Please return all correspondence to:

Memorial Medical Center
8600 LaSalle Rd. Suite 625
Towson, MD, 21286

NPI: XXXXXXXXXX
Tax ID: XX-XXXXXXX
PTAN: XXXXXX

May 19, 2019

Payer Health Care
Attn: Provider Appeals Unit
P.O. Box 497
Toledo, OH 43697-0497

Dear Reviewer:

This is a request for payment in full on John Doe's denied claim for inpatient services at Memorial Medical Center. The following is a summary of the denial from Payer Health Care, 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 HIC Number	XXXXXXXXX
Claim Dates of Service	01/28/2019 - 01/31/2019
Reason(s) for Denial	Allegation: Services provided not reasonable or medically necessary
Principal Diagnosis	Hemoptysis
Comorbidities/Complicating Factors	Severe protein-calorie malnutrition Hypo-osmolality and hyponatremia Centrilobular emphysema Chronic obstructive pulmonary disease Alcohol dependence Iron deficiency anemia Localized swelling, mass and lump, trunk Essential (primary) hypertension Other specified abnormal findings of blood chemistry Nicotine dependence, cigarettes Chronic idiopathic constipation Kyphosis, thoracic region Segmental and somatic dysfunction of thoracic region
Procedures	PEP therapy

	Flutter valve treatment Med nebulizer treatments Continuous pulse oximetry Cardiac monitor CIWA scale Seizure precautions CT scan chest Pulmonary consult Social Service consult
Social Factors	Malnourished (BMI 17.63) Alcohol dependence (6 pack day) Nicotine dependence (2 packs day/45 years)

Justification for Appeal

John Doe was a 60 year-old single gentleman with a complex and significant medical history as outlined above and a family history of heart disease (mother) and kidney disease (mother).

John Doe presented to the hospital Emergency Department after experiencing two days of **massive hemoptysis; coughing up blood with bright, large blood clots**. Upon assessment, he appeared **anxious**, **tachycardic (heart rate 107)**, and **hypertensive (BP 170/99).** He had **decreased breath sounds bilaterally**, and was **actively coughing up blood throughout the examination** (ED Provider Notes, p.5, p.8, p.12; ED Triage Notes, p.24; Discharge Summary, p.67; Flowsheets, p.146). Of note, his **oxygen saturation decreased to 89%** (Flowsheets, p.152).

CT of the chest showed advanced COPD-bullous emphysematous pattern particularly in the upper lobes and irregular soft tissue density or consolidation within the right upper lobe (Radiology, p.115). His lab work was quite abnormal. Most notably, he was anemic with a h**emoglobin of 11.9 (L)** [13.1-17.6] and a r**ed blood cell count of 4.10 (L)** [4.30-5.86]. His **iron level was low at 60 (L)** [65-175]. Blood loss is a common cause of anemia. His **platelets were elevated (H) at 441** [154-393], as was his **D-dimer at 324 (H)** [0-241] both indicating increased risk of blood clotting. His **c-reactive protein was elevated (H) at 9.99** [<3.00] [Lab results, p.100-108], a marker of inflammation.

Mr. Doe was admitted with **hemoptysis with the concern for underlying malignancy with thrombocytosis and hyponatremia** (History and Physical, p.34-35). A pulmonary consult was obtained to further evaluate the cause of hemoptysis. A bronchoscopy was planned, however his hemoptysis resolved. Therefore, Pulmonary recommended an outpatient PET scan be performed to determine if CT FNA (fine needle aspiration) or bronchoscopy would be a more favorable approach to any PET avid lesion (Progress Notes, p.44). A malnutrition assessment revealed **severe malnutrition, 3rd degree** (Progress Notes, p.62).

Mr. Doe was promptly started on **IV fluid infusion** for hydration, **IV antibiotics (Zosyn IV every 8 hours)** preventatively, **Nicoderm patch** to prevent nicotine withdrawal, **med nebulizer treatments (every 4 hours)** to decrease COPD symptoms, **PEP therapy (every 4 hours)** to

keep airways open, **flutter valve treatments (every 4 hours)** to improve mucous clearance, **cardiac monitor** to assess for abnormal arrhythmias, **continuous pulse oximetry** to monitor oxygen saturation (advanced COPD), **CIWA (clinical institute withdrawal assessment) with vital signs every 4 hours** to monitor for possible withdrawal and **seizure precautions** preventatively due to possibility of withdrawal (Orders, p.74, p.80, p.84-85, p.93; Meds & Administration, p.119-120, p.122).

Mr. Doe slowly improved and was able to safely be discharged after 3 days of aggressive inpatient management. The hemoptysis resolved and his hemoglobin was stable (11.7). He was instructed to follow-up with pulmonary for an outpatient PET scan to further evaluate the cause of the hemoptysis and the abnormal CT scan of the chest (mass or abscess in the apex of the lung). Prior to discharge, Social Services met with Mr. Doe and noted he had overall poor understanding of his illness/disease and noncompliance issues. Mr. Doe was discharged home with instructions to take Augmentin for 10 days (Progress Notes, p.47; Discharge Summary, p.65-67; Care Plan Notes, p.131).

In summary, Ms. Doe presented with **active hemoptysis with large clots requiring intensive care monitoring and IV antibiotics.** Further workup would be required due to possible mass versus abscess in the apex of the lung**. He required aggressive inpatient treatment for approximately 73 hours that could not have been safely done at home or on an outpatient basi**s. Inpatient care was clearly required for this unfortunate gentleman. Memorial Medical Center is requesting payment at an inpatient level of care as originally billed.

Let's now examine the reason given for the denial, "*service required authorization, missing treatment authorization".* At the time of admission, Mr. Doe was listed as traditional Medicaid. When the claim was submitted to Medicaid, it denied. Coverage through Payer Health Care was added after discharge; however, the claim denied stating "service required authorization". Please review the above information for approval of inpatient services.

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 indicates this patient was at high risk for adverse events and/or poor outcomes.

Justification of Treatment and Setting by Evidence Based Guidelines

Source/Reference	**List of Medicare severity diagnosis-related groups (MS-DRGs) arithmetic mean length of stay – FY 2016 final rule. As found on:** *https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2016-IPPS-Final-Rule-Home-Page-Items/FY2016-IPPS-Final-Rule-Tables.html*

<table>
<tr><td>Evidence Based Guideline/Practice Guideline Recommendation</td><td><table><tr><th>DRG</th><th>Arithmetic Mean LOS</th></tr><tr><td>204 RESPIRATORY SIGNS AND SYMPTOMS</td><td>2.8</td></tr></table></td></tr>
<tr><td></td><td></td></tr>
<tr><td>Source/Reference</td><td>Earwood, J. S., Thompson, T. D. (2015). Hemoptysis: Evaluation and Management. American Family Physician, Volume 91, Number 4, 243-249. As found on: http://www.aafp.org/afp/2015/0215/p243.pdf</td></tr>
<tr><td>Evidence Based Guideline/Practice Guideline Recommendation</td><td>“Indications for Admission to the Intensive Care Unit or Referral to Specialty Center in Patients with Hemoptysis:
Etiology with high risk of bleeding (e.g., aspergillosis, lesions with pulmonary artery involvement)
Gas-exchange abnormalities (respiratory rate > 30 breaths per minute, oxygen saturation < 88% in room air, or need for high-flow oxygen [> 8 L per minute] or mechanical ventilation)
Hemodynamic instability (hemoglobin < 8 g per dL [80 g per L] or a decrease of more than 2 g per dL [20 g per L] from baseline, consumptive coagulopathy, or hypotension requiring fluid bolus or vasopressors)
<u>Massive hemoptysis</u> (> 200 mL per 48 hours or > 50 mL per episode in <u>patients with chronic pulmonary disease</u>)
<u>Respiratory comorbidities</u> (e.g., previous pneumonectomy, <u>chronic obstructive pulmonary disease</u>, cystic fibrosis)
Other comorbidities (e.g., ischemic heart disease, need for anticoagulation)” [p. 246]</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Source/Reference</td><td>Halpin, D. (2008). Mortality in COPD: Inevitable or Preventable? Insights from the Cardiovascular Arena. COPD, 5(3), 187–200. doi:10.1080/15412550802093041. As found on: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442901/</td></tr>
<tr><td>Evidence Based Guideline/Practice Guideline Recommendation</td><td>“COPD frequently coexists with other chronic conditions and the presence of these co-morbidities adversely affects outcome.” [p. 187]
“COPD death rates increase with age, and are higher in males than in females (35).” [p. 188]
“Severe exacerbations of COPD have been shown to be associated with a worse prognosis, and mortality increases with the frequency of exacerbations” [p. 190]
“Exacerbations of COPD severe enough to require hospitalization have a significantly greater effect on mortality...” [p. 190]</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Source/Reference</td><td>Hillas, G., Perlikos, F., Tsiligianni, I., & Tzanakis, N. (2015). Managing comorbidities in COPD. International Journal of Chronic Obstructive Pulmonary Disease, 10, 95–109.</td></tr>
</table>

	http://doi.org/10.2147/COPD.S54473
Evidence Based Guideline/Practice Guideline Recommendation	• "**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." [p. 96] • "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…" [p. 96] • "The presence of COPD-asthma overlap syndrome is associated with impaired quality of life and more frequent and severe exacerbations compared with COPD only patients." [p. 97] • "Congestive heart failure is among the leading causes of hospitalization and death for patients with COPD and worsens their prognosis." [p. 98] • "The presence and severity of COPD are associated with increased risk for atrial fibrillation/atrial flutter and non-sustained ventricular tachycardia." [p. 98] • "Hospitalization mortality in severe COPD patients with arrhythmia has been reported to be as high as 31%..." [p. 98] • "The presence and severity of COPD are associated with increased risk for atrial fibrillation/atrial flutter and non-sustained ventricular tachycardia." [p. 98] • "Hospitalization mortality in severe COPD patients with arrhythmia has been reported to be as high as 31%..." [p. 98] • "Venous thromboembolism prolongs hospitalization by 4.4 days and increases one-year mortality by 30%. If not diagnosed and treated adequately, the risk of death during hospitalization for exacerbations is increased by 25%. COPD not only shares certain common risk factors with venous thromboembolism, like smoking, but also systemic inflammation due to COPD induces pulmonary and systemic endothelial dysfunction and coagulopathy." [p. 99] • "Diabetes worsens the outcomes of COPD by affecting a number of parameters: shortening time to first hospitalization and increasing hospitalization time and risk of death during exacerbations, increasing Medical Research Council dyspnea scores, and reducing six-minute walking distance. Diabetes worsens 5-year mortality in COPD patients." [p. 99] • **The combination of COPD and obstructive sleep apnea syndrome (OSAS) leads to an increased risk of death** due to more frequent exacerbations and an increased risk for development of cardiovascular comorbidities like pulmonary hypertension and right heart failure. [p. 100]

	• "Studies show that up to 94% of COPD patients have at least one comorbid disease and up to 46% have three or more." [p. 102]
Source/Reference	**Berggren, U., et al. (2009). Thrombocytopenia in Early Alcohol Withdrawal is Associated with Development of Delirium Tremens or Seizures. Alcohol & Alcoholism, 44(4), 382–386. doi:10.1093/alcalc/agp012. As found on: https://academic.oup.com/alcalc/articlelookup/doi/10.1093/alcalc/agp012**
Evidence Based Guideline/Practice Guideline Recommendation	• "DT (delirium tremens) has been estimated to occur in∼5–20% of the individuals who undergo treatment for alcohol withdrawal…" [p. 382] • "DT is a severe manifestation of the AWS and the mortality rate may be in the range of 5–15% and historically it has even been reported to be as high as 20%." [p. 382] • "**Alcohol-related seizures generally occur 6–48 h after the end of alcohol consumption** and frequently in the absence of other signs of the AWS" [p. 382] • "**Alcohol-related seizures are in >50% of the individuals** associated with concurrent risk factors such as epilepsy, structural • brain lesions related to stroke or trauma, and use of other drugs." [p. 382] • "…the development of alcohol-related seizures is associated with ∼4-fold increase in the mortality rate." [p. 382] • **Risk factors/predictors for the development of a severe AWS** include: o History of previous DTs and/or withdrawal seizures o **Concurrent medical illness** or infectious diseases o Elevated pulse rate ≥100 bpm o Elevated systolic blood pressure of ≥145 o CIWA scores of >15 points o **Low serum potassium levels (hypokalemia)** o Elevated liver enzymes (ALT, AST and GGT) o Elevated carbohydrate-deficient transferrin (CDT) and o mean corpuscular volume (MCV) o Low blood platelet count [pp, 382-383] • "The study sample comprised 334 patients, 57 females (17%) and 277 males (83%), admitted to the alcohol treatment unit of the university hospital during the years 1997–1998." In this study, "among those who developed DT during their treatment period, a **significantly higher proportion had thrombocytopenia** (<150 × 109/L, according to the lower reference limit of the laboratory) in comparison to those who did not developed DT." [p. 384] • "Those who developed seizures during their treatment period had significantly lower blood platelet count and a higher proportion of

	these patients had thrombocytopenia in comparison to those who did not develop seizures (75% versus 25%).” [p. 384]

Conclusion

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

Denise R. Wilson

Denise Wilson MS, RN, RRT

Submitted with the authority of the Provider,

Please return all correspondence to:

Memorial Medical Center
8600 LaSalle Rd. Suite 625
Towson, MD, 21286
Fax (443) 955-6983

NPI: XXXXXXXXXX
Tax ID: XX-XXXXXXX
PTAN: XXXXXX