrez GE, Isaacs SD, Bazargan N, You X, et al. (2002). Hyperglycemia: An Independent Marker of In-Hospital Mortality in Patients with Undiagnosed Diabetes. The Journal of Clinical Endocrinology & Metabolism 87(3):978–982. As found on: http://jcem.endojournals.org/content/87/3/978.full.pdf+html** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * New hyperglycemia was considered a fasting glucose of > 126, or a random blood glucose > 200 on 2 or more determinations [p. 978]
* “Newly discovered hyperglycemia was associated with higher in-hospital mortality rate (16%) …” [p. 978]
* “New hyperglycemic patients had a longer length of hospital stay …” [p. 978]
* In-hospital hyperglycemia is an important marker of poor clinical outcome and mortality with and without diabetes [p. 978]
* Patients with newly diagnosed hyperglycemia had a higher mortality rate than patients with diabetes or normoglycemia [p. 978]
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**Regulatory Arguments**

1) Limitation on Liability

«Facility» did not know, and could not reasonably have been expected to know, that payment would not be made for the services provided and therefore this claim meets the statutory criteria of the Social Security Act § SEC. 1879. *[42 U.S.C. δ 1395pp]* to allow payment for such claims.

Additionally, reimbursement to «Facility» for the same services on other claims prior to the instant case and subsequent to the case would not be considered notice of non-payment for such services.

Section 1879. *[42 U.S.C. δ 1395pp]* of the Social Security Act provides that payment can be made for certain denied claims if two (2) criteria are met under a “limitation on liability” provision. These criteria are: (1) a determination is made that, by reason of section 1862(a)(1) or (9) or by reason of a coverage denial described in subsection (g), payment may not be made under part A or part B of this title for any expenses incurred for items or services furnished an individual by a provider of services or by another person pursuant to an assignment under section 1842(b)(3)(B)(ii), and (2) 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.”

«Facility» did not have actual or constructive knowledge that this claim would be denied. A provider is considered to have known that the services were not covered if the provider had notice. The Code of Federal Regulations 42 C.F.R. δ 411.406 state that the “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 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.

 (b) Notice from the PRO, intermediary or carrier. The PRO, intermediary, or carrier had informed the provider, practitioner, or supplier that the services furnished were not covered, or that similar or reasonably comparable services were not covered.

 (c) Notice from the utilization review committee or the beneficiary's attending physician. The utilization review group or committee for the provider or the beneficiary's attending physician had informed the provider that these services were not covered.

 (d) Notice from the provider, practitioner, or supplier to the beneficiary. Before the services were furnished, the provider, practitioner or supplier informed the beneficiary that--

 (1) The services were not covered; or

 (2) The beneficiary no longer needed covered services.

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

Knowledge may be imparted to a provider in several ways. However, the evidence must be clear and convincing that the provider could have been expected to know. This section further provides that “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**.”

2) Treating or Attending Physician Rule

«Patient\_First» «Patient\_Last» was certified for admission at «Facility» by a physician who determined that such services were medically necessary and reasonable; there is no evidence to the contrary supporting the payer’s denial that such services were not medically necessary and reasonable.

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. Coffman v. Bowen, 829 F.2d 514, 517 (4th Cir. 1987), superseded by Statute for the purpose of Social Security Disability claims, 20 C.F.R. § 404.1527(d) (2) (1991); superseded by Regulation, see Winford v. Charter, 917 F. Supp. 398, 400 (E.D. Va. 1996).

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.” Mitchell v. Schweiker, 699 F.2d 185, 187 (4th Cir. 1983), superseded by Regulation for the purpose of Social Security Disability claims, 20 C.F.R. § 404.1527(d) (2) (1991). See Ward v. Charter, 924 F.Supp. 53, 55 (W.D. Va. 1996).

Although the “treating or attending physician rule” is typically applied in Social Security disability cases, see id, the rule has been held to be of even greater force in the context of Medicare reimbursement. Hill v. Sullivan, 1991 W.L. 417526 (W.D.N.Y. 1991); Gartmann v. Secretary, 633 F. Supp. 671, 680 (E.D. N.Y. 1986).

Indeed, the legislative history of the Medicare statute clearly states, “the physician is to be the key figure in determining utilization of health services.” 1965 U.S. Code Cong. & Ad. News, 1943, 1986; Gartmann, 633 F. Supp. At 681; Hultzman v. Weinberger, 495 F.2d 1276, 1279 (3d Cir. 1974); Reading v. Richardson, 339 F. Supp. 295, 300-01 (E.D. Mo. 1972); see also Kuebler v. Secretary, 579 F. Supp. 1436, 1440 (E.D. N.Y. 1984); Breeden v. Weinberger, 377 F. Supp. 734, 737 (M.D. La. 1974).

Recent regulations from the Social Security Administration provide that when evaluating disability claims the administration will “give more weight to opinions from treating sources” and if a treating source’s opinion is “well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record, it will be given controlling weight.” 20 C.F.R. § 404.1527(d) (2) (1991). See Ward v. Charter, 924 F. Supp. 53 (W.D. Va. 1996).

The physician certified that «Patient\_First» «Patient\_Last» met all admission and continuing treatment criteria under the Medicare guidelines. The only medical opinion in the record determines that treatment rendered «Patient\_First» «Patient\_Last»was medically necessary and reasonable. This medical opinion should be given controlling weight. There is no evidence that did not require the intensity of services ordered and provided.

«Patient\_First» «Patient\_Last»’s treatment was clearly ordered by the treating physician as being required medical treatment. In the case now under appeal, a qualified physician clearly certified that «Patient\_First» «Patient\_Last» required the medical treatment delivered by «Facility». The services rendered were deemed by the physician to be reasonable and necessary for the active treatment of the patient’s condition. «Facility» relied on this opinion in treating «Patient\_First» «Patient\_Last» during the denied period.

**Conclusion**

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

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

Respectfully,

Image\_Signature

«Facility\_Signature»

Submitted with the authority of the Provider,

**Please return all correspondence to:**

«Facility\_Description»

NPI: «Facility\_NPI»

Tax ID: «Facility\_Tax\_ID»

PTAN: «PTAN»

«TableEnd:PATIENTINFO»