


**MAXIMUS**  
Federal Services 

If you have questions, write or call:

**MAXIMUS Federal Services**  
QIC Part A West  
P.O. Box 62410  
King of Prussia, PA 19406

Provider Inquiries

Visit: [www.g2a.org](http://www.g2a.org)  
Or  
Call: 484-688-8900

Beneficiary Inquiries

Call:

1-800-MEDICARE  
Or  
1-800-633-4227

Who we are:

We are MAXIMUS Federal Services. We are experts on appeals. Medicare hired us to review your file and make an independent decision.

November 10, 2009

██████████  
██████████  
██████████ MN ██████████

RE: Beneficiary: ██████████  
HIC #: ██████████  
Appellant: ██████████ (Appointed Representative and Power of Attorney)  
Dates of Service: January 21, 2008 through January 25, 2008

Dear Ms. ██████████:

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 requested an appeal for Medicare Part B of A outpatient hospital services provided to the beneficiary, ██████████, during the period of January 21, 2008 through January 25, 2008.

**The appeal decision is favorable.** Our decision is that your claim is covered by Medicare. More information on the decision is provided below. You are not required to take any action.

A copy of this letter was also sent to the provider.

MAXIMUS Federal Services (MAXIMUS) was contracted by Medicare to review your appeal.

### Appeal Details at Issue

Claim Line Number	DCN	Provider/Supplier	Dates of Service Appealed
1-14	[REDACTED]	[REDACTED] Hospital	01/21/08-01/25/09

### Summary of the Facts

- The beneficiary, [REDACTED], was admitted to [REDACTED] Hospital during the dates of January 21, 2008 through January 25, 2008. The utilization review department at [REDACTED] Hospital reviewed the inpatient order and found that criteria were not met to qualify the stay as a medically necessary inpatient stay. After the beneficiary's physician disagreed with findings, a second utilization review was performed affirming their decision to bill for the beneficiary's stay at an outpatient level. Executive Health Resources performed a second-level independent review of the claim on January 23, 2008 and affirmed the assessment of the utilization review department and determined that the beneficiary's condition did not meet the documentation conditions of inpatient medical necessity, and the claim was billed at an outpatient level.
- Six days after the beneficiary's discharge from [REDACTED] Hospital, a Medicare Part A inpatient claim auto released from the Central Billing Office of [REDACTED] Hospital. After learning of the error, [REDACTED] Hospital cancelled the inpatient claim and returned all Medicare Part A remuneration received to the Centers for Medicare & Medicaid Services.
- [REDACTED] Hospital submitted the claim for the ancillary outpatient hospital services, which on January 21, 2008 included: low osmolar contrast material (HCPCS code Q9967), comprehensive metabolic panel (HCPCS code 81001), Amylase (HCPCS code 82150, glucose; quantitative, blood (HCPCS code 82947), Lipase (HCPCS code 83690), complete blood count (HCPCS code 85025), prothrombin time (HCPCS code 85610), culture, bacterial; with isolation and presumptive identification of each isolate, urine (HCPCS code 87088), radiologic examination, chest, two views, frontal and lateral (HCPCS code 71020), computed tomography of the pelvis with contrast material(s) (HCPCS code 72193), computed tomography of the abdomen with contrast material(s) (HCPCS code 74160) and computed tomography scan of the head/brain without contrast material (HCPCS code 70450).
- The services were provided in relation to diagnoses of: unspecified psychosis (ICD-9 code 298.9), altered mental status (ICD-9 code 780.97), idiopathic normal pressure hydrocephalus (ICD-9 code 331.5), dementia in conditions classified elsewhere with behavioral disturbance (ICD-9 code 294.11), Parkinson's disease (ICD-9 code 332.0), atrial fibrillation (ICD-9 code 427.31), depressive disorder (ICD-9 code 311), anxiety state, unspecified (ICD-9 code 300.00), macular degeneration (senile) of Retina, unspecified (ICD-9 code 362.50) and esophageal reflux (ICD-9 code 530.81).

- The initial determination was rendered on April 17, 2008 and provided Medicare Part B of A payment for the claim at an outpatient level. The beneficiary was found liable for the coinsurance applied to the claim.
- On May 26, 2009, the affiliated contractor with jurisdiction, Noridian Administrative Services, LLC (Noridian), received a request for redetermination of the outpatient services provided on January 21, 2008 through January 25, 2008 from [REDACTED], appointed representative and Power of Attorney for the beneficiary. The appellant argued that the services provided to the beneficiary on January 21, 2008 through January 25, 2008 should be covered as inpatient under Medicare Part A, and not as an outpatient claim under Medicare Part B of A. Included with the request were the following documents: letters of appeal, Power of Attorney documentation, a letter from [REDACTED], M.D., Medicare Summary Notices, letters from [REDACTED], [REDACTED] and [REDACTED] of [REDACTED] Hospital, letters from the State of Minnesota Office of the Attorney General dated April 17, 2008, April 22, 2008, May 5, 2008, May 27, 2008, July 1, 2008, November 7, 2008, November 24, 2008 and December 3, 2008, a Voluntary Authorization for Release of Medical and Insurance Information, a letter from [REDACTED], M.D., a letter from [REDACTED], M.D., hospital records and a Report on Medicare Compliance.
- Noridian reached the redetermination on May 26, 2009. Noridian rendered a determination only with regard to the coinsurance remaining on the claim as billed under Medicare Part B of A, and determined that the beneficiary was responsible for the coinsurance amount for the date of January 21, 2008.
- On September 11, 2009, MAXIMUS received a request from the appellant for reconsideration of the outpatient services provided by [REDACTED] Hospital on January 21, 2008 through January 25, 2008.
- The appellant argued that the period of January 21, 2008 through January 25, 2008 should be regarded as a single hospital stay under Medicare Part A, and not an outpatient hospitalization under Medicare Part B of A.
- Included with this request were the following: a letter of appeal, a copy of a letter from the appellant dated February 2, 2009, a copy of the redetermination decision and an Appointment of Representative.
- On November 6, 2009, MAXIMUS sent a request via facsimile to [REDACTED] of Patient Financial Services, [REDACTED] Hospital, for a copy of the original inpatient universal billing form (UB-04). This request specified that the information was due by November 9, 2009.
- This case was sent to the MAXIMUS Federal Services medical reviewer to determine whether the services provided to the beneficiary on January 21, 2008 through January 25, 2008 met Medicare Part A inpatient coverage criteria.
- On November 9, 2009, MAXIMUS sent a second request to Mr. [REDACTED] for additional hospital records. This request specified that the information was due by November 10, 2009.

- On November 10, 2009, MAXIMUS received the UB-04 form from Mr. [REDACTED]. Also on November 10, 2009, MAXIMUS received additional medical records from [REDACTED] of [REDACTED] Hospital.

### Decision

We have determined that Medicare Part A will cover the claim for the services provided to the beneficiary on January 21, 2008 through January 25, 2008 as an inpatient stay. We have also determined that you are not responsible for payment for these services.

### Explanation of the Decision

The issue is whether the services provided to the beneficiary on January 21, 2008 through January 25, 2008 met Medicare Part A inpatient coverage criteria.

According to the Medicare Benefit Policy Manual, Publication 100-2, Chapter 1, Section 10-Covered Inpatient Hospital Services Covered Under Part A, inpatient hospital services include bed and board, nursing services and other related services, use of hospital or Critical Access Hospital (CAH) facilities, medical social services, drugs, biologicals, supplies, appliances, and equipment, certain other diagnostic or therapeutic services, medical or surgical services provided by certain interns or residents-in-training and transportation services, including transport by ambulance.

According to Section 10, the physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. 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.

Under Section 10, the 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 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.

According to the Program Integrity Manual, Publication 100-8, Chapter 6, Section 6.5.2, the medical reviewer shall consider any pre-existing medical problems or extenuating circumstances that make admission of the beneficiary medically necessary. Factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission. Inpatient care rather than outpatient care is required only if the beneficiary's medical condition, safety, or health would be significantly and directly threatened if care was provided in a less intensive setting.

A licensed healthcare professional reviewed this case and determined that the hospital services under review were reasonable and necessary per Medicare inpatient coverage criteria. The patient was a 79-year-old man who presented to the emergency room (ER) from his assisted living facility with progressive altered mental status over the prior week. He previously had been fully oriented and now was found to be quite disoriented, which defines the state of delirium. In the ER and at hospital admission the patient's delirium was thought to be related to recent medication changes. It appears that the patient's evaluation and management was limited to observation while transitioning off of one new medication and the addition of another, along with Neurology consultation. The patient's sedation improved but not his disorientation and he was discharged to skilled care for the services of a memory unit. Hospital documents available for review are limited to admission and discharge notes and the neurologist's admission consultation. Multiple beneficiary family and provider appeal letters are available for review.

Delirium represents an acutely life-threatening condition, evaluation and management of which can be complex and extended. Although this patient's management appears not to have been complex, and although the leading element in his physician's differential diagnosis (which turned out to be correct) would not have presaged complexity, it was not reliably predictable at the time of admission that the necessary work-up of the balance of the differential diagnosis would have been able to be completed within a reasonable period of hospital observation. Medicare coverage criteria allow for inpatient status in the absence of highly complex care when the care must be provided in a hospital and it is foreseeable that the required services likely will extend beyond a reasonable period of observation. The chart makes it reasonably inferable in this case that these criteria were met. Therefore, Medicare coverage criteria for an inpatient stay were met for the dates of service under review.

You can receive copies of statutes, regulations, policies, and/or manual instructions we used to arrive at this decision. For instructions on how to do this, please see 'Other Important Information' on the page titled "Important Information About Your Appeal Rights."

Medicare requires that all evidence be presented before the reconsideration is issued. On further appeal, an ALJ will not consider any new evidence unless you show good cause for not presenting the evidence to the Qualified Independent Contractor (QIC). This requirement does not apply to beneficiaries, unless a provider or supplier represents the beneficiary. You can find this rule at 42 Code of Federal Regulations Section 405.966.

#### **Who is Responsible for the Bill?**

You meet Medicare Part A inpatient coverage criteria for the services provided to the beneficiary by Fairview Ridges Hospital during January 21, 2008 through January 25, 2008. Medicare is responsible for the bill.

If you need more information or have any questions, please call the phone number on the front of this letter.

Sincerely,



Barbara M. Yakimowicz, J.D., M.H.A., PMP  
Project Director

BMY/ams

cc: [REDACTED] Hospital  
Attn: [REDACTED], Patient Financial Services  
[REDACTED]  
[REDACTED] MN [REDACTED]

Noridian  
(via facsimile)