Successfully Appealing High Dollar Denials Involving NCDs and LCDs

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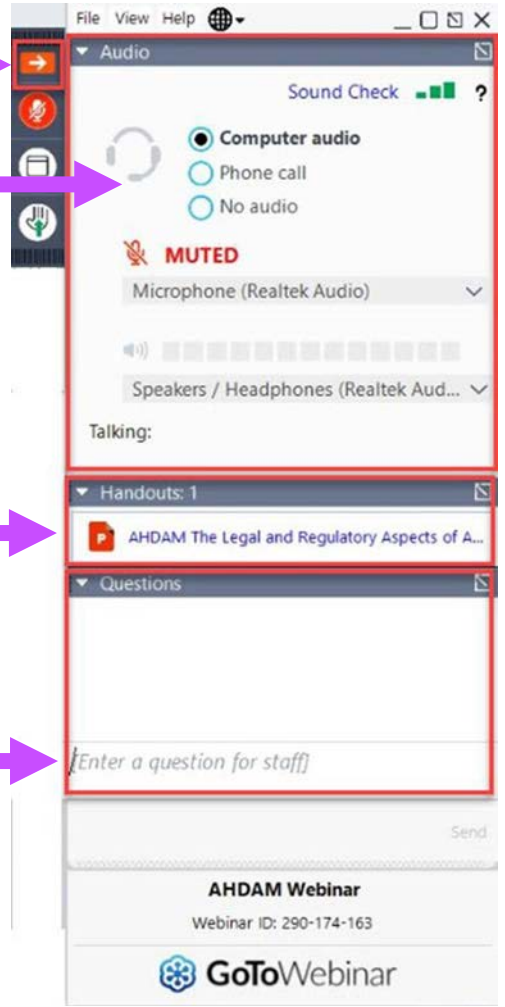

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Host and Presenter

Denise Wilson MS, RN, RRT, Senior Vice President, PayerWatch/AppealMasters, President, AHDAM

Denise has over thirty years of experience in healthcare, including clinical management, education, compliance, and appeal writing.

Denise has extensive experience as a Medical Appeals Expert and has personally managed hundreds of Medicare, Managed Medicare, and Commercial appeal cases and presented hundreds of cases at the Administrative Law Judge level. Denise is a nationally known speaker and dynamic educator on Medicare and Commercial appeals processes, payer behaviors, standards of care, appeal template development, and building a road map to drive the payer to a decision in the provider's favor. She has educated thousands of healthcare professionals around the country in successfully overturning healthcare denials.

Presenter

Karla Hiravi, RN, BSN
Vice President | PayerWatch - AppealMasters

Karla is a registered nurse and holds a BSN from the University of Pittsburgh, Johnstown. She has over thirty years of experience in healthcare, including Clinical Documentation Improvement (CDI), management of a CDI department, development of a hospital-based denial and appeal program, development of an oncology research program, nurse and physician education, appeal writing, presentations at the Administrative Law Judge (ALJ) level, and direct management of appeals at every level, up to post ALJ appeals.

She was a frequent guest speaker at the University of Pittsburgh, Johnstown for many years, and served as a preceptor for nurse practitioner and Pharm D. students while they studied medical research. Karla continues to participate in and educate clinicians and coders about the medical appeal process.

Presenter

Kendall Smith, MD
Chief Physician Advisor | PayerWatch - AppealMasters

Dr. Kendall Smith is a Senior Fellow in Hospital Medicine (SFHM) and currently acts as Chief Physician Advisor for PayerWatch - AppealMasters, a leading appeal educator and appeal services firm for hospitals and health systems. He's been deeply involved in denial and appeals management throughout his hospitalist career. He has served as a physician leader on hospital revenue cycle management teams while also serving as the Physician Advisor for Clinical Resource Management. Dr. Smith is also an AHIMA ICD-CM/PCS approved trainer/ambassador.

Learning Objectives

At the conclusion of the webinar, the learner will be able to:

Self-report they can list 2 procedures covered by an NCD or LCD and identify where the associated documentation requirements can be found.

Attendees should be able to identify:

- Where to locate national and local coverage determinations
- The diagnoses and documentation requirements within an NCD or an LCD
- A successful strategy to help providers follow NCD or LCD guidelines for documenting the medical necessity of the procedure or service

NCDs and LCDs – What are they?

- These acronyms represent policies that are published by CMS and the Medicare Administrative Contractors (MACs) to manage the cost and utilization of healthcare services by their subscriber members.
- NCDs – National Coverage Determinations
- LCDs – Local Coverage Determinations

National Coverage Determinations - NCDs

- NCDs are written and published by the Centers for Medicare and Medicaid Services (CMS).
- NCDs apply only to traditional (Fee for Services, or FFS) Medicare and managed Medicare claims.
- NCDs apply to all Medicare and managed Medicare claims in the Unites States and its territories regardless of where in the US the services were provided, or which Medicare Administrative Contractor (MAC) has jurisdiction over the area.

Local Coverage Determinations - LCDs

- LCDs are similar to NCDs except they are written and published by the MACs.
- LCDs apply only to traditional (Fee for Services, or FFS) Medicare and managed Medicare claims.
- LCDs apply to Medicare and managed Medicare claims in the MAC jurisdiction where the LCD was published.
- LCDs typically address coverage of diagnostic or therapeutic procedures or services (such as home health visits).

NCDs and LCDs – What services are involved?

- NCDs and LCDs typically address coverage of diagnostic or therapeutic procedures or services (such as home health visits).
- NCDs and LCDs are especially focused on procedures and services that are high-cost, of questionable diagnostic or therapeutic value, or could be prone to fraudulent billing.
  - High cost: Implantable Cardiac Defibrillator
  - Questionable value: Acupuncture
  - Prone to fraudulent billing: Motorized wheelchairs

Local Coverage Determinations - LCDs

- LCDs typically cover procedures and services for which no NCD already exists.
- LCDs are not allowed to conflict with a respective NCD or other Medicare policy*.

*Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations13.5.1 - General Requirements *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf*

NCDs and LCDs – Where are they posted?

- CMS MCD = Medicare Coverage Database
- Where all NCDs and LCDs are stored
- Search by keyword, code, state, MAC

https://www.cms.gov/medicare-coverage-database/search.aspx

CASE STUDY 1 - OVERTURNED

From the RAC:
The documentation does not include congestive heart failure classification.
The record includes echocardiographic reports dated August 5, 20xx, and April 2, 20xx, which include a LVEF. However, the documentation provided does not include a LVEF dated after April 3, 20xx. Furthermore, the preoperative anesthesia note indicates the beneficiary had a LVEF of 50 percent that was measured by stress test; however, this test was not included in the documentation provided.

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70-year-old gentleman with **previous insertion** of a CRT-D (Cardiac Resynchronization Therapy-Defibrillator)

- Developed malfunction of the atrial lead.
- Received a generator change with atrial lead revision and pocket revision.

CASE STUDY 1

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Rule #1

Never, EVER believe the payer's rationale for denial is correct
…no matter how convincing the argument sounds on its face.

Rule #2

Understand the payer's rationale for denial prior to looking at the medical record.

As you go through the medical record, it will be easier to spot documentation/results to directly refute any erroneous claims by the payer.

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CASE STUDY 1

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One way to refute the auditor's claims:

- **Reviewer**: "The documentation does not include congestive heart failure classification."
- **Hospital Response**: Neither LCD 39080 nor NCD 20.4 requires classification of CHF for patients receiving a **replacement** CRT-D.

- **Reviewer:** "…the documentation provided does not include a LVEF dated after April 3, 20xx."
- **Hospital Response**: Neither LCD 39080 nor NCD 20.4 requires LVEF from specific time frames. As long as the LVEF is documented, that is sufficient.

- **Reviewer:** "…this test (stress test) was not included in the documentation provided."
- **Hospital Response**: Neither LCD 39080 nor NCD 20.4 requires specific tests to be included – only documentation of the results.

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CASE STUDY 1

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Per NCD 20.4:
Patients with an existing ICD may receive an ICD replacement if it is required due to the end of battery life, Elective Replacement Indicator (ERI), **or device/lead malfunction.**
1.Patients must be clinically stable (e.g., not in shock, from any etiology);

- Hospital Response: **Criteria MET:**
  - ✓ **The procedure was elective and there is no evidence the patient was not stable** prior to the procedure (H&P, p. 23).

2. LVEF must be measured by echocardiography, radionuclide (nuclear medicine) imaging, cardiac Magnetic Resonance Imaging (MRI), or catheter angiography;

- Hospital Response: **Criteria MET:**
  - ✓ **The LVEF was documented to be 50% per a stress test** (Pre-anesthesia evaluation, p. 69)
  - ✓ Historical results of LVEF were found to be **30 – 35% and about 40%** (H&P, p. 2; Consult, p. 15)

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CASE STUDY 1

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<u>Per NCD 20.4</u>: (continued)

3. Patients must not have:
   - Significant, irreversible brain damage; or,
   - Any disease, other than cardiac disease (e.g., cancer, renal failure, liver failure) associated with a likelihood of survival less than one (1) year; or,
   - Supraventricular tachycardia such as atrial fibrillation with a poorly controlled ventricular rate.

➢ Hospital Response: **Criteria MET:**

✓ **There is no evidence in the medical record that Mr. Doe suffered from any of the conditions listed above.**

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Case Study 1: ALJ Decision

The documentation shows the Beneficiary was clinically stable enough to undergo CRT-D revision; he did not have any other illnesses that would result in a life expectancy of 1 year or less; he did not have irreversible brain damage; and he did not have supraventricular tachycardia. The documentation contains two echocardiographies showing the Beneficiary's LVEF to be 30-35% or about 40%; and he needed RA lead revision and ERI generator change. NCD 20.4 does not mention when an LVEF needs to be done. I find the documentation contains two echocardiographies with documentation showing the Beneficiary's LVEF was 30-35% or 40% (FOF 1-7). Based on the foregoing, I find the inpatient hospital admission for CRT device generator replacement and new right atrial lead implantation was reasonable and necessary and meets Medicare coverage criteria under Medicare Part A (§ § 1812(a)(1) and 1862(a)(1) of the Act; NCD 20.4; and MPIM, Ch. 6, §6.5.2A).

CASE STUDY 2

79 year old lady
Recent history included:
Acute on chronic systolic CHF
Worsening known ischemic cardiomyopathy
Admitted with chest pain, developed bradycardia (thought due to med interactions) into 20's
CPR performed, patient resuscitated and transferred to another facility.
EF 30 – 35%
Elevated troponins thought to be due to AKI and decompensated heart failure, NYHA class "unknown"
Underwent CRT-D implantation

2 days later had a PCI with DES for a NSTEMI.

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The entire medical stay, including the CRT-D, was denied.

LCD not met:

CRT will be considered medically necessary when the following criteria for a given beneficiary are met:

- LVEF ≤ 35%, with ischemic or non-ischemic cardiomyopathy, on maximally tolerated guideline-directed medical therapy (GDMT) for at least 3 months and with no reversible causes; *and*
  - QRS ≥ 150 ms; and
  - Any type bundle branch block with evidence of dyssynchrony; and
  - NYHA class III or ambulatory IV HF

NCD not met:

- Same as above plus:

For these patients identified in B4, **a formal shared decision-making encounter must occur** between the patient and a physician (as defined in Section 1861(r)(1) of the Act) or qualified non-physician practitioner (meaning a physician assistant, nurse practitioner, or clinical nurse specialist as defined in §1861(aa)(5) of the Act) **using an evidence-based decision tool on ICDs prior to initial ICD implantation. The shared decision-making encounter may occur at a separate visit.**

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- An appeal was done to the best of our ability, per client wishes, while remaining truthful.
- The decision letter noted they could not approve the CRT-D, but would pay for a new DRG for the inpatient admission with the PCI/stent.
- The client accepted payment for the new DRG.

Take aways:

- We have to do what is right for the individual patient
- Might have been a good case for the 30-day discussion period with a peer-to-peer discussion
- There is a difference between a formal shared d**ecision-making encounter** and an **evidence-based decision-making TOOL on ICDs**
  - **You need BOTH**
  - **Educate, educate, educate**

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CASE STUDY 3- OVERTURNED

Insufficient documentation to support procedure code. 02RF38Z (replacement of aortic valve with zooplastic tissue, percutaneous approach) is removed from the coding sequence.

The DRG is changed from billed DRG 267 to DRG 307.

Per cert medical director, submitted record does not support billed procedure.

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Justification for Appeal

Jane Doe was a 90-year-old lady with known aortic stenosis that progressed to symptomatic severe aortic stenosis. Aortic valve replacement was recommended. (H&P, p.264)

The risks and benefits of both TAVR and SAVR were explained to Ms. Doe and family by the cardiologist, Dr. ABC. A consult letter from Dr. XYZ, cardiac and thoracic surgeon, noted having seen Ms. Doe in consultation. (Office Visit, p.405; consult letter, p.406)

The Edwards 20 mm heart valve system was placed without complications. Aspirin/Plavix six hours postoperatively and antibiotics for 24 hours were administered. Ms. Doe had an echocardiogram on 9/25 with negative aortic regurgitation and negative pericardial effusion. Upon discharge, she would follow-up with her cardiac surgeon. (Operative Note, p. 307; Discharge Note, p. 360)

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Case Study 3

NCD Requirement	**The procedure is furnished with a complete aortic valve and implantation system that has received FDA premarket approval (PMA) for that system's FDA approved indication.**
Medical Record Documentation	***Edwards 20 mm heart valve system (pgs. 9, 15, 307)*** ***Commercial Implant NCT 01737528, IDE N/A (pg. 364)***
NCD Requirement	**The patient (preoperatively and postoperatively) is under the care of a heart team: a cohesive, multi-disciplinary, team of medical professionals. The heart team concept embodies collaboration and dedication across medical specialties to offer optimal patient-centered care.** **The heart team includes the following:** **Cardiac surgeon and an interventional cardiologist experienced in the care and treatment of aortic stenosis who have:** • **independently examined the patient face-to-face, evaluated the patient's suitability for surgical aortic valve replacement (SAVR), TAVR or medical or palliative therapy;** • **documented and made available to the other heart team members the rationale for their clinical judgment.** **Providers from other physician groups as well as advanced patient practitioners, nurses, research personnel and administrators.**
Medical Record Documentation	***Office Visits (pgs. 400-410); H&P (ps. 264-274); Pre-anesthesia evaluation (pg. 302); Perioperative Services Flow Sheet (pgs. 27-33); Operation Summary (pgs. 9-10); Structural Heart Team Note (pgs. 320-326)***

Case Study 3

NCD Requirement	**The heart team's interventional cardiologist(s) and cardiac surgeon(s) must jointly participate in the intra-operative technical aspects of TAVR**
Medical Record Documentation	***Operation Summary (pgs. 9-10): Dr. ABC, MD-Cardiothoracic surgeon; Dr. XYZ, MD-Cardiologist, Interventional; Dr. LMN, MD-Cardiologist***
NCD Requirement	**TAVR must be furnished in a hospital with the appropriate infrastructure that includes but is not limited to:** **On-site heart valve surgery and interventional cardiology programs,** **Post-procedure intensive care facility with personnel experienced in managing patients who have undergone open-heart valve procedures**
Medical Record Documentation	***PACU note (pg. 309); Valve Clinic (pg. 407);Structural Heart Team Note (pgs. 320-326); Operation Summary (pgs. 9-10)***

Compliance Strategies

- **Stay up-to-date on NCD/LCD guidelines:** Healthcare providers should regularly review the NCD and LCD guidelines to stay current with any changes and ensure that they are providing services and procedures that meet the guidelines' requirements.
- **Document all relevant information**: Providers should document all relevant information related to the medical necessity of a procedure or service, including the patient's medical history, clinical findings, and any other factors that support the necessity of the procedure or service.

Compliance Strategies

- **Use standardized templates and forms:** Providers can use standardized templates and forms to document the medical necessity of procedures or services, as these can help ensure that all required information is captured and documented correctly.
- **Use coding accurately**: Providers should ensure that they are coding procedures and services accurately to reflect the medical necessity and ensure compliance with NCD/LCD guidelines.

Compliance Strategies

- **Conduct regular internal audits**: Providers can conduct regular internal audits to ensure that their documentation practices are compliant with NCD/LCD guidelines and identify any areas where they may need to improve.

TAKE AWAYS

- Never, ever believe the payer's conclusion was correct until you investigate.
- Look at the sources used by the payer – if they are not correct, point it out and use the correct ones to appeal.
- Try to disprove every denial reason.
- There is a difference between a formal shared d**ecision-making encounter** and an **evidence-based decision-making TOOL on ICDs.**
  - **You need BOTH.**
- Use the discussion period to your advantage.
- Educate providers if there are gaps in their documentation/processes.
- Stay up-to-date on NCD/LCD guidelines
- Use standardized templates and forms.
- Ensure coding accuracy.
- Conduct regular internal audits.

References

- Medicare Program Integrity Manual, Chapter 13 – Local Coverage Determinations13.5.1 - General Requirements *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf*
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Thank you for attending!

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