**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.***

|  |  |  |
| --- | --- | --- |
| **Source/Reference** | [**Marcum ZA**](http://www.ncbi.nlm.nih.gov/pubmed?term=Marcum%20ZA%5BAuthor%5D&cauthor=true&cauthor_uid=22389461)**,** [**Pugh MJ**](http://www.ncbi.nlm.nih.gov/pubmed?term=Pugh%20MJ%5BAuthor%5D&cauthor=true&cauthor_uid=22389461)**,** [**Amuan ME**](http://www.ncbi.nlm.nih.gov/pubmed?term=Amuan%20ME%5BAuthor%5D&cauthor=true&cauthor_uid=22389461)**,** [**Aspinall SL**](http://www.ncbi.nlm.nih.gov/pubmed?term=Aspinall%20SL%5BAuthor%5D&cauthor=true&cauthor_uid=22389461)**, et al. (2012). Prevalence of potentially preventable unplanned hospitalizations caused by therapeutic failures and adverse drug withdrawal events among older veterans [Abstract].** [**J Gerontol A Biol Sci Med Sci.**](http://www.ncbi.nlm.nih.gov/pubmed/22389461) **2012 Aug;67(8):867-74. doi: 10.1093/gerona/gls001. Epub 2012 Mar 1. As found on: http://biomedgerontology.oxfordjournals.org/content/67/8/867.full.pdf+html** | |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Study included unplanned hospitalizations caused by a therapeutic failure (TF) and/or an adverse drug withdrawal events(ADWE)of older (age ≥ 65 years) [p. 867] * “…most common therapeutic failures were heart failure exacerbations, coronary heart disease symptoms, tachyarrhythmias, and chronic obstructive pulmonary disease exacerbations.” [p. 867] | |
|  |  | |
| **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  Altered mentation  Dyspnea at rest/resting tachypnea/oxygen saturation <90%  Hemodynamically significant arrhythmia  New onset of rapid atrial fibrillation  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  Associated comorbid conditions  Pneumonia  Pulmonary embolus  Diabetic ketoacidosis  Symptoms suggestive of transient ischemic accident or stroke  Repeated ICD firings  Previously undiagnosed HF with signs and symptoms of systemic or pulmonary congestion   * “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]   **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 |
|  |  | |
| **Source/Reference** | **National Guideline Clearinghouse. (Revised 2011).** [Heart failure in adults.](http://www.guideline.gov/content.aspx?id=34840&search=congestive+heart+failure)**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   + Arterial oxygen saturation (SaO2) < 90%   + Coughing up pink/frothy sputum   + Dizziness or syncope   + Chest pain   + Systolic blood pressure (BP) <90 and symptomatic   + Cyanosis   + Decreased level of consciousness   **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   + Severe symptoms of heart failure refractory to outpatient therapy   + Pulmonary edema or severe respiratory distress   + Thromboembolic complications requiring interventions   + Severe complicating medical illness   + Management of clinically significant arrhythmias   + Generalized edema (Anasarca)   + Inadequate social support for safe outpatient management   + Symptomatic hypotension or syncope   + Hyperkalemia |
|  |  | |
| **Source/Reference** | **Sarraf M, and Schrier RW. (2011). Cardiorenal Syndrome in Acute Heart Failure Syndromes. International Journal of Nephrology. Vol. 2011; 1-10. As found on: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056318/ and** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3056318/pdf/IJN2011-293938.pdf> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Patients with acute heart failure syndromes are usually admitted because of severe systemic congestion that frequently presents with dyspnea, low cardiac output and/or systemic hypotension. [p. 1] * “… the main driver of morbidity, mortality, and readmission to the hospital is volume overload [p. 1] * Patients admitted with AHFS and renal dysfunction have worse outcomes [p. 1] * Loop diuretics relieve congestion but reduce glomerular filtration [p. 8] * Inotropes improve hemodynamics but can increase mortality and arrhythmias [p. 8] * Natriuretic peptides may worsen kidney function and increase mortality [p. 8] * Vasodilators can cause hypotension while improving hemodynamics [p.8] |
|  |  | |
| **Source/Reference** | **Anker SD, Ponikowski P, Varney S, Chua TP, et al. Wasting as independent risk factor for mortality in chronic heart failure [Abstract]. Lancet. 1997 Apr 12;349 (9058):1050-3. As found on: http://www.ncbi.nlm.nih.gov/pubmed/9107242** |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Cachexia is a non-intentional weight loss of at least 7.5% of previous normal weight. [p. 1050] * Cachexia is predictive of mortality which is “18% at 3 months, 29% at 6 months, 39% at 12 months, and 50% at 18 months.” [p. 1050] * Patients with cachexia and a low peak oxygen are at extremely high risk of death.” [p. 1050] |
|  |  | |
| **Source/Reference** | **Holland R, Rechel B, Stepien K, Harvey I, and Brooksby I. (2010). Patients' Self-Assessed Functional Status in Heart Failure by New York Heart Association Class: A Prognostic Predictor of Hospitalizations, Quality of Life and Death. Journal of Cardiac Failure. 16(2-4): 150–156. As found on:** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2817782/> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * “SA-NYHA class is predictive of hospitalization, quality of life, and mortality among patients with heart failure.” * “… 4 categories (I, II, III, IV), with higher class indicating more severe symptoms, limitation in physical activity, and worse health.” * “Patients from higher SA-NYHA groups also had longer length of stay in hospital…” |
|  |  | |
| **Source/Reference** | [Torgersen](http://www.ncbi.nlm.nih.gov/pubmed/?term=Torgersen%20C%5Bauth%5D) **C,** [Schmittinger](http://www.ncbi.nlm.nih.gov/pubmed/?term=Schmittinger%20CA%5Bauth%5D) **CA,** [Wagner](http://www.ncbi.nlm.nih.gov/pubmed/?term=Wagner%20S%5Bauth%5D)**S,** [Ulmer](http://www.ncbi.nlm.nih.gov/pubmed/?term=Ulmer%20H%5Bauth%5D) **H, et al. (2009). Hemodynamic variables and mortality in cardiogenic shock: a retrospective cohort study. Crit Care. 13(5): R157. As found on: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2784383/ and** <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2784383/pdf/cc8114.pdf> |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * Cardiogenic shock is evidenced by hypotension (systolic blood pressure < 90); an acute decrease of the left ventricular ejection fraction < 40%; and continuous infusion of inotropic drugs (any dose of dobutamine, epinephrine, milrinone and/or levosimendan). [p. 2] * “…almost two-thirds of the study population developed cardiogenic shock as a result of an acute coronary syndrome…” [p. 5] |
|  |  | |
| **Source/Reference** | **Goldman L, & Kirtane, A. (2003). Triage of Patients with Acute Chest Pain and Possible Cardiac Ischemia: The Elusive Search for Diagnostic Perfection. *Ann Intern Med.* Volume 139; No. 12: 987-995. As found on:** <http://www.annals.org/content/139/12/987.full> | |
| **Evidence Based Guideline/Practice Guideline Recommendation** | * A coronary care unit is appropriate for patients whose probability of acute MI is > 20%… For patients whose risks are lower, admission to telemetry is recommended [p. 988] * Any patient who has EKG evidence of new infarction has too high a risk to be safely discharged, regardless of the history or exam findings [p. 989] * Chest pain similar to previous episodes of cardiac ischemia are in a high-risk category [p. 989]   **Intermediate care unit indication:** Any of the following conditions [p. 990]   * Unstable coronary artery disease * Systolic blood pressure < 110 * Rales above the bases * Major arrhythmias * New-onset typical ischemic heart disease that meets criteria for unstable angina | |
|  |  | |
| **Source/Reference** | **ACC AHA 2007 Guidelines for the Management of Patients With Unstable Angina/ Non-ST-Elevation Myocardial Infarction. Journal of the American College of Cardiology. Vol. 50, No. 7:e1-157. As found on: http://circ.ahajournals.org/content/116/7/803.full.pdf** | |
| **Evidence Based Guideline/Practice Guideline Recommendation** | **Inpatient admission is appropriate for ACS/ ASC with: [p. e31-32, 34]**   * Ongoing ischemic symptoms * Positive cardiac biomarkers * New ST-segment deviations * New deep T-wave inversions * Hemodynamic abnormalities/instability * Positive stress test * Recurrence of chest pain strongly suggestive of ACS * Significant ECG change * Positive functional/ stress test or CCTA are generally [inpatient admissions] * Recurrent symptoms during observation suggestive of ACS * New abnormalities on 12-lead ECG, cardiac biomarkers   **High Likelihood That Signs and Symptoms Represent an ACS Secondary to CAD [e17]**   * Chest or left arm pain or discomfort as chief symptom reproducing prior documented angina * Known history of CAD, including MI * Transient MR murmur, hypotension, diaphoresis, pulmonary edema, or rales * New, or presumably new, transient ST-segment deviation (1 mm or greater) or T-wave inversion in multiple precordial leads * Elevated cardiac TnI, TnT, or CK-MB   **Intermediate Risk That Signs and Symptoms Represent an ACS Secondary to CAD [e17]**   * Chest or left arm pain or discomfort as chief symptom * Age greater than 70 years * Male sex * Diabetes mellitus * Extra-cardiac vascular disease * Fixed Q waves * ST depression 0.5 to 1 mm or T-wave inversion greater than 1 mm * Normal cardiac markers * Adults > age 70 have increased risks of both underlying CAD and multivessel CAD and are more likely to have atypical symptoms. [p. e20] * Diabetes, and the presence of extracardiac (carotid, aortic, or peripheral) vascular disease, and hypertension are risk factors for poor outcome in patients with ACS and have a higher mortality rate and risk of acute HF. [p. e20] * “The average age of a person having a first heart attack is 65.8 years for men and 70.4 years for women…” [p. e6] | |
|  |  | |
| **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 | |
|  |  | |
| **Source/Reference** | **Cleveland Clinic. (2012). Understanding Your Ejection Fraction. As previously cited in: As found on:** [**Ejection Fraction Heart Failure Measurement**](http://www.heart.org/HEARTORG/Conditions/HeartFailure/SymptomsDiagnosisofHeartFailure/Ejection-Fraction-Heart-Failure-Measurement_UCM_306339_Article.jsp)**,** [Heart.org](http://www.heart.org/HEARTORG/Conditions/HeartFailure/SymptomsDiagnosisofHeartFailure/Ejection-Fraction-Heart-Failure-Measurement_UCM_306339_Article.jsp). **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] | |
|  |  | |
| **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] |
|  |  | |
| **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] |

**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»