



MEDICARE

Part A Intermediary
Part B Carrier

August 10, 2010

MEDICARE REDETERMINATION DECISION

[REDACTED]

Medicare Beneficiary:

[REDACTED]

Contact Information

If you have questions, write or call:
Palmetto GBA
P. O. Box 100238
Columbia, SC 29202-3238

Provider: 1-877-567-9249

Beneficiary: 1-800-633-4227

Dear [REDACTED]

This letter is to inform you of the decision on your Medicare Appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you made an appeal for outpatient services.

The appeal decision is **unfavorable**. Our decision is the claim is not covered by Medicare.

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). You must file your appeal, in writing, within 180 days of receiving this letter. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal, see the section of this letter entitled, "Important Information About Your Appeal Rights."

A copy of this letter was also sent to [REDACTED] Hospital. Palmetto GBA was contracted by Medicare to review your appeal. For more information on how to appeal, see the section titled "Important Information About Your Appeal Rights."

Summary of the Facts

Provider	Dates of Service	Type of Service
[REDACTED] Hospital	05/22/2009-05/28/2009	outpatient

Palmetto GBA

Part A Appeals, AG-630

Post Office Box 100238 ♦ Columbia, South Carolina ♦ 29202-3238

A CMS Contracted Intermediary and Carrier

- A claim was submitted for 3 pharmacy charges, 7 intravenous (IV) solution pharmacy charges, 1 non-sterile supply charge, 34 laboratory charges, 4 x-ray charges, 2 CT scan charges, 6 respiratory therapy charges, 6 physical therapy charges, 1 speech language pathology charge, 1 emergency department charge, 1 cardiovascular department charge, 17 detailed pharmacy injection charges, 1 self administered medication, 7 electrocardiogram (EKG) charges and 1 hospital observation room charge. According to the documentation submitted, the hospital stay from May 22, 2009 through May 28, 2009 was billed as an observation status hospital stay.
- An initial determination on this claim was made on August 12, 2009
- On July 19, 2010 we received a request for a redetermination
- Documentation submitted with the redetermination request included Medicare Part A Redetermination acknowledgement letter dated July 28, 2010, admissions registration form dated May 22, 2009, [REDACTED] Hospitals Observation Initial Review determination record dated May 23, 2009, [REDACTED] Hospitals Observation Continued Stay Review determination dated May 23, 2009, full discharge summary, history and physical notes dated May 22, 2009, care management discharge planning notes, emergency department notes, consultation notes, inpatient consult emergency department notes, diagnostic cardiology report, inpatient progress notes, radiology reports, laboratory reports, physician orders, physical therapy continuation notes, discharge destination form, rhythm strips, department of prosthetics and orthotics progress notes/proof of delivery slip and reason for referral form, medication administration records (MAR), respiratory care records, vital sign records, intake/output records, graphics, nursing assessments, a letter of appeal written by Mrs. [REDACTED], Medicare Summary Notice (MSN), Medicare Rights statement, assessment report, letter of appeal written by [REDACTED] on June 28, 2009, a letter written by [REDACTED] manager of patient accounts dated July 14, 2009, a letter to Quality Improvement Organization dated July 27, 2009 written by [REDACTED], a letter written by [REDACTED] Review Specialist dated July 31, 2009, a photocopy of the January – February 2010 ARRP article on Hospital Stays Are Under Observation, [REDACTED] itemization of out patient hospital pharmacy charges, a copy of the Medicare Part A benefits and coverage requirements, a letter from [REDACTED] Convalescent Center stating a transfer to a certified bed dated June 4, 2010, a letter written by [REDACTED] Director of Medical Records/Billing, a Medicare Summary Notice (MSN) Part B Medical Insurance statement, a Wikipedia statement definition for ambulatory payment classifications, and an article titled Medicare Fraud Effort Gives Elderly Surprise Hospital Bills.

Decision

We have determined the above claim is not covered by Medicare. [REDACTED]
Hospital is liable for the charges and can not bill [REDACTED]

Explanation of the Decision

According to the information submitted, [REDACTED] was admitted to the [REDACTED] emergency department on May 22, 2009. It was noted [REDACTED] had fallen while attempting to fix her garage door. As the result from the fall, [REDACTED] complained of back pain and neck pain with pain and numbness to her right upper extremity. [REDACTED] was stated not losing consciousness, not dazed and alert and oriented. Numerous tests were performed for a full evaluation from her fall. It was noted a CT scan of the spine confirmed a cervical vertebra fracture of acute nature. A neurosurgeon was consulted and a magnetic resonance imaging (MRI) was obtained for evaluation of further ligament injury and right upper extremity pain and paralysis. Treatment was stated as pain control by small doses of Morphine with scheduled Tylenol with C-collar placement for twelve weeks.

In addition to the treatment of the acute cervical fracture, [REDACTED] complained of reproducible chest pain and shortness of breath. It was noted [REDACTED] has a prior history of these conditions. A cardiac workup was performed which was stated as negative. [REDACTED] was placed on aspiration precautions and encouraged to use an incentive spirometer due to her ongoing pulmonary issues. CPAP was continued as at home. A speech evaluation was also performed due to worsening chronic swallowing issues. Finally, laboratory reports were performed to evaluation [REDACTED]s International Normalized Ratio (INR) for her anticoagulant treatment. Her Coumadin does was held one night and then restarted at her home dose.

Documentation submitted supports [REDACTED] received intravenous (IV) fluids of Normal Saline at 50cc/hour from nine fifteen o'clock May 23, 2009 through May 28, 2009. [REDACTED] last received IV morphine for pain on May 27, 2009 at eight thirty five o'clock in the morning. In addition, the medication administration record (MAR) for May 26, 2009 indicated [REDACTED] received IV Magnesium Sulfate 1 gram for a one time dose due to a drop in her magnesium level from admission.

On page 6 of 9 of the emergency department notes, it was noted [REDACTED] was admitted to Internal Medicine. Prior to this, at eight seventeen o'clock May 22, 2009, [REDACTED] was stated as stable with pain all over and admitted to Med H for pain control and patient safety. These electronic records were electronically signed by the resident doctor [REDACTED] on May 25, 2009. At one minute after one o'clock May 23, 2009, [REDACTED] was admitted to room 8307. According to the documentation submitted, Palmetto GBA believes [REDACTED] was admitted as an inpatient to the [REDACTED] hospital for pain control and patient safety with discharge plans of a skilled nursing facility (SNF).

The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital. In certain specific situations coverage of services on an inpatient or outpatient basis is determined by the following rules:

Minor Surgery or Other Treatment - When patients with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for only a few hours (less than 24), they are considered outpatients for coverage purposes regardless of: the hour they came to the hospital, whether they used a bed, and whether they remained in the hospital past midnight.

Under original Medicare, the Quality Improvement Organization (QIO), for each hospital is responsible for deciding, during review of inpatient admissions on a case-by-case basis, whether the admission was medically necessary. Medicare law authorizes the QIO to make these judgments, and

the judgments are binding for purposes of Medicare coverage. In making these judgments, however, QIOs consider only the medical evidence which was available to the physician at the time an admission decision had to be made. They do not take into account other information (e.g., test results) which became available only after admission, except in cases where considering the post-admission information would support a finding that an admission was medically necessary. Refer to the Medicare Benefit Policy Manual Chapter 1, Section 10.

Palmetto GBA would have allowed payment for the inpatient admission of [REDACTED]. However, the provider billed [REDACTED] hospital stay at [REDACTED] from May 22, 2009 through May 28, 2009 as outpatient observation. Therefore, payment will not be allowed for an inpatient hospital admission due to billing issues. The provider must submit a corrected UB-04 bill type with a request for adjustment to change the outpatient admission to an inpatient admission. This would allow proper payment of the hospital stay as well as the admission to [REDACTED] Convalescent Center. The skilled nursing facility (SNF) admission criteria stated by the Center of Medicare and Medicaid is the beneficiary must experience a 3 day consecutive hospital stay prior to admission to the SNF.

According to the Medicare guidelines, there must be a 3-day qualifying hospital stay. In order to qualify for post-hospital extended care services, the individual must have been an inpatient of a hospital for a medically necessary stay of at least three consecutive calendar days. The three consecutive calendar days requirement can be met by stays totaling three consecutive days in one or more hospitals. In determining whether the requirement has been met, the day of admission, but not the day of discharge, is counted as a hospital inpatient day.

To be covered, the extended care services must have been for the treatment of a condition for which the beneficiary was receiving inpatient hospital services, including services of an emergency hospital, or a condition, which arose while in the SNF, or for treatment of a condition for which the beneficiary was previously hospitalized. In addition, the qualifying hospital stay must have been medically necessary. (CMS Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 8, Section 20 and Section 20.1)

It has been determined that beneficiary should have known or could have been expected to know that the services were non-covered as benefits are excluded without the 3-day qualifying hospital stay. (Refer to the CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 30, Section 70)

There were three (3) pharmacy charges, six (6) respiratory therapy charges, and 1 speech language pathology charge that were not considered in this review due to billing issues. One (1) medication charge (in the amount of \$760.54) was not considered in this review. The provider billed this medication as a non-covered excluded self-administered medication.

When a redetermination request is made for Part B services billed on a Part A claim, all documentation to support the services being appealed must be included with the request for redetermination. It is the provider's responsibility to submit complete documentation to substantiate that the services were rendered, ordered, and reasonable and necessary. Refer to 42 CFR Section 424.5 (a) (6).

Who is Responsible for the Bill?

We have determined that the provider is responsible for the charges for the observational hospital stay as they could reasonably been expected to know the services were non-covered. This determination was made because the provider had access to the Medicare manuals and publications in the CMS

Manual System via the Internet-Only Manuals (IOM's), Code of Federal Regulations (CFR), Resident Assessment Instrument Version 2 Long Term Care Manual, Department of Health and Human Services Federal Register Part II and Part III, and the Local Coverage Determinations (LCD).

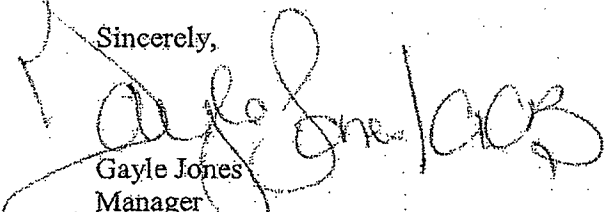
What to Include in Your Request for an Independent Appeal

Palmetto GBA is unable to pay this claim. To issue a favorable decision at the next level of appeal, the provider should submit a correct UB04 xx7 bill type requesting to change the observation status of the hospital stay from May 22, 2009 through May 28, 2009 to an inpatient admission.

Special Note to Medicare Providers Only: Any additional evidence as indicated in this notice must be submitted to the QIC. It should accompany the request for reconsideration. All evidence, including evidence that is not indicated in this notice, must be presented before the reconsideration is issued. If all additional evidence as indicated above and/or otherwise is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence in subsequent appeals unless you can demonstrate good cause for not presenting the evidence to the QIC. This evidence requirement also applies to providers who represent beneficiaries in the appeals process.

NOTE: you do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration process.

Sincerely,



Gayle Jones
Manager
Part A Appeals

Angelia Brazell, RN
Palmetto GBA
A Medicare Contractor