**Please return all correspondence to:**

Memorial Hospital

123 Maple Avenue

Anywhere, IL 12345

November 29, 2023

Aetna

1700 Crossover Ave

Detroit, MI 54321

Dear Reviewer:

Memorial Hospital disagrees with Aetna’s adverse determination for this claim. Aetna was wrong to deny John Doe’s claim for services at Memorial Hospital. The following is a summary of the incorrect denial from Aetna, as well as evidence of the claim’s medical necessity and the denial’s illegality. In addition, it will be shown that Aetna’s denial of this claim violated the law. Aetna must authorize and pay this claim in accordance with the law to avoid corrective action by Memorial Hospital.

If Aetna granted prior authorization for this inpatient admission, Memorial Hospital stands by the prior authorization regulation at 42 CFR 422.138 which states, “If the MA organization approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity and may not reopen such a decision for any reason except for good cause (as provided at[§ 405.986 of this chapter](https://www.ecfr.gov/current/title-42/section-405.986)) or if there is reliable evidence of fraud or similar fault per the reopening provisions at § 422.616***.***

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| **Beneficiary Name** | John Doe |
| **Member ID or**  **MBI Number** | 123456789 |
| **Claim Dates of Service** | 11/1/2023 – 11/8/2023 |
| **Reason(s) for Denial** | Allegation: Services provided not reasonable or medically necessary |
| **Principal Diagnosis** |  |
| **Comorbidities/Complicating Factors** |  |
| **Procedures** |  |

**Clinical Justification for Inpatient Status**

The facts will show that care provided to this patient was medically necessary considering the totality of the member’s circumstances and was provided in accordance with appropriate clinical criteria, nationally recognized guidelines, and the payer’s policies including, for Medicare Advantage Plans, the coverage criteria specified in the 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) and the statutory requirements at section 1852(a) of the Social Security Act and 42 C.F.R 422.100. These standards for coverage criteria are meant to ensure that basic benefits coverage for MA enrollees is no more restrictive than Traditional Medicare.

John Doe was a XX-year-old lady/gentleman with a medical history as outlined above.

John Doe presented to the hospital Emergency Department/Emergency Department via ambulance/as a direct admit on mm/dd/yyyy at 00:00 AM/PM after experiencing (describe acute symptoms). Continue describing the patient’s presenting signs and symptoms, abnormal findings on physical exam, abnormal test results, treatments started in the ED and the outcome of those treatments, and any failure of outpatient treatment. Include the ED physician’s presumed or admitting diagnoses, if documented). John Doe was admitted as an inpatient/initially placed in observation on mm/dd/yyyy at 00:00 AM/PM. The status order is located at (name of document, page number).

Summarize the admitting physician’s history and physical and plan of care documentation that supports the need for hospital care. Focus on what is known at the time of the decision to admit. Cite all relevant abnormal findings and explain their significance. Include the relevant specialty and interdisciplinary consultations ordered along with their findings. Review the discharge summary and summarize any major events that occurred during the hospitalization.

Establish in the summary how the clinical evidence supports the need for hospital care that is expected to span at least two midnights.

**Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A, 10 - Covered Inpatient Hospital Services Covered Under Part A, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf**

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services (see §10.2 below). Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights 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 the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation. 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.

**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 Standards of Care**

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| **Source/Reference** | **List of Medicare severity diagnosis-related groups (MS-DRGs) geometric mean length of stay – FY 2023 final rule. As found on:** *https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/fy-2023-ipps-final-rule-home-page* |
| **Evidence Based Guideline/Practice Guideline Recommendation** | |  |  | | --- | --- | | **MS-DRG** | **Geometric Mean LOS** | | 438 | 4.7 | | 439 | 3.1 | | 440 | 2.4 | |
|  |  |
| **Source/Reference** | Ashraf, H., Colombo, J. P., Marcucci, V., Rhoton, J., & Olowoyo, O. (2021). A Clinical Overview of Acute and Chronic Pancreatitis: The Medical and Surgical Management. Cureus, 13(11), e19764. <https://doi.org/10.7759/cureus.19764>. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8684888/ |
| **Evidence Based Guideline/Practice Guideline Recommendation** | There are multiple etiologies responsible for AP, with the two most common being gallstones, which account for up to 40% of cases, and alcohol, which is responsible for approximately 30% of cases.  The diagnosis can be made if at least two of the following criteria are met: abdominal pain consistent with the disease process, serum amylase and/or lipase greater than three times the upper limit of normal, and characteristic findings on CECT.  Serum pancreatic enzyme levels peak on the first day and normalize around three to seven days, although lipase has greater sensitivity and specificity than amylase both early and later in the disease course.  The initial risk assessment should include the factors that have a high predictability of a severe course. These factors include age greater than 60 years, comorbid health problems, BMI greater than 30, chronic alcohol use, presence of systemic inflammatory response syndrome (SIRS), laboratory markers of hypovolemia (e.g., elevated BUN and hematocrit), and pleural effusions and/or infiltrates on chest X-ray.  Initial management of patients presenting with AP focuses primarily on the acute symptoms. All patients with pancreatitis are initially treated with aggressive fluid resuscitation, pain control, and temporary discontinuation of oral feeds.  Initially, patients are made nothing per mouth (NPO) in the early stages of pancreatitis to allow the pancreas to recover. Subsequently, patients are recommended to be placed on an oral low-fat soft diet to promote faster recovery and decrease the risk of infection. Severe pancreatitis, which includes any form of organ failure such as acute kidney injury, signs of an inflammatory response, and altered mental status, requires more aggressive ICU management. Antibiotics are typically used in patients suspected of having abscesses, necrosis, or extrapancreatic indications.  Patients with AP secondary to gallstone impaction in the sphincter of Oddi are potential candidates for ERCP, a procedure done by advancing an endoscope into the second part of the duodenum and progressing it through the ampulla of Vater and pancreatobiliary tract.  ERCP has limited value in patients with mild suspected biliary pancreatitis who show signs of clinical improvement, henceforth, MRCP and endoscopic ultrasound (EUS) are better choices for diagnostic purposes.  Open surgical necrosectomy, which was originally the treatment of choice for managing pancreatic necrosis, has increasingly been replaced by minimally invasive modalities including endoscopic drainage and percutaneous catheter drainage.  A pancreatic pseudocyst can be defined as a non-necrotic encapsulated fluid collection confined within a well-defined inflammatory wall. Approximately 5% to 15% of episodes of pancreatitis are complicated by the development of pseudocysts. |
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**Conclusion**

Aetna’s denial of this claim violated the law. Memorial Hospital will fully exercise its rights under law and contract, including reporting Aetna to the State’s department of insurance, the Centers for Medicare and Medicaid Services, or the Employee Benefits Security Administration; and pursuing any other process or recourse available. Aetna must authorize and pay this claim in accordance with the law to avoid such action.

provided medically necessary services to John Doe with the expectation that those services would be reimbursed according to the documentation in all payer communications. Aetna must reconsider this claim and submit payment to for the services provided to John Doe in this case (including any monies due under the State’s prompt payment laws).

Please contact me should you have any questions.

Respectfully,

**Regulatory Arguments**

1) Limitation on Liability

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. d 1395pp] to allow payment for such claims.

Additionally, reimbursement to 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.

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. 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. The Code of Federal Regulations 42 C.F.R. 411.406 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

was certified for admission at 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 (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).

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. 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 671; 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).

The physician certified that Doe met all admission and continuing treatment criteria under the Medicare guidelines. The only medical opinion in the record determines that treatment rendered was medically necessary and reasonable. This medical opinion should be given controlling weight. There is no evidence that did not require two midnights of hospital care as ordered and provided.