Please return all correspondence to:

General Hospital
2900 Oak Lane
California, CA 99999

NPI: 123456789
Tax ID: 12345678
PTAN: 12345

12/21/2021

ABC Insurance
Attn: Appeals & Grievances
10987 Insurance Road
Anywhere, OH 54321

Dear Reviewer:

This is a request for Medical Necessity Provider Appeal on John Doe's denied claim for inpatient services at General Hospital. The following is a summary of the denial from ABC Insurance, as well as substantiation of the medical necessity that supports the need for services as provided and billed.

Beneficiary Name	John Doe
Member ID or MBI Number	MD123456
Claim Dates of Service	09/07/2021 - 09/15/2021
Reason(s) for Denial	Allegation: Services provided not reasonable or medically necessary.
Principal Diagnosis	Chronic obstructive pulmonary disease with (acute) exacerbation
Comorbidities/Complicating Factors	Chronic obstructive pulmonary disease (COPD) Current smoker Atrial fibrillation on Eliquis Congestive heart failure Cardiac pacemaker/defibrillator Asthmatic bronchitis
Procedures	Echocardiogram CT chest
Social Factors	Homeless

Reason Given for Denial

The authorization tracking # provided by ABC Insurance was YZ109876543 (UBO4).

In the denial notice dated 09/16/2021, the auditor indicated the decision to deny inpatient level of care was based on **MCG criteria: COPD**. **MCG criterion is merely an objective tool to help guide physicians in decision-making regarding whether John Doe's condition was severe enough to be admitted to inpatient status. This criterion did not consider specific comorbid conditions that placed John Doe at a greater risk of adverse outcomes.** The decision to admit John Doe to inpatient status was a complex decision that went far beyond basic MCG guidelines. The attending physician was charged with evaluating the entire presentation, including acute and chronic comorbidities, to determine the appropriate setting for John Doe. MCG was one (1) tool to help in the decision-making process. It was not designed to replace the physician's professional training and expertise.

These **clinical guidelines should <u>not</u> be abused** in making the decision to allow inpatient admission coverage. Instead, the **guidelines should be used in conjunction with clinical judgement** of the treating physician and consideration to quality care of the patient.

Justification for Appeal

On 09/07/2021, John Doe, age 73 with a medical history outlined above, presented to the hospital emergency department (ED), by ambulance, suffering from a **productive cough** for two days and a sudden onset of **dyspnea**.

In the ED, he was tachycardic with a **heart rate of 125 in atrial fibrillation** with rapid ventricular response (RVR). He was tachypneic with a **respiratory rate of 22.** Abnormal lab results included **WBC 17.3**, elevated **BUN 21**, elevated **BNP 905**, and elevated **lactic acid 1.77**, indicating possible infection, kidney insufficiency, and congestive heart failure. His arterial blood gas indicated **acute hypoxemic respiratory failure with a pH of 7.52, pCO2 of 30, and a pO2 of 73 on room air.** On exam, breath sounds were described as **wheezes with rales and stridor**. ED treatments included an **IV Cardizem bolus with continuous drip, IV Solu-Medrol and ceftriaxone, Zithromax, and Duo-Nebs.** When the heart rate, respiratory rate, and breath sounds did not improve after treatment in the ED, the decision was made to admit the patient. (pp. 1-3, 7-10, 31)

John Doe was admitted as an inpatient diagnosed with (1) **acute hypoxemic respiratory failure with underlying COPD exacerbation**, (2) **congestive heart failure with acute exacerbation**, (3) **paroxysmal atrial fibrillation**, and (4) **leukocytosis**. The treatment plan included **IV Cardizem**, **IV ceftriaxone, IV Solu-Medrol, IV Lasix, Zithromax**, **Duo-Nebs,** and an echocardiogram. Mr. Doe **required IV Cardizem for 3 days total**. Echocardiogram revealed an **ejection fraction (EF) of 20-25%** and dilated cardiomyopathy. (pp. 5, 10, 15, 20)

John Doe's **acute exacerbation of COPD with underlying CHF and atrial fibrillation** supported the need for hospital inpatient admission. He arrived at the hospital unstable. Failure to provide aggressive treatment increased the risk for respiratory arrest. Mr. Doe's providers understood care would extend beyond a period of observation. Mr. Doe needed time to return to his baseline respiratory status, receive sufficient IV steroids to ease breathing, and antibiotics to clear the infection. **His homelessness was also of concern for discharge**. Discharging John Doe while still unstable and not fully recovered may have resulted in an urgent readmission.

Acceptable Standards of Medical Care in the Community

Acceptable standards of medical care within the community should always be a consideration in any decision to admit a patient to inpatient status in a hospital. Evidence based guidelines presented below support inpatient admission and/or indicate this patient was at high risk for adverse events and/or poor outcomes.

Justification of Treatment and Setting by Evidence Based Guidelines

Global Initiative for Chronic Obstructive Lung Disease (GOLD). **Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease, 2021 Report.** As found on**:** *https://goldcopd.org/wp-content/uploads/2020/11/GOLD-REPORT-2021-v1.1-25Nov20_WMV.pdf*

COPD exacerbations are defined as an acute worsening of respiratory symptoms that result in additional therapy.

Potential Indications for Hospitalization Assessment*:

- Severe symptoms such as **sudden worsening of resting dyspnea**, high respiratory rate, decreased oxygen saturation, confusion, drowsiness.
- Acute respiratory failure.
- Onset of new physical signs (e.g. cyanosis, peripheral edema).
- Failure of an exacerbation to respond to initial medical management.
- Presence of **serious comorbidities** (e.g. **heart failure**, newly occurring arrhythmias, etc.)
- **Insufficient home support**

*Local resources need to be considered.

Hillas, G., Perlikos, F., Tsiligianni, I., & Tzanakis, N. (2015). **Managing comorbidities in COPD.** *International Journal of Chronic Obstructive Pulmonary Disease*, *10*, 95–109. *http://doi.org/10.2147/COPD.S54473*

Most commonly COPD is associated with lung cancer and other cancers, asthma, obstructive sleep apnea syndrome, hypertension, cardiovascular disease, diabetes, metabolic syndrome, dysfunctional skeletal myopathies, osteoporosis, and mental disorders. Clinical practice guidelines usually mention but seldom address comorbidities practically in their recommendations. Furthermore, clinical trials investigating COPD treatment routinely exclude patients with multiple comorbidities or advanced age.

Congestive heart failure is among the leading causes of hospitalization and death for patients with COPD and worsens their prognosis. The presence and severity of COPD are associated with **increased risk for atrial fibrillation/atrial flutter and non-sustained ventricular tachycardia**. **Hospitalization mortality in severe COPD patients with arrhythmia has been reported to be as high as 31%.**

Conclusion

General Hospital provided medically necessary services to John Doe with the expectation that those services would be reimbursed according to the documentation in all payer communications. General Hospital respectfully requests that you reconsider this claim and require payment to be made to General Hospital for the services provided to John Doe in this case.

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

Respectfully,

Dr. Kendall Smith

Raymond Kendall Smith, Jr., MD, SFHM
Chief Physician Advisor
PayerWatch/AppealMasters
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