The Letter Brief

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73. You can always submit a Medicare document. What is a “Medicare document”?
74. What are “non-Medicare documents” and when should they be submitted?
75. What are the Medicare Internet-Only Manuals?
76. Which of the Medicare Internet-Only Manuals explain the rules regarding LCDs?
77. Can you use the Medicare Program Integrity Manual (MPIM) on LCDs to your advantage?
78. What is the strongest evidence for LCD policies and how will you use this?
79. What is the second strongest evidence for LCD policies?
80. What is the third strongest evidence for LCD policies?
81. What is the most common substantive reason used by Medicare to deny payment?
82. What does the phrase “not medically reasonable and necessary” mean?
83. Where does the phrase “medically reasonable and necessary” come from?
84. Is there a list of requirements for “medically reasonable and necessary”?
85. What “documents” should you have in front of you before you start writing?
86. If you know a service will be denied, what statement should you incorporate in the progress note?
87. What should you send with the CMS-20033 reconsideration appeal request form?
88. How should you organize the letter brief?
89. Where do you find the address for the QIC you are sending your letter brief to?
90. How should you format the letter portion of the letter brief?
91. How should you organize the first page of the letter brief?
92. How many claims can you appeal in a single letter brief?
93. How should you organize hundreds of codes in a single letter brief?
94. How does the number of codes being appealed affect the number of pages in a letter brief?
95. What kind of “demographic” table do you need, and where should it be placed?
96. Do you have to send copies of cited “Medicare” documents as attachments?
97. Do you have to send copies of the “non-Medicare documents” as attachments to the letter brief (to the QIC)?
98. How do you organize the documents that share a single attachment number?
99. How do you identify the attachment number and page numbers of the attachments?
100. How can you send a diagram and a simple explanation of the patient’s problem?
101. Can you send your digital images of the patient to the QIC in an email?
102. What determines the number of attachments you will send with the letter brief?
103. What should be the order of the documents you attach to your letter brief?
104. How should you arrange the “patient care documents” attached to the letter brief?
105. How should you arrange “journal articles” attached to the letter brief?
106. How should you arrange “textbook sections” attached to the letter brief?
107. How should you arrange standard-of-care statements attached to the letter brief?
108. What should you do if the LCD did not allow the service?
109. How should you number the pages in your letter brief?
110. Must you prove you sent a copy of the request for the ALJ appeal to each patient?
111. Must you prove each patient received a copy of your request for an ALJ appeal?
112. Do you have to send a copy of the letter brief to each of the patients?
113. What is the least expensive way to prove you sent a copy of the ALJ appeal request to each patient?
114. How do you avoid HIPAA violations when using the OMHA-100A form?
115. How should you fill out Section 7 on the OMHA-100 form?
116. What is the best way to describe the problem, what you did, and why it was correct?
117. What should you write when you did not meet some MAC requirements for a service?
118. What should you write when the service is prohibited in the contractor’s LCD?
119. What can you do when your contractor says “no” but another contractor says “yes”?
120. What should you do if an applicable, older LCD says “no” but the current LCD says “yes”?
121. What can you do when a claim is denied as “not medically reasonable and necessary”?
122. What must you prove when a claim is denied as “experimental/investigational”?
123. Will you be surprised when a claim is denied as “experimental or investigational”?
124. What can you do when a critical term such as “experimental or investigational” is not defined by Medicare?
125. Can you use the Anthem BC BS definition of “investigational”?
126. How would you use Anthem’s definition of “investigational”?
127. What do you tell the ALJ when the “vendor” assured you Medicare would pay?
128. What if the vendor actually signed a piece of paper assuring Medicare payment?
129. An example of a vendor’s magic show: the selling of platelet-rich plasma (PRP) for the repair of ruptured tendons around the ankle.
130. How should you decide whether to cite and include a document?
131. Should you rely on common sense when you are writing the letter brief?
132. What are the contractor’s strongest arguments against payment?
133. Where do you include the contractor’s arguments in your letter brief?
134. What do you do with a weakness in the contractor’s argument against payment?
135. What do you do with a weakness in your argument for payment?
136. What do you do with a questionable weakness in an argument?
137. You didn’t send a letter brief to the QIC. Can you send a letter brief to the ALJ?
138. If you send a letter brief to the ALJ, do you have to send copies to the patients?
139. Will the ALJ accept your letter brief under these facts?
140. Does your letter say what you want it to say and will the ALJ understand it?
141. What should you do if you can’t find support for the denied service?
142. Did you present your strongest evidence first?
143. Other than the QIC, who else do you have to send the letter brief to?
144. How much emotion should you include in your letter brief?
145. What should you do if the QIC raises new arguments in the reconsideration decision?
146. What if you forgot to include an important piece of evidence in the letter sent to the QIC?
147. Does any of this apply to you if your medical group does all your billing and appeals?
148. If you don’t want to write letter briefs and do ALJ hearings, what should you do?

In addition to the Code of Federal Regulations (CFR) sections, the following is based on my experience prosecuting thousands of denied Medicare codes for payment and litigating for a broad cross-section of providers in front of a diverse group of Administrative Law Judges (ALJs). While I did not write “in my experience” or “in my opinion” at the beginning of the answer to each of the following questions, you should assume one of those phrases applies.

1. **What is a letter brief?**
   For our purpose of appealing denied Medicare claims, we will define a “letter brief” as an informal legal brief written to convince the ALJ to order payment of your denied claim.
2. **What is the goal of a letter brief?**
The goal of the letter brief is to get you paid for the denied service. You need to write what the ALJ needs to read in order to award payment of the denied claim.

3. **What should the letter brief say?**
Reduced to its simplest form, the letter brief should explain what you did, why you did it, why that treatment was correct, and why the contractor’s denial reasons are wrong.

4. **What are the key questions you must answer in every letter brief?**
In the fewest number of pages possible, here are the questions you must answer in the letter brief for the judge to rule in your favor. The judge will not award payment if the judge does not know and understand the answers to these questions:

   a. **In lay terms, what kind of problem does the patient have?** The ALJ must have a basic understanding of the patient’s problem in order to rule in your favor.
   b. **Why did the problem require treatment?** Do not take this question for granted. You must convince the judge the patient’s problem needed to be treated.
   c. **What service/supply did you provide for the patient’s problem?** Keep it simple and state exactly why the denied service/supply was the best and most logical choice for the patient.
   d. **How do you know that treatment was the correct thing to do?** What medical authorities support what you did? Provide copies of those authorities as attachments to the letter brief.
   e. **Why is each denial reason offered by the contractor in the redetermination denial letter wrong?** No matter how silly the contractor’s reasons may be, you have to address and dismantle each denial reason.

Your letter to the QIC should be as brief as possible, but the letter must address all of the above questions. Most importantly, your letter must be in plain English and must be understandable to a layperson.

5. **Who is the target audience for the letter brief?**
The target audience for the letter brief is always the ALJ team. Each ALJ usually has two staff attorneys along with a paralegal and/or legal secretary assisting her. These people make up the “ALJ team.”

   One of the staff attorneys will review your documents before turning them over to the ALJ, and it is reasonable to think the ALJ will want to hear the staff attorney’s opinion regarding your letter brief.

   Everything you do during the appeals process should be done with the ALJ team in mind as your target audience.

6. **I will use the pronoun “her” when referring to the ALJ.**
It is too cumbersome to use the pronouns “him/her” when referring to an ALJ. I will just use the pronoun “her” with the understanding an ALJ may be a man or a woman. Currently, I think both sexes are equally represented in the group of federal Medicare ALJs.

7. **What documents will you attach to the letter?**
The documents attached (stapled) to the letter will include copies of patient photographs, patient care documents (progress notes, consultation letters, lab and imaging study reports, operative
reports, pathology reports, etc.), peer-reviewed journal articles, textbook sections, and standard-of-care statements published by authoritative professional organizations that represent your specialty/business.

8. **Should you attach every patient care document to the letter?**
No. Only attach the documents that will support payment of the denied claim. If a multicolored document in the patient’s chart is attractive but won’t help you get paid, don’t attach it to the letter.

You won’t help yourself by boring the judge or her staff attorney. Attach only those documents that will serve as bricks in your wall of evidence supporting payment of the denied claim.

9. **How does the letter brief help you get paid?**
The letter gives the ALJ an explanation of your arguments in favor of payment and an easy-to-follow road map through all of your evidence (the stapled attachments). As a result of the letter brief, the judge will be familiar with your evidence when the hearing starts, so you can use your actual hearing time to tell the patient’s “story.”

During the hearing, when the judge asks you a question about your treatment of the patient, you will answer the question and will tell the judge which patient care documents or policy statement attached to the letter brief support your answer.

You will need a list of the attachments IN LARGE BLOCK PRINT in front of you so you can find the patient care documents or policy statement very quickly.

10. **Whose point of view should you take as you write the letter brief?**
Take the point of view of the judge as you write the letter brief. As an ALJ, what would convince you to award payment? I think the answer is easy. You would want to be certain the denied treatment was medically reasonable and necessary, and you would want to know all of the contractor’s denial reasons were wrong or, for good reason, should not be applied to the claims at issue.

11. **Why are you sending the letter brief to the QIC instead of to the ALJ?**
You have to. In 2005, Medicare changed the rules regarding appeals of denied claims. The most important change was the new rule stating all evidence has to be submitted when the second-level (reconsideration) appeal is requested. See 42 CFR Section 405.966.

12. **Why does it make the most sense to submit the letter brief to the QIC?**
You already know the answer. The letter brief should be submitted when you submit your patient care documents. And your patient care documents must be submitted when you request the reconsideration appeal. Without the letter, there will be nothing to tie your patient care documents together so the reader can make sense of them.

13. **Will an overworked ALJ team organize and analyze unorganized documents?**
Without a letter that cites the attached documents, it is unlikely the overworked ALJ or her even more overworked attorney advisor will spend time they don’t have organizing and analyzing your documents.

The letter portion of your letter brief is the “treasure map” that enables the ALJ to follow your arguments—based on your organized patient care documents, articles, textbook sections, and standard-of-care documents that you are attaching as evidence.
14. **What can the letter brief do for you that you can’t do any other way?**
The letter brief allows you to speak to the judge without interruption or opposition and allows you to frame the payment dispute for her.

15. **Do ALJs issue favorable “on the record” decisions just based on letter briefs?**
Absolutely, yes! See 405.1000. A well-written letter may convince the judge to rule in your favor before the hearing even takes place. But even if your letter brief does not result in payment without a hearing, you can get the judge to walk into the hearing already biased in your favor and already primed to hear your story.

16. **Do ALJs issue favorable “on the record” decisions without letter briefs?**
Yes. Even without letter briefs, ALJs issue favorable “on the record” decisions. So, is it reasonable to think a well-written letter brief—that clearly explains the issues and convincingly argues the denied treatment was medically reasonable and necessary—will tip the scales in favor of an “on the record” decision? Of course it is.

17. **Why will the ALJ consider your letter brief to be a miracle?**
Most providers who send evidence to the QIC for the reconsideration appeal just copy the patient’s chart and send everything without organizing anything. And after the QIC denies the reconsideration appeal, the entire claim file is forwarded to the ALJ’s office when the ALJ appeal is requested.

Your letter brief will be nothing short of a miracle to the ALJ team—like a glass of water to a person wandering in the desert. Why? Because your letter brief will give the judge a clear view of your arguments with immediate access to all of the supporting documents attached as evidence.

18. **Make it easy for the ALJ and avoid ALJ denials based on ignorance.**
Whatever you can do to make the ALJ’s job easier, do it. Although many appeals are decided on issues that leave no room for argument, just as many appeals can be decided either way. If there is anything you can do that will help the judge understand the dispute and decide in your favor, you should do it.

On the flip side, when a judge does not understand the medicine and/or is unaware of the medical authorities supporting the provided treatment, she will likely rely on the denial rationale offered by the Medicare contractor and the QIC.

When you submit a short letter brief that clearly explains the medicine, details why you should be paid, and includes photographs and authoritative documents as attachments that support your arguments, the judge will not deny your appeal out of ignorance.

Make it easy for the judge to decide in your favor.

19. **The letter brief is one of two “loopholes” available in the appeals process.**
Other than the “proposed decision” you send along with the request for an ALJ appeal (see the chapter on ALJ appeals), the letter brief is the only other procedural “loophole” in the entire Medicare appeals process that works entirely in your favor. The letter brief lets you tell your story the way you want to tell it, without interruption or opposition.
20. Is it ever okay to not send a letter brief?
No. You work too hard to walk away from these denials. Even a one-page letter brief allows you to frame your arguments for the judge in a voice that is persuasive and in a light most favorable to your version of the dispute. Suck it up and get it done.

21. What is the ALJ’s response to no letter brief explaining why you should be paid?
You are asking the ALJ to go out on a limb and order payment after the contractor and the QIC have already said “no.” If you were the ALJ, would you go out on that limb for a provider who can’t be bothered to explain in a short letter why the claim should be paid? I don’t think I would.

22. Does your letter say what you want it to say?
Have someone with no medical education read your letter and then have that person tell you what the letter says. If that person gets it, the ALJ will get it. If that person does not understand what you have written, it is likely the ALJ will not understand what you have written either.

23. If you are a terrible writer, how can you convince the judge to award payment?
If you can write a progress note, you can write a letter brief to an ALJ. The ALJ doesn’t care if your style stinks. The ALJ just wants the answers to the five basic questions: what was wrong with the patient, why did the problem require treatment, what did you do for the patient, how do you know it was the correct thing to do, and why are the MAC denial reasons wrong? No matter how much or how little talent you have as a writer, you can do this by always following the same approach. This will eliminate your anxiety and will allow you to get the job done in the shortest period of time.

You have to be able to tell this story like you would tell it to a patient, with the goal of having the patient understand the story the very first time you tell it. Why? Because it is likely the judge will only read your letter brief once.

24. How academic should your letter brief be?
Do not provide the judge with an academic essay. Just tell her what was wrong with the patient, why the patient’s problem needed to be treated, what the treatment consisted of, how you know that was the right thing to do, and why the contractor’s denial reasons are wrong. Sorry for the repetition, but if these five questions are the only thing you get out of this book, your time and money will have been well spent.

Speaking of the medical authorities that support what you did, use one or two authoritative policy statements, articles, or textbook sections. Do not list 50 articles, with 5 of them in another language just because you can.

Do not get fancy. Stay with plain English. The three-page (or less) letter should be written without any terms of art. For example, the diabetic patient did not have diabetic angiopathy with atherosclerosis obliterans of the dorsalis pedis and posterior tibial arteries. Instead, the patient had diabetic vascular disease with blockage of the major arteries bringing blood into the foot.

Keep it simple. Use very short sentences. The goal is not to impress the ALJ with your writing ability or your knowledge of medicine. The goal is to make the ALJ understand your answers to the five key questions so you will get paid.
25. Why should the letter portion of your letter brief be less than three pages?
The ALJ will always read a three-page brief. The ALJ will never read a 30-page brief. And if you understand why the service was denied, you should be able to explain in one or two sentences why the denied service should be paid.

Okay, sometimes an ALJ will read a 30-page brief. But you should have compelling reasons for a longer brief over a shorter one.

26. Can the letter portion of your letter brief be only one page?
Yes! If you can prove the service was medically reasonable and necessary and can prove the denial rationale was wrong in one or two paragraphs, that is exactly what you should do.

ABOUT THE ALJ AND THE LETTER BRIEF

27. You will lose the ALJ appeal if the ALJ finds these things in your documents.
The ALJ may know very little about the patient’s medical problem, but ALJs are experts when it comes to reviewing documents. If your documents regarding the service at issue are not legible, were not written at the time the service was provided, do not support the diagnosis (International Classification of Diseases [ICD]-10) code(s) on the claim form, or do not support the CPT and/or HCPCS (Healthcare Common Procedure Coding System) II codes on the claim form, you are going to lose.

28. What progress note “crime” will not be forgiven by the ALJ?
Here is the crime: You dictate an initial history and physical (H&P)/patient encounter note that is adequate in every regard. However, you then cut and paste that initial H&P note and use it in its entirety for every subsequent progress note for the patient, changing only a word or two here or there.

Without reading another “fact” in the case, that ALJ is going to rule against you, and she probably should.

You were far more credible when you were handwriting your notes. Do not cut and paste large portions of the initial H&P note into your subsequent progress notes.

29. Do not underestimate the ALJ’s lack of medical knowledge.
You must not underestimate the ALJ’s lack of medical knowledge when you (1) write the letter brief, (2) as you make your oral presentation during the hearing, and (3) while you are answering the judge’s questions during the hearing. Everything you write and say has to be understood by the judge and has to make sense.

The judge knows as much about medicine as you (Medicare providers) know about the law, which is to say, nothing. But if the judge does not understand why you did what you did, there is no chance you are going to get paid. You should write it and say it to the ALJ the same way you would write it and explain it to a patient.

30. How is the letter brief tied to your fear of Medicare?
Your fear of Medicare stops you from billing for the appropriate level of complexity E&M codes and stops you from billing for all of the procedure/supply codes you are entitled to bill.

The first step in eliminating your fear of Medicare is knowing all of the codes you are entitled to bill and knowing how to use the modifiers that will qualify you for payment of the very small universe of E&M, procedure, and supply codes you bill every day.
The second step is making sure all of the appropriate codes are submitted to Medicare for each patient encounter.

The third step is knowing how to fight when payment is mistakenly denied and having the confidence to fight all the way through an ALJ hearing, if necessary.

Otherwise, you will continue to choose incorrect lower level of complexity E&M codes and you will avoid billing for all the procedure/supply codes you are entitled to bill—out of fear.

The letter brief will give you the courage needed to fight mistaken denials during the ALJ hearing. And, having seen this many times, once you win your first ALJ hearing, you will find yourself addicted to the knowledge that you can fight back and win when a denial is in error.

31. How does the letter brief affect your presentation during the hearing?
The judge will read your letter brief before the hearing and will already know the facts of your case. As a result, the letter brief enables you to concentrate on telling your patient’s story during the hearing rather than wasting hearing time on a list of medical facts.

Sun Tzu, an attorney who represented Medicare providers in 500 BC, wrote in *The Art of War*: “All battles are won or lost before the battle takes place and all Medicare ALJ hearings are won or lost before the hearing takes place.” Sun was right! Make it easy for the judge to rule in your favor. The brief allows you to tell your story in a way that is organized, easy to understand, and persuasive.

32. How is your brief related to your answers during the hearing?
The ALJ will never let you ramble on and on during a hearing. Writing the brief will force you to organize your thoughts, which will result in shorter, more effective answers during the hearing.

33. What should you do if the QIC adds new denial reasons in the QIC decision?
If the QIC denial letter contains new denial reasons that were not offered by the contractor in the redetermination denial letter, you must send the ALJ a second letter brief that addresses just the new QIC denial reasons.

34. How should the second letter brief be written?
The second letter brief should be written in the same format as the first letter brief. However, the only issues you will address in the body of the second letter will be the new denial reasons that were offered for the first time in the QIC decision letter.

Do not anger the judge by forcing her to reread what you wrote in the letter brief sent to the QIC. Worse, do not make the judge stop reading your second letter brief as soon as she realizes you are repeating yourself.

35. Why should you be able to submit your reconsideration appeals on time?
Usually, you will be fighting for payment of the ten codes that are most commonly denied payment in your practice/business. It will be the same fight over and over again. You should have a library of reconsideration appeal documents on your office computer that you can use for each of these commonly denied codes.

36. How long do you have to submit a reconsideration appeal request?
You have to submit the reconsideration appeal to the QIC within 185 calendar days of the postmarked date on the envelope containing the notice of redetermination. See 405.962(a)(1).
Everybody wants to argue about the 185 days, as opposed to the 180 days noted in the code section, so let me explain. The language in this code section states you have 180 calendar days after you receive the redetermination denial to get your appeal request to the QIC. But the same code section also states the date of receipt of the redetermination denial will be assumed to be 5 calendar days after the date of the notice of redetermination. In other words, the 180-day clock does not start running until the fifth day after the postmarked date on the envelope containing the redetermination denial.

In addition, if you mail the request for the reconsideration appeal within the 185 calendar days, you can always make the argument that you met the 405.962(b)(3) good cause requirements cited in 405.942(b)(2) and (b)(3)—so your appeal was timely. In other words, you will argue: “I mailed it within the 185 days. It just didn’t get there on time.”

37. If you are pressed for time, can you just submit the reconsideration appeal form?
Yes! You have at least four weeks after you send the CMS-20033 appeal form to get your letter brief to the QIC. As long as you get the letter brief to the QIC before the QIC publishes its decision, the QIC has to consider your letter brief and the brief has to be included in the appeal file sent to the ALJ. See 405.966(a)(2).

When was the last time you received a reconsideration decision within four weeks of sending the request for a reconsideration appeal? The answer is “never.” And four weeks should be plenty of time to collect additional evidence, write your letter brief, and send it all to the QIC.

38. Will an ALJ award payment just based on a clever legal argument?
No. An ALJ will never award payment based on a clever legal argument if the ALJ is not convinced the denied service was medically reasonable and necessary.

39. Why are clinical photographs always your strongest evidence?
A clinical photograph is worth a thousand articles. If the patient’s underlying problem can be captured in a photo, take pictures and submit them along with the request for the reconsideration (QIC) appeal.

Describing the patient’s problem in words when you can show the patient’s problem in a photograph is like describing the Mona Lisa instead of showing someone the painting.

Don’t rely on a progress note written in medical jargon to describe the patient’s problem. Grab the judge’s attention with a graphic photo and keep her attention with a short story in understandable English that explains the patient’s problem and the denied treatment that was medically reasonable and necessary.

40. Will you have to authenticate the photos in the letter brief?
Yes. You will have to authenticate/prove the photos you send are images of the patient whose claim is at issue and you will have to prove when the images were taken.

41. How do you authenticate clinical photographs?
The easiest way to authenticate a clinical photograph is by including the necessary information within the imaging field when the picture is taken.

Use your office computer to print the patient’s initials, the patient’s Medicare number, and the date, in size 36 font (or larger) on a letter-sized piece of paper. Use that piece of paper as the background for each picture you take of the patient and check to make sure the identifying information clearly shows in the images after you take the pictures.
42. What happens if you don’t authenticate photographs for the judge?
Unless the patient is at the hearing, the judge will probably not accept the submitted photographs as “evidence.”

43. Can you ask the patient to participate in the ALJ hearing?
Of course you can. In fact, the patient’s presence at the hearing will probably increase your chance of winning payment.

Having the patient sitting next to you during the video teleconference ALJ hearing changes the dynamic of the hearing. Now the ALJ is looking at a real person who needed care rather than looking at a pile of documents. And if the patient is willing to show the judge the affected body part during the hearing and is willing to answer the judge’s questions as to symptoms and treatment, you are almost assured of payment.

44. Can you submit late-taken photos of the patient to the ALJ?
Maybe. If the patient has a chronic condition so the judge knows the late-taken photographs accurately reflected the patient’s problem on the date of service at issue, and you were smart enough to “authenticate” the photos when they were taken, the judge may allow them to be entered into the record.

The worst thing that happens is that the judge will not accept the photos as evidence for the hearing.

45. Once the judge looks at the photos, can the judge un-ring that bell?
No. And the human response is to look at the photos. Once the judge looks at the photos, nothing can un-ring that bell.

46. What argument should you make to get late-submitted photos accepted?
You should consider saying something like this to the judge:

Your Honor, these photos are incorporated by descriptive reference in the patient’s progress notes that were previously submitted in this appeal. Therefore, these photos are not “new evidence” and should be accepted by the Court for this appeal.

47. How should you take and store photos for hearings?
Use your smartphone to take the digital images and send the images to a cloud email address. The digital images (later converted to hard copies that you will send to the QIC) will probably be more important to the judge than the rest of your testimony, and probably more important than the rest of your prehearing letter brief.

However, do not waste time or money converting digital images to hard copy images unless the claim is denied.

48. How can you use photos when the denied service is “included” in another service?
If the patient’s problem, and what you do for that problem, can be captured in photographs, then those photographs will always be your strongest evidence for payment. Here is an example of a simple billing problem ripe for photographic presentation to an ALJ:

Suppose you perform matricectomy procedures at both the tibial and fibular borders of the same left hallux nail (both edges of the left big toenail are surgically, permanently removed). You are probably thinking Medicare will pay for the first matricectomy procedure and will deny
payment for the second matricectomy procedure, and there is nothing you can do about it. I would argue otherwise, and advise using something like the following explanation in your letter brief to the QIC:

The MAC paid the 11750-TA code for the tibial border matricectomy of the left great toenail and denied the 11750-TA-59 code for the fibular border matricectomy of the left great toenail. Both matricectomy procedures were performed on [first, last name of beneficiary] on the same day.

The 11750 CPT code is defined as: “Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail), for permanent removal.” This definition describes the excision of nail and nail matrix from one contiguous surgical site, whether part or all of the nail and nail matrix is removed. This 11750 definition does not address the clinical situation where separate excisions of nail and nail matrix are performed at each nail border, leaving the central portion of nail, nail matrix, and nail bed intact.

The -59 modifier is described in the “Appendix A—Modifiers” section of the CPT Manual as follows:

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. (Emphasis added.)

Usually, either the medial (tibial) or lateral (fibular) border of a nail requires a matricectomy procedure. It is unusual for both the tibial and the fibular borders of the same toenail to require matricectomy procedures at the same time, but it does happen. And based on the CPT Manual description regarding the use of the -59 modifier, we have different surgeries performed at different sites, with separate excisions for separate lesions, on the same toe, on the same day.

The “separateness” of the surgical (matricectomy) procedures is supported by all of the following clinical facts:

1. Two separate partial avulsion procedures were performed, first at the tibial border and then at the fibular border of the same nail plate. (Show the photographs of each avulsion.)
2. A matricectomy procedure was then performed at each surgical site. (Show the photographs of each matricectomy procedure.)
3. You cannot get to the second surgical site from the first surgical site because you have a wide zone of nail plate along with the underlying skin of the nail bed separating the two surgical sites. (Show an end-on view of the toe that demonstrates the intact nail plate separating the two surgical sites.)
4. You can get a postoperative infection at one surgical procedure site that does not involve the other surgical procedure site. (Because infection following a matricectomy procedure is not uncommon, take advantage of the opportunity to photograph this...
exact occurrence when it presents so you will have a clinical example photograph you can show the ALJs.)

5. **You can have a recurrence of the problem (ingrown toenail) at one surgical procedure site while the other surgical procedure is a complete success.** (Unfortunately, recurrence is also not uncommon. When it occurs, photograph it so you can show this to the ALJ as you are making the argument for the separateness of the two matricectomy procedures.)

The denied 11750-TA-59 code for the fibular border matricectomy of the left great toenail should be paid because the two surgical procedures were identifiably separate and the -59 modifier was appropriately used to show the separateness of the procedures.

That takes care of what you will write in the letter brief. Now, what will you tell the ALJ? First, you should assume the ALJ has read your letter brief. As a result, you will **not** want to repeat the same sentences the judge already read in your letter brief.

And because you are smart enough to know you will **always be denied** payment for the second matricectomy procedure performed on the same toe on the same day, you will keep a hard copy set of digital images that demonstrate tibial and fibular border matricectomy procedures performed on the same toe as well as hard copies of post-op infection at one surgical site and recurrence at one surgical site available for use in letter briefs. You only have to take this set of images once. You will keep the original images on your smartphone and you will keep five sets of hard copies of these images in your desk for future appeals of this same problem. You will submit one set of these images to the QIC, as part of your letter brief, with your request for the reconsideration appeal.

Here is how I would present this issue to the ALJ:

*Your Honor, the images submitted to the QIC represent the matricectomy procedures performed on [first, last name of beneficiary’s] left great toe. Although these images are not of this patient’s toe, the images demonstrate the exact same procedures performed at the same time, for the same problem (infected, ingrown tibial and fibular borders of a great toenail).

First, the great toe was locally anesthetized for the two surgical procedures. If you imagine the patient’s toe on cross-section as a circle, and you convert that circle to a square, we have to anesthetize the nerve at each corner of the square in order to make the surgeries painless. In addition, Your Honor, if you squeeze the skin on your thumb as I am (turn your hand around so the judge can see what you are doing), you can see the hourglass appearance of your thumb. Where the hourglass is most concave is where we deposit the anesthetic solution because that is where the largest subcutaneous space is available for a pain-free injection. Where the hourglass is most convex, at the level of the joint prominence, is where we do not want to inject the anesthetic solution because that is where the smallest subcutaneous space is available and where an injection of local anesthetic would be most painful. (Do not miss an opportunity to engage the judge!)

The next images demonstrate the surgical scrub of the foot and the placement of a tourniquet at the base of the toe. The tourniquet is used to prevent blood flow into the surgical sites while the chemical (phenol) is applied to destroy the nail-forming tissue. We want to avoid dilution of the phenol as it is applied to the nail forming tissue (the nail matrix). So we are using the tourniquet to give the phenol time to act.*
The next images demonstrate the surgical removal of the tibial border of the nail, back to and including that portion of the nail plate growing from under the skin of the proximal nail fold.

The next images demonstrate the surgical removal of the fibular border of the nail, back to and including that portion of the nail plate growing from under the skin of the proximal nail fold.

Then, you see the application of the phenol to the tibial border as the first surgical site and then the application of the phenol to the fibular border as the second surgical site.

Significantly, the central portion of the nail plate between the two surgical sites, the underlying nail bed, and the associated skin of the proximal nail fold are not violated during these two separate surgical procedures.

The next images demonstrate the application of the surgical dressing materials to each site and then to the entire toe.

In addition, the following images demonstrate a postoperative infection at one of the two matricectomy sites on a toe and recurrence at one of the two sites.

Your Honor, the letter brief submitted to the QIC and the images reviewed today support the conclusion that the -59 modifier requirements have been met for payment of the second matricectomy procedure. I am respectfully requesting the court to order payment of the denied 11750-TA-59 code for the fibular border matricectomy of the left great toenail.

Why am I advising you to present all of this to the judge?

You want the judge to step into the story and then into the room when you performed the matricectomy procedures. You want the judge to experience what you did and why you did it. You want the judge to objectively and personally understand why the denial of payment for the second surgical procedure is unsupportable based on the 59 modifier conditions being met, unreasonable based on the obvious “separateness” of the procedures, and yes, “unfair” based on the judge constructively being there and seeing what you did.

The images will keep the judge’s attention. The short statements accompanying the images will enable the judge to understand what you did for the patient if you can show her big pictures and explain each picture in just a few words.

49. How is the letter brief and oral argument related to books for children?

Before you learned how to read, your parents read books to you that had big pictures and just a few words on each page. Why? Because you couldn’t read, you needed big pictures and short explanations in order to hold your attention and enable you to understand the story. Well, if the ALJ doesn’t know the medicine involved in the dispute, you better use big pictures and short explanations if you want to get paid.

For those of you who mistakenly think I am demeaning the ALJs, consider the following question: Is there a difference in your level of attention at a medical meeting where a nationally acclaimed surgeon is lecturing on a surgical procedure and is just using slides with words only, as opposed to the same surgeon lecturing on the same surgery but using clinical slides that illustrate each portion of the procedure? Of course there is.

Judges are no different. You will be most successful in keeping the judge’s attention and enabling her to understand what you did for the patient if you can show her big pictures and explain each picture in just a few words.
50. How can you distinguish separate services without photographs?

Make sure you are incorporating an explanation in your progress note as to how and why the services are separate.

If you are frequently providing the same two services at the same time, you should take the time to research and write a paragraph that explains why the services are separate, and the paragraph should cite recognized authorities that support the “separateness” of the services. You want to keep that paragraph handy when you are dictating your progress notes.

A good example would be the established diabetic patient who returns with a deep plantar ulcer complicated by cellulitis. You know in advance that the MAC will deny payment of the E&M code billed with the wound debridement code and that the MAC will claim the E&M was included in the debridement code. In this situation, you should dictate something like the following into the patient’s progress note:

This patient required a 99215 E&M service in addition to the code submitted for debridement of the ulcer because the E&M service required for this patient’s limb-threatening/life-threatening problem far exceeded the E&M included in any wound debridement code. Similarly, the 99215 Clinical Examples in Appendix C of the CPT Manual includes the example of an “Office visit for an established diabetic patient with a cellulitic deep plantar abscess and history of previous forefoot amputation of the contralateral side. (Podiatry Surgery).”

Whether your patient had a “history of previous forefoot amputation of the contralateral side” is irrelevant. What matters is that the patient’s current problem is serious enough to warrant the 99215 E&M service. The expert committee of physicians who write the clinical examples in Appendix C of the CPT Manual know a 99215 E&M service is required in this clinical situation and they want you to know this as well.

51. What is considered “new evidence” at the time of an ALJ hearing?

If Medicare did not write it, or if Medicare did not rely on it to determine a Medicare coverage policy, then the document in question will be considered “new evidence” at the time of the hearing.

Assuming you just submit a CMS-20033 reconsideration appeal request form and nothing else, what would be considered “new evidence” at the ALJ hearing? All of your patient records, photographs, procedure reports, lab reports, letters about the patient exchanged with other treating doctors, journal articles, textbook chapters, and standard of care statements would be considered “new evidence.”

52. What does Medicare say about “new evidence” at the time of an ALJ hearing?

Medicare says new evidence will not be admitted and/or considered by the ALJ—no matter how convincing that evidence may be—unless you can prove to the ALJ that you have “good cause” for the late submission. See 405.966(a)(2).

53. How does Medicare define “good cause” for new evidence at the ALJ hearing?

Medicare doesn’t define it. Why not? Because Medicare does not want to define it. This way the ALJ can make an individual decision, but that is not always a bad thing.

In my experience, many of the ALJs have bent over backward to find a reason to admit late-submitted evidence, especially when the ALJ thought that evidence would and should determine the outcome of the case.
54. With the backlog of cases, how will the ALJs respond to “new evidence”?
The work pressure on the Medicare ALJs is spiraling out of control as a result of the huge backlog of ALJ appeals. As a result, the past looks better than the future for any provider who wants to submit late evidence to an ALJ.

55. What is not “new evidence” at the time of an ALJ hearing?
If Medicare wrote it or relied on it to determine a Medicare coverage policy, that document is never “new evidence” and that document can always be presented, for the first time, at the ALJ hearing.

   This means you can present any of the articles or textbook sections cited in the applicable LCD at the time of your hearing. Because many Medicare contractors use the same old articles year after year to support out-of-date coverage policies in their newer versions of the same LCD, you may have a powerful argument that the contractor’s “current” LCD policy does not reflect the current standard of care.

ABOUT THE DENIAL AND THE LETTER BRIEF

56. Are you missing something that may kill your appeal?
Yes! Your Medicare contractor makes the original determination on your claim and the same Medicare contractor decides the outcome of your redetermination appeal. If you think a denial reason offered by your contractor in the Remittance Advice (RA) and repeated in the redetermination denial letter makes no sense, chances are you are missing something.

   Make no assumptions. You must know for sure why your claim was originally denied. You have to understand what the denial codes on the original Remittance Advice notice mean and then you have to apply those definitions to the code at issue.

57. How can you find out why your claim was denied?
Purchase the book Denial Codes Plain English Descriptions, published by DecisionHealth and available at www.codingbooks.com. The individual Medicare denial codes and the Medicare denial code combinations are explained in detail and in plain English.

   In the alternative, you can ask the patient to send you a copy of the letter the patient received explaining the denial. While the Medicare contractor sends you a denial explanation using denial codes—see 405.921(b)(2)(iii)—that same contractor has to send the patient an explanation (in plain English) designed to be understood by a layperson. See 405.921(a)(1).

   Last but not least, pretend you are the contractor. Use the denial codes on the RA, and use the explanation in the redetermination denial letters (the one you received and the one the patient received) to reverse-engineer the denial of your claim. Be aggressive as you role-play. Tear your claim apart, looking for reasons to deny payment.

   Make no assumptions. You must look up and understand every denial code in the RA and every Medicare Manual section cited in the redetermination denial letter, and you have to apply those denial code definitions and Medicare Manual sections to the code at issue—as though you were the contractor.

58. What happens when you role-play as the contractor during your analysis?
At first, you will be surprised how frequently you missed a big piece of the contractor’s denial rationale. But soon, you will be doing this role-switching regularly because it works. And don’t feel bad. One of the most common errors made by lawyers is the sin of telling yourself your version of the
story so many times you not only believe it, you are actually unable to see your opponent’s counterarguments until it is too late.

Once you know exactly why the claim was denied, you have to think: What are my most effective arguments against the denial and what is my strongest evidence supporting those arguments? The answers to these questions will determine how you will write the letter brief.

59. How will the redetermination denial affect the judge’s questions at the hearing?
The redetermination denial reasons are the 600-pound gorilla in the hearing room because the judge is going to key her questions on the redetermination denial reasons. You must neutralize the redetermination denial reasons in your letter brief, and you must be competently conversational with the redetermination denial reasons during the hearing.

Based on the denial codes and based on the denial rationale in the redetermination decision, you should know where you will be most vulnerable to attack by the ALJ during the hearing and you must be prepared to answer the ALJ’s questions directed at those vulnerabilities.

60. What should you do with a vulnerable point in your argument?
Embrace the vulnerability! For example, suppose you are representing a radiation oncologist who is appealing a denial of payment for the robotic stereotactic body radiation therapy (R-SBRT) treatment of a patient with localized prostate cancer. The judge says: “The LCD specifically states R-SBRT cannot be used for the treatment of prostate cancer. Why should I award payment when the doctor knew he was prohibited from using R-SBRT for this patient?”

If you weren’t sweating before the hearing, you would probably be sweating when the judge asks that question. But think how effective it would be to respond to the judge with the following answer:

*Your Honor, we know the LCD policy on the use of R-SBRT for prostate cancer was based on two textbooks and one article published ten years before the patient was treated. We know this is true because the LCD lists those two textbooks and that one article as the source documents used to write the LCD section on “Indications for the use of R-SBRT.”

We also know the current versions of the same two textbooks, published before this patient was treated, as well as a large number of articles published in peer-reviewed radiation oncology journals before this patient was treated, all support the use of R-SBRT for localized prostate cancer. In addition, ASTRO, the American Society for Radiation Oncology, approved the use of R-SBRT for localized prostate cancer before this patient was treated. The newer version of the textbook sections, the newer articles, and the standard of care published by ASTRO are all included as attachments in the letter brief sent to the QIC.

In clinical terms, Your Honor, the use of R-SBRT allowed the radiation oncologist to treat the patient’s cancer with much greater accuracy than was possible with the older, LCD-approved intensity modulated radiation therapy (IMRT). And the R-SBRT allowed the radiation oncologist to administer his radiation in five sessions as opposed to the 45 radiation therapy sessions required with the older IMRT. The R-SBRT also allowed the radiation oncologist to treat the patient with half the total dose of radiation that would have been used with IMRT. And finally, Your Honor, R-SBRT is nothing more than an updated and improved version of IMRT.*

No longer sweating? I didn’t think so.
61. Will the stated denial reasons always tell you what you have to prove to the ALJ?
Yes. And once you know why payment was denied, you have to counter each denial reason.

62. What are the common denial reasons and what do you have to prove for each?
Here are common reasons for denials and what you have to prove for each:

- If the contractor denies payment, stating the service was not medically reasonable and necessary, you will have to prove the service was medically reasonable and necessary.
- If the contractor denies payment stating the service was experimental/investigational, you will have to prove the service was not experimental/investigational.
- If the contractor denies the E&M code stating the E&M service was included in the procedure code and that procedure code was paid by the contractor, you will have to prove the E&M code should be paid as a separate service. You will also have to prove you met the E&M code requirements on the date of service at issue.
- If the contractor down-codes the submitted E&M code, you will have to prove the higher complexity E&M code should be paid based on the complexity of the patient’s problem and based on the contents of your progress note on the date of service at issue.
- If the contractor’s LCD allowed the denied service but the contractor denied payment stating some requirements were not met (e.g., the reporting forms required for diabetic shoes were not all submitted, there was an inadequate time interval between the same services, there was no indication of symptoms requiring the provided service, there was no indication of complicating medical factors justifying the provided service), you will have to prove how and why the requirements were met, or why the service was medically reasonable and necessary and should, therefore, be paid.
- If the overall surgical service qualifies for payment but the contractor states payment was denied for the surgical code at issue because you unbundled the primary surgical code in order to bill the code at issue, you will have to prove why the denied surgical service qualifies for payment as a separate and distinct surgical service.

Basically, whatever the MAC asserts as the reason for denial, you will have to prove the opposite is true or that an exception should be made to the denial reason.

63. When required information is missing, how do you argue denied E&M codes?
Here is what I would recommend. First, offer a capsulized version of each patient’s problem. Then, quote the CPT clinical example that is similar in complexity to each denied E&M code. Once you convince the judge that the seriousness of each patient’s problem is similar to a clinical example in Appendix C of the CPT Manual, the only other thing you must do is prove you met the record-keeping requirements for the use of each code.

If one or more record-keeping requirements are missing in the applicable progress note, you may consider using a modification of the following argument when you are making your presentation to the judge:

Your Honor, in Appendix C of the 2018 CPT Manual, an example for E&M code _______ states: “_____________. With very similar complexity, first, last [name of patient] had [describe the patient’s problem].

In addition, the section at the very beginning of the CPT Manual on the use of E&M codes states the complexity and seriousness of the patient’s problem determines the selection of the
correct E&M code. Here, based on the complexity and seriousness of [first, last’s] problem and based on the equivalent CPT example, we know the correct E&M code for the claim at issue is ________.

It is true that some of the information in the history/physical examination on the date of service is missing in the ________ E&M code progress note. However, the missing information should not drive the court’s decision regarding payment because the missing information was not material to the management of the patient’s problem. The clinically significant history and examination findings, needed to manage the patient’s care, were included in the submitted progress note.

In summary, the denied ________ code should be paid because the complexity of the patient’s problem calls for the E&M code used, because the clinically necessary information by history was obtained, and because the clinically necessary examination was performed.

64. Is an LCD policy binding on an ALJ?
No, an LCD policy is not binding on an ALJ. As stated in 405.1062: “ALJs are not bound by LCDs, but will give substantial deference to these policies if they are applicable to a particular case.” (Emphasis added.)

65. What is the practical effect of the “substantial deference” rule?
The word “will” does not mean “may” or “can” or “should.” The word “will” means the ALJ “must” state in the ALJ’s written decision why the LCD policy was not followed (see 405.1062). And the ALJs know the Council (the Medicare Appeals Council) will reverse an ALJ decision on appeal if the ALJ awards payment but does not adequately explain how “substantial deference” was paid to the LCD policy in the ALJ’s written decision.

66. Does “substantial deference” affect your burden of proof?
Of course it does. The standard of proof in a Medicare ALJ hearing is by a “preponderance of the evidence” (see 45 CFR Section 150.443). This means, in order for the ALJ to rule in your favor, she just has to find your evidence is 51% more persuasive than Medicare’s 49%.

However, the ALJ is not going to rule in your favor when you prove you are right by a mere preponderance of the evidence (51% to 49%). You will have to prove to the ALJ, at least by the standard of “clear and convincing evidence” (75% to 25%), if not by the standard of “beyond a reasonable doubt” (95% to 5%), that you are right and Medicare is wrong.

So, depending on the bone versus cartilage content of the ALJ’s spine, your argument has to be either very convincing or incredibly convincing in order to win the ALJ decision when the applicable LCD policy says “no.”

67. What are the differences between “substantive” denials and “procedural” denials?
Procedural denials occur when you make a procedural/technical mistake (e.g., you make a clerical error on a claim form or you submit a claim form or an appeal too late).

By contrast, in a substantive denial, even if you fill everything out correctly on the claim form and you get everything submitted on time, Medicare thinks the service doesn’t qualify for payment. Why? Because there is a Medicare policy or rule that prohibits payment of the claim. With a substantive denial, Medicare is saying the service you billed should never be paid under the clinical facts surrounding your claim.
68. When are you most likely to win a procedural denial and a substantive denial?
When you are appealing a procedural denial, you are likely to win at the redetermination or reconsideration level of appeal.
When you are appealing a substantive denial, you are unlikely to win before the ALJ hearing.

69. If you sent your patient care documents to the QIC, can you send a letter brief to the ALJ?
Yes. You will tell the judge your letter explains the patient care documents already submitted to the QIC but does not present any new evidence. You will not be able to send the ALJ any articles, textbook sections, or standard of care statements because they would all be “new evidence,” but you can send a letter explaining the patient care documents.

70. Will you be notified when your contractor sends the ALJ a position paper?
Probably not. Your MAC may submit a “position paper” to the ALJ regarding the service at issue. And although the contractor is required to send you a copy of any position paper the contractor submits to the ALJ (see 405.1012), in my experience, the contractors never send a copy of their position paper to the provider/supplier. When you submit your request for an ALJ hearing, be sure to ask the ALJ in writing to send you a copy of any position paper submitted by the contractor, and a week before the hearing, call the ALJ’s assistant and ask if a position paper has been submitted by the MAC.

71. The contractor sends a position paper to the ALJ but not to you. What should you do?
At the beginning of the hearing, you should raise the issue of the contractor’s failure to send you a copy of the position paper and you should politely ask the ALJ to give no consideration to the contractor’s position paper. Under 405.1010, the ALJ must comply with your request and must exclude the position paper.

72. Uh-oh . . . what if you cannot find support for the service you provided?
If you cannot find journal support for the denied service, you may want to rethink the appeal and, more importantly, you may want to rethink the denied service. Maybe you were wrong and should be doing something different.

ABOUT THE DOCUMENTS FOR THE LETTER BRIEF

73. You can always submit a Medicare document. What is a “Medicare document”?
“Medicare documents” are documents written by or relied upon by Medicare and include the following:

   a. Medicare Internet-Only Manual sections (e.g., Medicare Program Integrity Manual 100-08 sections)
   b. Sections from the CPT (Common Procedural Terminology) Manual (otherwise known as the HCPCS I Manual) written by the AMA (American Medical Association)
   c. Sections from the HCPCS II Manual (Healthcare Common Procedure Coding System Level II Codes) written by CMS
d. LCDs (the LCD published by your contractor and the LCDs published by other contractors on the service at issue)
e. Articles published by CMS

74. What are “non-Medicare documents” and when should they be submitted?
“Non-Medicare documents” are documents that were not written by or relied upon by Medicare but are the documents needed to persuade the ALJ to award payment. The non-Medicare documents should always be submitted as attachments to your letter brief when you request the reconsideration appeal.

“Non-Medicare documents” include the following:

a. All medical records specific to the patient whose denied claim is being appealed
b. Articles published in peer-reviewed journals
c. Textbook sections
d. Summary articles published by non-CMS authorities

75. What are the Medicare Internet-Only Manuals?
The old paper-based Medicare Manual, published by CMS, contained all of the rules and regulations for Medicare. The Medicare Manual has been converted into “Medicare Internet-Only Manuals (IOMs).”

76. Which of the Medicare Internet-Only Manuals explain the rules regarding LCDs?
It is the Medicare Program Integrity Manual (MPIM) that explains how LCDs are written, what LCDs should contain, and what LCDs must not contain.

77. Can you use the Medicare Program Integrity Manual (MPIM) on LCDs to your advantage?
Medicare has gifted you with the following words on LCDs in Section 13.1.3 of Chapter 13 of the MPIM: “Contractors develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community.”

78. What is the strongest evidence for LCD policies and how will you use this?
Chapter 13, Section 13.7.1 of the MPIM states: “Published authoritative evidence derived from definitive randomized clinical trials or other definitive studies is the strongest evidence for LCD policies.”

If you have articles based on “definitive randomized clinical trials or other definitive studies” from the journals that apply to your specialty or business, you should cite those articles in the letter brief and write something like this:

The article titled “_________________” and published in ____________ on [date of publication] states: “_________________. Although the LCD policy that was the basis for the denial was correct when the articles cited in the LCD were published, the standard of care for the treatment of (the patient’s problem) has evolved. Based on published, definitive studies as of [the date of service at issue], the denied service was medically reasonable and necessary and should be paid.”
79. What is the second strongest evidence for LCD policies?
Section 13.7.1 states: The second strongest evidence is “general acceptance by the medical community (standard of practice), as supported by sound medical evidence based on scientific data or research studies published in peer-reviewed medical journals.”

If this is your supporting evidence you will write something like this:

The denied service ______ was the standard of practice in the medical community as of [date of service], as evidenced in the attached article titled “______” and published in the peer-reviewed journal ________ on [date of publication].

80. What is the third strongest evidence for LCD policies?
Section 13.7.1 states: “The consensus of expert medical opinion (i.e., recognized authorities in the field); or medical opinion derived from consultations with medical associations or other health care experts.” This is the third strongest evidence for LCD policies.

As to the advice of local medical societies and medical consultants and comments from the provider community, you will reference the written policy statements of the recognized societies that support your treatment for the patient at issue.

If this is your supporting evidence, you will write something like this:

The American College of ______ / the American Society of ______ published a policy statement on [date policy statement was published] regarding the treatment of _______. A summary of the policy statement would read as follows: “______.” A complete copy of the policy statement is attached.

Call your Medicare Carrier Advisory Committee (CAC) representative. It is likely your CAC representative has this “medical opinion” information you are looking for.

81. What is the most common substantive reason used by Medicare to deny payment?
The most common substantive denial code states: “The services you provided were not medically reasonable and necessary.”

82. What does the phrase “not medically reasonable and necessary” mean?
This is a Medicare “term of art” that does not mean what you think it means. The phrase actually means the service in question is not allowed because there is at least one CMS, Medicare, or contractor rule that prohibits payment for the service.

A medical service may be perfectly reasonable and necessary in the ordinary use of the phrase but will still not be paid. For example, even though a patient desperately needed diabetic shoes, you did not meet the CPT and/or ICD coding requirements on the claim forms and/or you did not meet the LCD documentation requirements. As a result, the service was “not medically reasonable and necessary.”

And even if you did meet the CPT and ICD coding requirements, and even if you were initially paid for the diabetic shoes, you may still receive a demand for repayment of overpayment for the diabetic shoes based on a single missing document required for payment.

In other words, if you decide to appeal a demand for repayment of overpayment for a pair of diabetic shoes, guess what the contractor is going to say when you submit copies of your patient care
documents that fail to meet the LCD document requirements for diabetic shoes? The contractor is going to uphold the demand for repayment of overpayment because the service was “not medically reasonable and necessary.”

83. Where does the phrase “medically reasonable and necessary” come from?
The phrase “medically reasonable and necessary” comes from Section 1862(a)(1)(A) of the Social Security Act (the Act):

Sec. 1862. [42 U.S.C. 1395y] (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. (Emphasis added.)

84. Is there a list of requirements for “medically reasonable and necessary”? Yes. The elements of the phrase “medically reasonable and necessary” are detailed in the MPIM, Chapter 13, “Local Coverage Determinations,” Section 13.5.1—Reasonable and Necessary Provisions in LCDs.

Make a copy of MPIM Section 13.5.1 and keep it in front of you every time you write a prehearing brief.

You must address each element of 13.5.1 in the prehearing brief you will submit to the QIC and you must include each element of 13.5.1 in the oral argument you will present to the ALJ. Section 13.5.1 of the MPIM reads as follows:

§ 13.5.1: A service may be covered by a contractor if it is reasonable and necessary under 1862(a)(1)(A) of the Act. Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

Safe and effective;

Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary); and

Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:

• Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member;
• Furnished in a setting appropriate to the patient’s medical needs and condition;
• Ordered and furnished by qualified personnel;
• One that meets, but does not exceed, the patient’s medical need; and
• At least as beneficial as an existing and available medically appropriate alternative.

85. What “documents” should you have in front of you before you start writing?

a. The progress note for the date of service
b. Any other progress note, procedure report, imaging report, or correspondence that directly supports the billed service
c. A hard copy of the digital photograph of the patient’s problem, taken on or near the date of service, with the patient’s initials, the date of service, and the patient’s Medicare number on a piece of paper as the background for the image. This will be the most convincing piece of evidence you can provide for the judge.
d. The initial claim form submitted to Medicare
e. The Remittance Advice denying payment
f. The redetermination appeal request form
g. The redetermination denial letter

86. If you know a service will be denied, what statement should you incorporate in the progress note?
In addition to using clinical photos as described above, here is an overview of what you should consider. If you know a claim will be denied as you are providing the service, and you know why the claim will be denied, then you know what you have to document in the progress note dictated on the day of the service. Here are some examples of “lead-ins” you can use when you are dictating the progress note:

- Although the time interval between today’s (CPT code) service, and the same (CPT code) service provided on ______ does not meet the LCD time interval requirement, the service provided today was medically reasonable and necessary (MR&N) because ________.
- The symptoms requiring the provided service included ________.
- The findings on examination and specifically, “________,” provided the medical necessity for the CPT code ________.
- The complicating medical factors justifying the provided service included ________.
- The (CPT code number) surgical service was separate and distinct from the (CPT code) primary surgical procedure for the following reasons: ________.
- The (description of) service was MR&N (medically reasonable and necessary) because ________.
- The (description of) service was not experimental/investigational because ________.
- The (CPT code) E&M code was not part of the (CPT code #) procedure code and is separately payable because ________.
- The (CPT code) E&M code for today’s encounter is appropriate because ________.

It takes almost no time to incorporate these phrases into your dictation, and although these phrases and the additional information may not prevent the contractor’s denial of payment, it is likely the QIC will pay attention, and it is almost certain the ALJ will take notice. Tell your transcriptionist to put these explanatory statements in bold in your progress notes.

ORGANIZING AND FORMATTING THE LETTER BRIEF

87. What should you send with the CMS-20033 reconsideration appeal request form?
Here is everything you should send in the same envelope with the CMS-20033 reconsideration appeal request [405.966]:

1. A less-than-three-page letter that explains what was wrong with the patient, exactly what you did, why that service was necessary, how you know that was the correct thing to do, and why the denial reasons are wrong—all in plain English.
2. If the patient has a problem that can be captured in a photograph, send a printed copy of the digital photograph with the patient’s name, Medicare number, and the date the photograph was taken, clearly showing in the picture. **In addition to a copy of the progress note for the date of service in question, the photograph will be the most important evidence you will submit to the QIC and, therefore, to the ALJ.**

3. A copy of all applicable patient records (the progress note, procedure report, imaging report, and/or lab findings for the service date at issue, other progress notes, such as initial H&P, and/or letters from referring or co-treating doctors).

4. Peer-reviewed journal articles supporting the service/supply you provided.

5. Textbook section(s) supporting the service/supply you provided.

6. Standard-of-care statements by specialty organizations that are recognized as authorities for your specialty/service/supply and that support the service/supply you provided.

**88. How should you organize the letter brief?**

Use the same writing outline every time. Having an outline will take the sting out of writing the letter brief and by having a skeleton outline you can always rely on, you will avoid being confused about what goes where.

The first page will have the demographic information about you and will reference the spreadsheet you will submit as Attachment #1 to the letter brief. In successive columns from left to right, that spreadsheet will list the beneficiary’s name, Medicare HICN (Health Insurance Claim Number), the MAC appeal number, the date of service, and the procedure code(s) at issue for the date of service.

The remainder of the first page, along with the second and third pages, will contain the answers to the following: what was wrong with the patient, why the problem needed treatment, what you did for the patient, why you know your treatment was correct, and why each denial reason offered by the contractor in the redetermination denial letter was wrong.

**89. Where do you find the address for the QIC you are sending your letter brief to?**

The address of the QIC where you will send your letter brief can be found at the end of the notice of redetermination letter.

**90. How should you format the letter portion of the letter brief?**

The letter portion of your letter brief should be less than three pages and should be double-spaced with a font size of 12. You can attach as many supporting documents (e.g., patient care documents, LCDs, journal articles, textbook sections) to the letter as you want to, but the letter should be three pages or less.

**91. How should you organize the first page of the letter brief?**

Here are some practical suggestions for organizing the first page of the letter brief:

1. Write the letter to the QIC on your office/business letterhead.
2. Put the date of the letter in the center of the page, under your office address, phone, and fax information.
4. Enter the name of the MAC that denied the claim(s) along with notice that the redetermination appeal numbers are included on a spreadsheet as Attachment #1.
5. Attachment #1: In alphabetical order by last name of the patient, the spreadsheet will contain: the beneficiary’s name and Medicare HICN number, the MAC appeal number, the date of service, and the procedure code(s) at issue for that date of service—for each claim.

6. Along the left-hand margin, put in the mailing address of the QIC exactly as it is written in the redetermination decisions.

92. How many claims can you appeal in a single letter brief?
The number of claims is not the issue. It’s how you organize your response to the denials or demands for repayment of overpayment that becomes the issue for the reader of your letter brief (the ALJ).

93. How should you organize hundreds of codes in a single letter brief?
Let’s say you are preparing for an ALJ hearing regarding a repayment-of-overpayment demand that includes claims for 200 patients. And let’s assume there are a total of 350 codes for the 200 patients that Medicare says were “overpaid,” for a total of $40,000. But when you make a list of the 350 codes, it turns out that there are only 8 separate E&M codes, procedure codes, and/or supply codes in the whole group of 350 codes.

Figure out the amount of money at stake for each of the eight codes. It is very likely two or three of the codes will account for the majority of the $40,000. You should address those two or three codes first in the letter brief.

For each code, you will have a general section that defines the code and describes what is required for payment of the code.

Do not detail how each patient met those requirements—one patient at a time—in the letter. Do that in a separate attachment for each patient. You do not want to lose the judge’s attention by distracting her with these details in the letter itself. The judge will look at the attachments after she reads the letter.

Also, do not give in to the temptation to write first about the single patient with 1 code that appears only once in the 350 codes, just because you want to, for whatever reason.

When the judge reads your letter brief, her attention will be strongest at the beginning of the brief and weakest at the end. Do not waste the opportunity to convince the judge early on, when she is paying the most attention, about the largest portion of the money at issue.

94. How does the number of codes being appealed affect the number of pages in a letter brief?
As a general rule, you get three pages for each denied code. But the general rule depends on the similarity of clinical facts for each group of patients. Let’s take the previous example where a matricectomy procedure is performed at both the tibial and fibular borders of the same nail, but only one matricectomy procedure is allowed for payment by the contractor. If there are ten of these patients being appealed at the same hearing, the clinical summary for all ten patients would require one short paragraph:

The Medicare identifying information for all of the patients in this appeal is included in the table in Attachment #1 following this letter.

All ten patients presented with painfully ingrown tibial and fibular borders of a single nail. In each case, separate surgical procedures were performed at the tibial border and at the fibular border of the same nail, but only one surgical matricectomy procedure code (11750) was allowed for
each toe. In each case, the second matricectomy procedure code (11750-51) should be allowed for the second, separate surgical procedure performed on the same toe but at a separate surgical site. The clinical photographs for these patients are found in the patient Attachments following this letter.

Then you will argue for payment of the second surgical procedure based on the presentation in #48 above.

In other claim sets, the clinical facts will vary enough from patient to patient so that even though you are billing for the same procedure code, you will have to give the judge a detailed explanation of the procedure performed on each patient—in each patient attachment to the letter brief. However, less is more. You want to focus your brief on the facts that justify payment of the denied codes and you want to avoid endless facts that will not result in payment.

95. What kind of “demographic” table do you need, and where should it be placed?
Attachment #1 in your letter brief will always be a table that will include the following information:

<table>
<thead>
<tr>
<th>Name of Provider/Supplier</th>
<th>Name of Patient</th>
<th>Medicare Number</th>
<th>Date of Service</th>
<th>Code(s) at Issue</th>
<th>Redetermination Appeal No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Mullens, DPM (first, last, degree, or name and type of business)</td>
<td>Boyd, Ann (last, first)</td>
<td>1A23-B45-CD67</td>
<td>06/11/2018</td>
<td>99213-25, 64455-59 (include all modifiers used on the claim)</td>
<td>The appeal number assigned to the claim by the contractor</td>
</tr>
<tr>
<td>David Mullens, DPM (first, last, degree)</td>
<td>Jones, Frank (last, first)</td>
<td>2B34-C56-DE78</td>
<td>06/12/2018</td>
<td></td>
<td>The appeal number assigned to the claim by the contractor</td>
</tr>
<tr>
<td>David Mullens, DPM (first, last, degree)</td>
<td>Smith, Steven (last, first)</td>
<td>3C45-D67-EF89</td>
<td>06/13/2018</td>
<td></td>
<td>The appeal number assigned to the claim by the contractor</td>
</tr>
</tbody>
</table>

This “demographic” table will always be the first attached page (“Attachment #1”) after the last page of your letter.

96. Do you have to send copies of cited “Medicare” documents as attachments?
No. The judge (the staff attorney who works for the judge) will have quick access to all of the “Medicare” documents cited in your letter.

97. Do you have to send copies of the “non-Medicare documents” as attachments to the letter brief (to the QIC)?
Absolutely, yes! The non-Medicare documents, including the patient records, are the crucial evidence in your appeal. Unless you provide this evidence as attachments to your letter brief, you stand no chance of winning.

You can cite the LCDs, Medicare articles, Medicare Manual sections, and the CPT/HCPCS II definitions in the letter, but you will always send actual copies of the patient’s photos, medical records, articles, textbook sections, and professional organization policies you refer to in your letter as attachments to the letter.
98. How do you organize the documents that share a single attachment number?
The easiest way to answer this is to give an example. If the medical records for Mr. John Smith (HICN: XXX-XX-1234 A) are Attachment #7, and the medical records include an initial H&P progress note, follow-up progress notes, an MRI report, an operative report, and a pathology report, here is how you can organize these documents in the table of contents:

Attachment #7 pages 1–4 of 39: the initial H&P progress note for J.S. (HICN:1234 A)
Attachment #7 pages 5–31 of 39: the follow-up progress notes for J.S. (HICN:1234 A)
Attachment #7 pages 32–35 of 39: the MRI report for J.S. (HICN:1234 A)
Attachment #7 pages 36–37 of 39: the operative report for J.S. (HICN:1234 A)
Attachment #7 pages 38–39 of 39: the pathology report for J.S. (HICN:1234 A)

If there are multiple documents that share a common attachment number (e.g., medical records of a patient), put the document with the earliest date on top and the document with the latest (most recent) date on the bottom.

99. How do you identify the attachment number and page numbers of the attachments?
Order a custom self-inking rubber stamp (e.g., from Amazon.com) that, when pressed to the bottom right-hand corner of each attachment page, reads:

\[ \text{Attachment #} \quad \text{Page(s) } \text{of } \text{of} \]

After writing the number of the attachment, you will handwrite the page number(s) out of the total number of pages in the attachment. If Attachment #7 has 39 pages, and you are stamping the first page of the MRI report pages, you would handwrite 7 after Attachment # and you would write Pages 32–35 of 39 on the second line of the stamped words:

\[ \text{Attachment # 7} \]
\[ \text{Page(s) } 32–35 \text{ of 39} \]

100. How can you send a diagram and a simple explanation of the patient’s problem?
Almost all common medical problems are captured in the Krames pamphlets for patients. Be sure to send the QIC a copy of the Krames pamphlet that demonstrates the patient’s problem along with a hard copy of the digital photograph of the patient’s problem.

Explain how the diagram in the Krames pamphlet relates to the patient whose claim you are appealing.

101. Can you send your digital photographs of the patient to the QIC in an email?
No. You have to make hard copies of the digital photographs and send them to the QIC when you request the reconsideration appeal. The QIC will forward those photographs to the ALJ after the QIC denies payment and you request the ALJ hearing.
Digital photographs taken on the date of the service at issue, with all of the authenticating information in the background of the picture are best (see #40–42 above).

The longer the time interval between date of the service at issue and the later date of the digital photograph, the less weight the ALJ will give the photograph.

102. What determines the number of attachments you will send with the letter brief?

There are a lot of documents you will consider sending to the QIC in anticipation of the ALJ appeal. What you actually send will depend on the complexity and nature of the appeal. For example, let’s assume you are fighting a demand for repayment of fees paid for diabetic shoes. In addition to the CMS-20033 reconsideration appeal request form, you would send a photograph of the patient’s foot taken when the decision was made to provide the diabetic shoes, a photograph of the patient’s feet and the diabetic shoes on the day the shoes were dispensed, the rest of the letter brief that includes the applicable progress note(s), and copies of the LCD-required documentation forms you were able to complete for the patient.

But if you are fighting for payment for a service that is not allowed in the applicable LCD, you would send almost all of the following to the QIC:

- A completed CMS-20033 reconsideration appeal request form
- A short (1–3 page) letter that includes a summary of the patient’s medical facts, what was done, why it was necessary, the authorities supporting the service, and why and how the related LCD section that prohibits payment has been misapplied by the contractor (not why the LCD policy is wrong)
- A demographic table (see #95)
- A table of contents (so the ALJ can find what she is looking for quickly)
- The progress notes, letters from referring or co-treating doctors, procedure reports, imaging reports, and/or lab findings
- Peer-reviewed journal articles supporting the service you provided
- Textbook section(s) supporting the service you provided
- Policy statements by authoritative organizations representing your specialty or business that support the service you provided
- A copy of the CMS-20027 redetermination appeal request form sent to the contractor
- A copy of the redetermination denial letter

103. What should be the order of the documents you attach to your letter brief?

Use the following order for the attachments:

- 1: demographic table
- 2: table of contents
- 3: pertinent parts of Medicare documents (LCDs, Medicare articles, etc.) but only if those Medicare documents contain “smoking gun” evidence that should persuade the ALJ to decide in your favor. For example, the page(s) of the version of the LCD that applies to the denied service or supply specifically allowed the service or supply. Otherwise, you will just refer to the Medicare documents in the body of the letter because the ALJs have immediate access to
104. How should you arrange the “patient care documents” attached to the letter brief?
In the attachment for each patient, the first patient care document should be the photo(s) of the patient. The next patient care documents should be all of the progress notes and reports for that patient, in chronological order, with the earliest dated progress note on top.

All of the claim-related documents, also in chronological order (with the earliest dated claim on top), should come last. Claim-related documents include the redetermination appeal request and the redetermination denial letter along with any extension, dismissal, or reopening documents associated with the claim.

A lot of people put the claim-related documents on the top of the pile. I think that is a mistake because it is the photograph of the patient that you want the judge to see first when the judge looks at each patient’s set of documents. The second thing you want the judge to see are the progress notes that support what the judge sees in the photograph. The claim-related documents are almost an after-thought because the file forwarded to the ALJ from the QIC should already have these. But you should still send copies of the claim-related documents because you don’t want to find yourself in the middle of the ALJ hearing only to find the judge does not have one or more of these documents in front of her.

105. How should you arrange “journal articles” attached to the letter brief?
If you are using journal articles to persuade the judge, make sure the articles have been published in peer-reviewed journals. The peer-reviewed journal article most supportive of the contested service should be the first article cited. However, not all journals are created equally. A moderately supportive article in the New England Journal of Medicine will be given more weight than a strongly supportive article published in an obscure journal.

Anecdotal reports and articles published by the manufacturer of the equipment or service at issue will be given very little weight, if any weight at all, by the ALJ.

Be very careful about using articles published after the contested date of service. The ALJ will be sensitive to the date of service and the date of any article you use to support payment for the denied claim. However, if the later published article cites studies that were published before the contested date of service, and those cited studies support the service for which payment was denied, then the later published articles are fine. If this is the case, spell it out for the judge as in:

Your Honor, this article was published after the service at issue was provided. However, the article was based on studies published before the service at issue was provided and those studies are listed at the end of the article.

106. How should you arrange “textbook sections” attached to the letter brief?
Sections from textbooks that are considered authoritative for a specialty or business are very persuasive evidence for ALJs. Make sure you include a photocopy of the title page of the book and the date of publication as well as the photocopy of the relevant textbook section.
107. How should you arrange standard-of-care statements attached to the letter brief?
If you have “smoking gun” evidence that should, on its own, make the ALJ decide in your favor, don’t bury that evidence in the back of the letter brief. Put that evidence right up front in the letter brief and put it **in bold**. If the authoritative evidence is overwhelmingly in your favor, and you can write the letter brief in one page—by all means do it. The ALJ will love you for not wasting her time.

In other words, if you have a policy statement of a professional organization that is recognized as authoritative for your specialty or business, and the policy statement **unmistakably** supports your denied service or supply, use it immediately in the letter brief.

You always want to put your strongest evidence at the beginning of the brief because you have a better chance the judge will read it. And, when you are making your presentation to the judge during the hearing, you always want to start with your strongest evidence while you have the judge’s attention.

**108. What should you do if the LCD did not allow the service?**
You will argue the service was medically reasonable and necessary based on the facts. And you will list those facts. In addition, you will have to prove to the ALJ, at least by the standard of “clear and convincing evidence” (75% to 25%), if not by the standard of “beyond a reasonable doubt” (95% to 5%), that the provided service was **safer than**, **more effective than**, and **less expensive than** the allowed service in the LCD.

Use common sense. If the contested service was obviously safer than and more effective than the LCD- indicated service, you are going to win. If the contested service was not as safe as or not as effective as the LCD- allowed service, you will not win.

The attachments you will consider sending when an LCD prohibits the service at issue are listed in #102 above and #119 below.

**109. How should you number the pages in your letter brief?**
This non-tech trick will save you a lot of aggravation. When you have the entire packet ready to go (the less than three-page brief, the patient care documents, the articles, the textbook sections, etc.), number all of the pages in the lower right-hand corner very lightly with a pencil.

The number 1 will be at the lower right-hand corner of the first page of your letter and all of the pages after will be numbered in order. This will save you countless headaches when pages of documents are dropped and/or the judge cannot find the document during the hearing that you are referring to. Write the numbers in light pencil because you will almost always have to erase and redo them.

**110. Must you prove you sent a copy of the request for the ALJ appeal to each patient?**
Yes. Section 405.1014(b)(2) requires you to send a copy of the request for the ALJ appeal to each of the patients whose claims are being appealed.

**111. Must you prove each patient received a copy of your request for an ALJ appeal?**
No. You only have to prove the copies were sent. You do not have to prove they were received. This makes a huge difference as to the type of mail you will use.

**112. Do you have to send a copy of the letter brief to each of the patients?**
No. If you are not sending any additional “evidence” with your request for an ALJ appeal, the answer is no. See section 405.1014.

The letter brief was sent with your request for a reconsideration appeal and the CFR sections on reconsideration appeals are silent on this topic.
113. What is the least expensive way to prove you sent a copy of the ALJ appeal request to each patient?
Go to your local post office and get a bunch of “certificate of mailing” forms (Form 3817). You will need to fill out a separate certificate of mailing form for each letter (containing a copy of the ALJ appeal request form) you send to each patient.

Each certificate of mailing form will cost $1.45. You will send each letter as first-class mail with a 55¢ stamp on the envelope. The total cost for this “proof of mailing” is $2. Do not waste money by using “proof of delivery” mail. You don’t need to prove each patient received a copy of the ALJ appeal request form. You only need to prove you sent each patient a copy of the ALJ appeal request form.

You will take the completed certificate of mailing forms with you when you go to the post office to mail the copies of the ALJ appeal request to the patients.

114. How do you avoid HIPAA violations when using the OMHA-100A form?
When you are requesting an ALJ hearing for only one beneficiary, you will just use the OMHA-100 form.

When you are requesting an ALJ hearing for multiple beneficiaries, you will use the OMHA-100 form plus the OMHA-100A form.

In order to avoid HIPAA violations, you will make enough copies of the completed OMHA-100 form and the completed OMHA-100A form to send one set of both copies to each beneficiary. On each OMHA-100A form, you will redact (black out) the information on all of the patients other than the information on the one patient you are sending that set of copies to.

115. How should you fill out Section 7 on the OMHA-100 form?
Section 7 on the OMHA-100 form asks you to state why you disagree with the reconsideration being appealed.

You will enter: “Please see the letter brief submitted to the QIC for the reconsideration appeal.”

However, if the QIC added new denial reasons in the reconsideration appeal denial letter, you will also enter: “In addition, please see the attached letter brief that addresses the new denial reasons offered by the QIC.”

ABOUT WRITING THE “HEART” OF THE LETTER BRIEF

116. What is the best way to describe the problem, what you did, and why it was correct?
Write the shortest possible version of the patient’s problem, describe what you did for the patient in lay terms, and include an explanation of why the service should be paid. For example:

Mr. J.S., an established patient in the practice, is a 65-year-old type 2 diabetic who returned to the office on January 2, 2017, with a foul-smelling (infected) ulcer on the ball of his left foot of several weeks’ duration. Although J.S. did not have a fever, the left foot was swollen and X-rays demonstrated a probable bone infection of the second metatarsal head, directly under the ulcer.

In addition to billing for 97602 surgical debridement of the ulcer (cutting away the dead and infected tissue), a 99215 E&M code was billed for the comprehensive history, the comprehensive examination, and the high complexity medical decision-making required for his
problem. The Medicare contractor denied payment of the 99215 code, stating the E&M service was included in the 97602 wound debridement code.

However, the amount of E&M required for Mr. J.S. far exceeded the E&M included in the 97602 code. A copy of the progress note for the January 2, 2017, date of service is included in Attachment #3. The progress note meets all of the CPT requirements for the 99215 code.

The E&M provided for J.S. is similar to the E&M in the 99215 example for podiatric surgery in the 2017 CPT Manual “Appendix C—Clinical Examples” section.

I am respectfully requesting payment for the 99215 E&M service provided for J.S. on January 2, 2017.

117. What should you write when you did not meet some MAC requirements for a service?
You will have to convince the ALJ that the medical necessity of the service should outweigh the technical reasons for denial. Here is one example of wording you could use in your response:

The [describe the service] was medically reasonable and necessary at the time it was provided for the following reasons:

On [date of service at issue], the findings by history included ________, and the findings by examination included ________. Without the denied service, the patient ________. As a result, it was medically reasonable and necessary to provide the denied service to [first, last] on [date of service]. In addition, the decision to provide this treatment, based on the findings on the date of service, is supported by the attached peer-reviewed journal article(s) and by the attached standard-of-care policy published by ________, the professional organization that oversees the specialty/business of ________.

118. What should you write when the service is prohibited in the contractor’s LCD?
Convincing an ALJ to pay for a service when the service is specifically prohibited in the contractor’s LCD is the toughest ALJ appeal. When you are in this fight, you want to be able to prove at least by clear and convincing evidence (the 75% burden of proof standard) that the denied service was medically reasonable and necessary.

The strongest statement you could make to the ALJ would be:

Your Honor, the [name of the denied service] is safer than, more effective than, and less expensive than the LCD-approved [name of the LCD-approved service] for the treatment of [description of the patient’s medical problem].

Realistically, you will be writing some combination of the following statements:

The denied service [describe the service] was medically reasonable and necessary for the following reasons:

The service provided [describe the service] is as safe as/safer than the “indicated” service [describe the “indicated” service] in the LCD and this statement is supported by ________.

The service provided [describe the service] is as effective as/more effective than the “indicated” service [describe the “indicated” service] in the LCD, and this statement is supported by ________.
The service provided [describe the service] is less expensive than the “indicated” service [describe the “indicated” service] in the LCD, and this statement is supported by ________.

Although the service provided for the patient’s problem is prohibited in the applicable LCD, based on all of the above, payment should be awarded for the [CPT/HCPCS ________] code service provided for Medicare beneficiary (initials) on [date of encounter].

The closer you are to “safer, more effective, and less expensive,” the more likely you are to win. Assuming the “indicated” service in the LCD and the denied service are equally effective in the treatment of the patient’s problem, if the denied service is not as safe as the “indicated” service in the LCD, you are going to lose. If the denied service can be proved safer than the “indicated” service in the LCD, you are going to win. And even though cost is not supposed to be considered by the ALJ, if the denied service is thousands of dollars cheaper than the “indicated” service and everything else is “equal,” you absolutely want to raise the issue of cost.

119. What can you do when your contractor says “no” but another contractor says “yes”?

This is why you have to look at the LCDs published by the other contractors regarding denied services. If you don’t read the other LCDs, you won’t know if another LCD allows the same service your Medicare contractor does not allow.

What is the most common reason two Medicare contractors have conflicting LCD policies regarding the same service? In my experience, the most likely reason was that one contractor was relying on older medical literature and the other contractor was relying on newer medical literature. You must check on the cited literature at the back of the LCD to determine how your contractor arrived at its coverage policy.

If you determine the service at issue has been denied because your contractor is relying on outdated literature, it is easy to write the appeal for the ALJ. Here is an example of what you can say:

The medical literature cited in the [name of contractor] LCD (L__________) regarding the denied service is out of date. Current medical literature, recognized as authoritative by the contractor, supports payment of the denied service. The current medical literature includes all of the following: ________.

In addition, although the LCD, L__________, prohibits the denied service, the LCD, L__________, published by [name of other contractor] allows the denied service under the same clinical circumstances. The difference between the two LCD policies is that my contractor’s LCD, L__________, is based on older literature, while LCD L__________ is based on current literature.

120. What should you do if an applicable, older LCD says “no” but the current LCD says “yes”?

Look at the documents the current version of the LCD relies on. The literature relied upon by the authors of the LCD is listed toward the end of the LCD. It is very possible the articles relied upon by the authors of the newer version of the same LCD were published at or before the time the contested service was provided. If so, your argument would be:
The articles and textbooks relied upon by the authors of the newest version of the LCD, L_______, were published before the (billing code) service was provided for [first, last] (the Medicare beneficiary). The newest version of the LCD correctly allows the denied service for the Medicare beneficiary’s problem [description of diagnosis/name of disease].

The older version of the LCD, although in effect at the time the service was provided, has been misapplied. The literature relied upon by the authors of the newest version of the LCD demonstrates the medical standard for the contested service had changed by the time the denied services were provided.

121. What can you do when a claim is denied as “not medically reasonable and necessary”?

First, establish the evaluation and management portion of the patient’s problem before you argue in favor of payment for the procedure performed or the supply/item dispensed. Here is how you could respond:

A photograph of the patient’s problem, with the patient’s initials, the patient’s Medicare number, and the date of the photograph all clearly evident in the background is included as Attachment # ___. The photograph demonstrates _______.

The patient is a ___-year-old male/female with [description of problem], who was seen in the office [or other location] on [date of encounter] complaining of/for follow-up of [complaint or problem being followed up].

The patient’s history revealed the following: _______.

The patient’s examination revealed the following: _______.

The diagnosis was _______.

Treatment included _______.

The complexity of medical decision-making was [straightforward/of low complexity/of moderate complexity/of high complexity] based on the [minimal/limited/multiple/extensive] number of diagnoses or management options; based on the [minimal/limited/moderate/extensive] amount and/or complexity of data to be reviewed; and based on the [minimal/low/moderate/high] risk of complications and/or morbidity or mortality.

See the patient records in Attachment #___.

Here are the contractor’s reasons for denial and why each reason is wrong: _______.

The [name of contractor] LCD that applies to the contested service is L_______. L_______ states: “______.”

An article from a peer-reviewed journal, with a diagram (or photograph) of a patient with an (almost) identical problem/deformity is included as Attachment #___. The article states_______.

The treatment guidelines for this problem, as published in the textbooks _______, _______, and _______, are enclosed as textbook sections in Attachment #___. The textbook(s) state(s) _______.

The treatment guidelines for this problem, as published by the [name of specialty organization], are enclosed as Attachment #___. The treatment guidelines state _______.

Based on all of the above, I am respectfully requesting payment for the medically necessary and reasonable service provided to [first, last] on [date].
122. What must you prove when a claim is denied as “experimental/investigational”?
You have to prove to the judge that the service was not “experimental” or “investigational.” But this is not as easy as it seems because Medicare has no definition of “experimental/investigational.”

123. Will you be surprised when a claim is denied as “experimental or investigational”?
Almost never. You know, or should know after the first denial for the same service, that the service you are providing is considered to be experimental or investigational by your Medicare contractor.

124. What can you do when a critical term such as “experimental or investigational” is not defined by Medicare?
When faced with terms that are not defined by Medicare, look to other sources for definitions.
If you cannot find a definition for a term on the http://Medicare.gov website, look at for-profit company websites.
If you cannot find the definition on for-profit company websites, you can always quote an authoritative source such as the Merriam-Webster dictionary.
The easiest thing to do, however, is to put the phrase “definition of _______” into the Internet search bar and let it do the work for you. You are looking for the definition that works best for you and is written by an unquestionably authoritative source.

125. Can you use the Anthem BC BS definition of “investigational”?
Yes. The Anthem BC BS, ADMIN.00005 document on “Investigational Criteria” states:

“Investigational” means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the WellPoint Technology Evaluation Criteria because it does not meet one or more of the following criteria:

- have final approval from the appropriate government regulatory body; or
- have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- be proven materially to improve the net health outcome; or
- be as beneficial as any established alternative; or
- show improvement outside the investigational settings.

126. How would you use Anthem’s definition of “investigational”?
“Investigational” is a big step up from “experimental,” and Medicare is almost always denying payment because the service was considered “investigational” rather than “experimental.”

In your letter brief, you will tell the ALJ:

Even though Medicare fails to define the phrase “experimental or investigational,” Anthem BC BS has provided a detailed definition for the term “investigational.” Here is Anthem’s definition and here is why the service I provided for [name of patient] was not experimental or investigational: ________.

First, you will provide the entire BC BS definition for “investigational” (see above).
Then, you will write something like the following:

*The [describe the service] provided for [name of patient] was not “experimental or investigational.”*

*The [describe the service] has final approval from [name of appropriate government regulatory body]. A copy of that approval is attached to this letter as Attachment #___.*

*The [describe the service] is supported by credible scientific evidence published in peer-reviewed medical literature recognized by the [name of the relevant medical community]. These studies permit reasonable conclusions concerning the effect of [describe the service] on health outcomes. Several of these peer-reviewed journal articles are attached to this letter as Attachments #___–___.*

*The [describe the service] has been proven to materially improve the net health outcome of the patients who received this service. Examples of studies proving this point are attached to the letter as Attachments #___–___.*

*The [describe the service] is as beneficial as any established alternative. A comparison of the [describe the service] to the established alternative service approved in the LCD is available in peer-reviewed journal articles attached to this letter as Attachments #___–___.*

*The [describe the service] shows patient improvement outside investigational settings. These results are evident in the peer-reviewed journal articles attached to this letter as Attachments #___–___.*

*The service at issue [describe the service], is as safe as/safer than, is more effective than/as effective as, and is less expensive than/no more expensive than the LCD-approved service [describe the LCD-approved service]. For all of these objective reasons, the denied service is not “experimental/investigative” and should be paid.*

127. **What do you tell the ALJ when the “vendor” assured you Medicare would pay?**

Please do not bother arguing that the vendor who sold you a piece of diagnostic or treatment equipment (or convinced you to provide an expensive service) assured you that the service meets all of the requirements for Medicare payment. Vendors are not always completely truthful.

When you are considering the purchase of a new, and usually expensive, piece of equipment, or you are considering providing a service associated with a big fee, have the vendor send you written proof that the equipment/service meets all of your Medicare contractor’s requirements for payment—*before* you buy the equipment/before you provide the service.

Make the vendor send you redacted (blacked out) copies of the Remittance Advice notices, previously known as Explanation of Medicare Benefits (EOMBs), from your Medicare contractor demonstrating payment for the equipment you are thinking about buying. Make sure you check with your contractor as to the combination of ICD and CPT codes that will qualify you for payment—*before* you buy the equipment or provide the service.

Vendors engage in bait-and-switch techniques in order to sell their product. And just because someone gets paid for using a piece of equipment or providing a service by using a wrong ICD and/or CPT code, that doesn’t mean the RAC will fail to discover this scheme *after* you have paid for the equipment; *after* you have used and billed for the services related to the equipment or after you have provided the big fee service; and *after* you have been erroneously paid by the contractor.
128. What if the vendor actually signed a piece of paper assuring Medicare payment?
Do not bother asking the vendor to sign a piece of paper stating the equipment/service meets all of Medicare’s requirements for payment. The vendor knows you are not going to waste the time and money needed to go after them. And even if you do, and the vendor then goes belly-up, who are you going to collect from once you have a judgment?

Name a single provider or supplier who has successfully gone after a vendor after Medicare has made the provider or supplier repay the money billed for the services provided with the vendor’s equipment.

Be smart before you buy expensive equipment/before you provide big fee services rather than trying to be smart after you have been taken to the cleaners/after you have been forced to repay a very large demand for repayment of overpayment.

129. An example of a vendor’s magic show: the selling of platelet-rich plasma (PRP) for the repair of ruptured tendons around the ankle.
In 2013, I had to research the topic of platelet-rich plasma for a client, and there were literally thousands of published anecdotal reports on the use of PRP. But there wasn’t one double-blind study published in a peer-reviewed journal supporting effectiveness. How could this be? Easy. Something that sounds good and has a big fee associated with it makes critical judgment go away. And as more and more people come to believe in the “emperor’s new clothes,” the less critical everyone is about reality.

Some of you will respond with: How can you do a double-blind study with something like PRP when the patient is expecting you to use it? The answer is easy. Two or more university hospitals can tell all of their ruptured Achilles tendon patients requiring surgery and/or all of their ruptured posterior tibial tendon patients requiring surgery that they are going to use or not use PRP at the time of the repair. Although the surgeon would know which patients received the PRP, the patient and the research coordinator recording the postoperative findings would not know.

I am not saying PRP does not work. I am saying I was amazed to find thousands of anecdotal reports and not one controlled study when I researched this.

130. How should you decide whether to cite and include a document?
When you are asking yourself whether to quote/cite a document in the letter and whether to include a copy of that document as an attachment to the letter, ask yourself this two-part question: Will the judge read and understand this document? If the answer is yes, ask yourself the next question: Will this document sway the judge in favor of payment? If the answer is yes to both questions, cite it and include it.

No matter how attractive a document may be, if the judge will not read it, if the judge will not understand it, or if the document will not sway the judge in favor of payment, don’t cite it and don’t send it.

131. Should you rely on common sense when you are writing the letter brief?
Yes. Suppose you are appearing before an ALJ during a video teleconference hearing regarding non-payment of diabetic shoes and you have been smart enough to have the patient attend the hearing. For a moment, pretend you are the ALJ. The one and only question you would have as the judge would be: Should I award payment?

The best, quickest, and surest way to convince the judge is to have the patient take off their shoes and show the judge the missing toe(s), partial amputation, plantar diabetic ulcer, and so on.
A common sense presentation of the contractor’s indications for diabetic shoes in the letter brief with the on-camera presentation of the patient’s foot during the hearing will result in a ten-second knockout. The hearing is over and you won. The rest of your conversation with the judge is just for the purpose of completing the record.

132. What are the contractor’s strongest arguments against payment?
Pretend you are an attorney representing the contractor. Now, tear your arguments apart. Where are your weaknesses? No case is perfect. Find your weaknesses before the judge finds them.

When you find a weakness in your argument, embrace it. Think about how you can best address that weakness in your letter brief and/or how you will answer the judge’s questions about that weakness during the hearing.

You should assume if you are able to find the weakness, the judge will find it as well.

133. Where do you include the contractor’s arguments in your letter brief?
It depends. If the contractor’s denial is based on a single factual assertion and you can prove that assertion is wrong, you will put the contractor’s denial reason and your proof the contractor is wrong right at the beginning of the letter brief. For example, if the contractor denied payment stating the applicable LCD prohibits the billed service, and the applicable version of the LCD actually allows the billed service, you would put all of this at the very beginning of the letter brief.

On the other hand, if the contractor’s argument is not wrong but the contractor’s argument should not determine the outcome of the hearing, you will put the contractor’s argument and your counterargument at the end of the letter brief. For example, if the contractor states the denied service is allowed but was provided too frequently, you will present all of the clinical information supporting the need for the service when the service was provided and will address the contractor’s denial reasons after you have made it clear the denied service was medically reasonable and necessary when it was provided based on the clinical facts.

134. What do you do with a weakness in the contractor’s argument against payment?
If you discover an important weakness in the contractor’s argument, address it in the first part of the letter. Leave out the adjectives. Just tell the judge why the contractor’s argument is wrong.

135. What do you do with a weakness in your argument for payment?
If you discover an important weakness in your request for payment, you can be certain that point will be brought up by the judge during the hearing and you must address that weakness in your letter.

136. What do you do with a questionable weakness in an argument?
If you discover a questionable weakness in the contractor’s argument or in your request for payment but that weakness will not determine the outcome of the ALJ hearing, leave it out of the letter or address it in a footnote.

137. You didn’t send a letter brief to the QIC. Can you send a letter brief to the ALJ?
If you sent all of the patient care documents to the QIC, you can write and send a letter brief to the ALJ based on the patient care documents. Your first sentence in the letter brief will read: “Your
Honor, this letter organizes and explains the evidence already submitted to the QIC. However, this letter contains no new evidence.

But remember, if you did not send the articles, textbook sections, and standard of care statements to the QIC, you cannot send these items to the ALJ. You can only send the ALJ a letter explaining the previously submitted patient care documents.

**138. If you send a letter brief to the ALJ, do you have to send copies to the patients?**
Yes. See 405.1014. By sending the letter brief to the QIC, you won’t have to send copies to all the patients whose claims are at issue as you will if you wait to send the letter brief, for the first time, to the ALJ.

**139. Will the ALJ accept your letter brief under these facts?**
Why not? And if the ALJ hearing is about something as visual as the diabetic problems that justify therapeutic shoes and you were smart enough to include hard copies of the digital images taken during treatment when you sent your evidence to the QIC, you stand a very good chance of winning payment. Even if you did not submit any digital images to the QIC, if the patient will appear at the hearing, you can have the patient show the judge the deformities that required the use of therapeutic shoes.

**AFTER YOU WRITE THE LETTER BRIEF . . .**

**140. Does your letter say what you want it to say and will the ALJ understand it?**
This is important enough to repeat. When you finish the letter, a layperson should be able to read your letter brief and understand the nature of the patient’s problem, what you did and why you did it, why your treatment was the best choice for the patient, and why the contractor’s denial reasons are wrong.

Do not get fancy. Stay with plain English. Have someone with no medical education read your letter and then have that person tell you what the letter says. If that person gets it, then the ALJ will get it. If that person does not understand what you have written, it is likely the ALJ will not understand what you have written either.

**141. What should you do if you can’t find support for the denied service?**
If you cannot find journal support for denied service, you may want to rethink the appeal, and more importantly, you may want to rethink the denied service. Maybe you were wrong and should be doing something different.

**142. Did you present your strongest evidence first?**
The judge’s interest will fade very, very quickly. Get your strongest piece of evidence in front of the judge at the very beginning of the letter. If you are not sure what your strongest piece of evidence is, here are my recommendations:

If you have a photograph that captures the patient’s problem, use it first in the letter and use it first during the ALJ hearing.

If you don’t have a photograph but you do have a clear-cut statement by a recognized authority that what you did was entirely correct, use that first.
If you don’t have a photograph or a statement by a recognized authority, but you do have a peer-reviewed journal article supporting the service at issue—use that first. Whatever you do, do not waste the beginning of the letter and/or the beginning of the hearing with information about unimportant issues or worse, non-issues.

Get to the point immediately. The judge is not interested in a display of knowledge regarding a topic in medicine. The judge just wants to know if you deserve to be paid for the service you provided.

143. Other than the QIC, who else do you have to send the letter brief to?
No one. The QIC will forward your letter brief to the ALJ’s office. While you must send copies of the ALJ appeal request form to each of the patients whose claims are the subject of the appeal (see 405.1014), you are not required to send them copies of the letter brief sent to the QIC.

144. How much emotion should you include in your letter brief?
None. Look for the adjectives in your letter brief and get rid of them.

The ALJ will be turned off by emotion in your letter brief and will be really turned off by emotion in your oral argument during the hearing. Think about this: Do you find yourself positively engaged when a Medicare beneficiary starts whining to you about the treatment they received at the hands of other providers or about how unfair Medicare is?

The ALJ will stop paying attention to what you have written and what you are saying when you start whining in your letter and/or when you start whining as you speak during the hearing. A display of emotion will result in the exact opposite effect you are trying to achieve.

145. What should you do if the QIC raises new arguments in the reconsideration decision?
If the QIC supports the contractor’s denial and offers additional reasons why your claim should not be paid, do you get to refute the additional new denial reasons offered by the QIC? Absolutely, yes. You will send a separate letter brief to the ALJ that lists all of the QIC’s new reasons for denial and explains why all of those reasons are wrong.

Under 405.1028, a provider/supplier always has good cause to send the ALJ a letter explaining why the new denial reasons offered by the QIC are wrong.

If the QIC raises new arguments in their denial letter, you will write and submit a second, short letter brief to the ALJ. The table you will use as Attachment #1 to the second letter brief will look like this:

<table>
<thead>
<tr>
<th>Name of patient</th>
<th>Medicare number</th>
<th>Beneficiary address, city, state, zip</th>
<th>Date of service</th>
<th>Code(s) at issue</th>
<th>QIC appeal number</th>
<th>Date copy of ALJ request sent to beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Robert</td>
<td>444555666A</td>
<td>22 Campbell Rd., Palo Alto, CA 94303</td>
<td>06/11/2019</td>
<td>99213-25, 64455-59 (include all modifiers used on the claim)</td>
<td>The appeal number assigned to the claim by the QIC</td>
<td>12/19/2019</td>
</tr>
</tbody>
</table>

You will limit your second brief to the new arguments raised by the QIC. Make it easy for the judge. List the new denial reasons and explain why each new reason is wrong.
146. What if you forgot to include an important piece of evidence in the letter sent to the QIC?
Relax. If everything in your letter brief makes sense and the evidence you failed to send is even loosely referenced in the letter brief, chances are the ALJ will allow that late-submitted piece of evidence to be admitted for the ALJ appeal.

147. Does any of this apply to you if your medical group does all your billing and appeals?
Knowing what you are doing with billing—and knowing how to fight effectively when payment for your services is denied—is a professional survival skill that you have to master and keep current. And for those of you who work in large groups and think someone else is taking care of all your billing concerns, that just isn't realistic.

If you are not regularly checking on what is and what is not being billed, what is being denied, and what is being done about the denials, you are losing money, possibly a lot of money. This is like turning your checkbook over to someone else and hoping they will take care of all your financial needs. Unless that other person is your spouse, it doesn't happen.

148. If you don't want to write letter briefs and do ALJ hearings, what should you do?
I am supposed to write something like this: If you are on top of your billing but you just don't want to write letter briefs and you don't want to defend yourself at ALJ hearings, call someone like me, a health care attorney, who will be happy to write the letter brief and will be happy to represent you at the ALJ hearing all on a contingency fee basis. At the end of the day, receiving 60% of the allowed Medicare fee as the provider/supplier is a lot better than receiving 0% of the allowed Medicare fee.

What I wanted to write was this: “Call me! Call me! I will represent you on a contingency fee basis, I am very experienced, I am hardworking, I am easy to work with, and I get results.”