May 5, 2010

Hospital Name: General Medical Center
HIC #999999999A
MRN # 1234567
Patient Name: Doe, John
Dates of Service: 2/6/2006-2/7/2006
RAC reference ID: 12345678901

To Whom It May Concern:

General Medical Center was notified by the RAC that it received Medicare payment in error for the above referenced claim. We are writing to request redetermination of the RAC Decision which states "the procedures performed (CPT 35473, 35474 and 75635) are on the CMS Hospital Based Outpatient Prospective Payment System/APC list for 2006 and therefore this claim should be billed at the appropriate outpatient level of care." General Medical Center has developed process and procedures for determining the clinically appropriate level of care. The process is based upon established clinical criteria, community standards of care, payer-specific guidelines and an internal clinical review process. A rigorous utilization assessment is conducted on all admissions and each case is validated for the appropriateness of the level of care assigned. General Medical Center is confident that we have billed this procedure correctly and in compliance with Medicare and other Federal laws which are presented in this appeal.

The admitting attending physician documented his intent for providing inpatient level of care at the time of admission by writing an inpatient admission order. Attached is a signed, dated and timed physician admission order to the Intensive Coronary Care Unit (ICCU). In summary, Mr. Doe is a 75 year old man with a past medical history of Peripheral Vascular Disease, Diabetes and Renal Insufficiency with an admission Creatinine of 1.9, who underwent angioplasty of his right common iliac artery and right superficial femoral artery with stent placement. His postoperative course was complicated by hypertension with BP's 180-210/70-80s which was treated with Hydralazine IV and HCTZ. He was monitored with intensive vital signs throughout his inpatient stay. He received pre and post intravenous bicarbonate and Mucomyst for protection against Contrast Nephropathy and continued on 100cc/h of IVF. The following day, he was discharged after careful monitoring of lab values specifically his Creatinine to ensure his renal status was stable. The utilization management protocol at the medical center leveled this case as inpatient. Based upon the physician intent and the clinical justification presented here, Medicare rules and regulations for establishing inpatient level of care have been met. The inpatient admission was reasonable and medically justified.

General Medical Center also requests redetermination of the decision that was based solely on the fact that a peripheral angioplasty is not on the Medicare Inpatient Only list. The Recovery Audit Contractor has misinterpreted the intent of the Medicare Inpatient Only list. The Medicare Inpatient Only list was created to identify the procedures that can only be safely done as an inpatient. It identified and excluded cases that could not be performed as an outpatient. Under the hospital Outpatient Prospective Payment

In the introduction, you should recap the denial, the date of the letter and issues the RAC identified. List the claim in question and the reason why it was denied.

Clear statement of disagreement with the RAC findings.

In this example, the RAC has denied inpatient level of care as not medically necessary. We begin building our argument by referencing the attached inpatient admission order from the attending physician. You should list as many clinical justifications as possible. For example, if your Utilization Management Plan addresses complex patient or complex procedures that support your position, then supply the specific guidelines and the described approval process at your hospital. Use Medicare's definition of an inpatient and describe how the case at hand meets those criteria.

System (OPPS) regulations, CMS has broad latitude to characterize a particular service as appropriate for outpatient care. Certain surgical procedures, radiologic procedures (including radiation therapy), clinic visits, partial hospitalization for the mentally ill, surgical pathologic evaluations, and cancer chemotherapy are listed by the agency as types of care that are probably appropriately performed on an outpatient basis. CMS has given some indication of the guidelines it uses in determining the appropriate setting for a medical procedure. An invasive procedure that requires at least 24 hours of recovery or observation before a patient can be safely discharged was sited as an example of a service that should be performed on an inpatient basis. See 65 Federal Register 18434-18820 (April 7, 2000). The placement of a procedure in the outpatient category does not mandate that it be performed in that setting, with the final determination ultimately dependent on patient-specific factors as determined by his or her physician. For instance, should a patient's underlying medical condition necessitate at least 24 hours of recovery or observation following what is normally considered an outpatient procedure, a hospital may perform that procedure in the inpatient setting.

Here, although certain of the Beneficiary's procedures were included in OPPS and assigned to an ambulatory payment classification (APC) as being "outpatient," Medicare coverage of resulting hospital admission is not precluded. According to the Medicare Benefit Policy Manual, 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.

In this case, there is no evidence to demonstrate that the physician's judgment to admit the Beneficiary as an inpatient was unnecessary or inappropriate. The decision to admit the Beneficiary was the result of a complex medical judgment that was only made after the physician considered the Beneficiary's complex medical history (including peripheral vascular disease status, diabetes, and renal insufficiency) and current needs. The Beneficiary presented for the surgery and, after the surgery was completed, time was needed in order to ensure that the Beneficiary did not experience complications based upon his co-morbidities. Given the Beneficiary's age, medical history, and presenting status, an overnight inpatient admission was both medically reasonable and necessary.

Accordingly, the hospital admission furnished to the Beneficiary meets Medicare coverage requirements. Therefore, the hospital admission at issue should be covered under Medicare.

Sincerely,

Mary Smith, RN, BSN
Appeal Specialist
General Medical Center

To conclude this example, we provide a comprehensive argument that the RAC has misinterpreted the the intent of the Medicare Inpatient Only list.

After your clinical arguments, your letter can be modified with different ALJ references that can be added to the letter to support the appeal. Cite commercial payer experience during the timeframe of the review to support community standard of care.

Always attach all supporting documentation. This is especially important for coding-relating denials in order to defend the coded claim. Reference sections of the medical record and cite the page (highlight entries and attach to the appeal).