BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of	)	
	)	
E G	)	OAH No. 20-0841-MDX
	)	Agency No.

DECISION

I. Introduction

E G is a Medicaid recipient who was an in-patient at Hospital A from May 5, 2020, the date of her admission, through June 3, 2020[1], when she was discharged. The Division of Health Care Services (Division), acting through its designated Medicaid claim third-party reviewer Comagine Health, determined that Ms. G's health care needs were not sufficient to justify hospitalization from May 11 through May 16 and May 25 through June 3, 2020 and declined Medicaid coverage for those portions of Ms. G's hospital stay.

The facts of this case show that Ms. G did not require a hospital level of care during May 11 through May 16 and May 25 through June 3, 2020. Her hospital stay during that time was due to the fact that her care needs were more complex than could be accommodated at her previous assisted living home and the hospital did not have a place to discharge her to. Regardless, she did not require an inpatient level of care during those two time periods and the Division's denial of authorization of payment for those time periods is AFFIRMED.

II. Facts

A. Ms. G's Hospital Stay

Ms. G is in her mid-60s and experiences dementia, hydrocephalus, seizures, and hypertension. Ms. G has a VP shunt for the hydrocephalus; however, it is occluded. She was living in an assisted living home and was admitted to Hospital A on May 5, 2020, after having been at the hospital during each of the three previous days. She had a diminished mental state, a possible urinary tract infection, and while in the emergency room experienced tachycardia with a

[1] There is some ambiguity as to whether Ms. G was discharged on June 2 or June 3, 2020. *See* Ex. D, p. 2, which refers to Ms. G's date of discharge being June 2, 2020, whereas Ex. D, p. 4, refers to the date of discharge being June 3, 2020. Because the actual hospital billing records were not supplied, this decision will use the later date of June 3, 2020.

heart rate near 200.[2] On May 9, 2020, while still in the hospital, she had a lumbar puncture performed to determine if there was an infection due to her shunt. That test came back negative.[3]

The medical records show no testing, or active treatments, including cardiology treatment, or other acute health events requiring active treatment, occurring between May 11 – 16, 2020, during which time Ms. G remained in the hospital. Instead, the records consistently refer to her as resting comfortably with the plan to return her to her assisted living home when she returned to her prior physical baseline.[4]

On May 17, 2020, the neurosurgeon made plans to conduct a procedure, an extraventricular drain, requiring hospitalization, to see if it would help Ms. G improve.[5] That procedure was performed on May 19, 2020. One of the hospitalists noted on May 20, 2020 that, while in the intensive care unit following the procedure, Ms. G would be reassessed in the next 2 – 3 days, and that she would need a new assisted living facility due to her current needs, and that hospice should be considered.[6] While in intensive care, Ms. G had two episodes of acute respiratory failure/pulmonary embolism, which were resolved.[7]

The medical records as of May 24, 2020 show that Ms. G had been moved from the intensive care unit back to medical, and that the intraventricular drain had been removed. Those records show no active treatment, but state she could not return to her previous assisted living facility due to her care needs, and that hospice should be considered.[8] Ms. G's medical records do not show any active treatments or acute medical issues during the remainder of her hospital stay.[9]

Ms. G's prior assisted living facility, where she had resided since 2015, did not have the staff to properly care for her and she was unable to return to it.[10] Instead, Ms. G was discharged from the hospital to a skilled nursing facility.[11]

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2 Ex. F, pp. 48 – 49.
3 Ex. F, pp. 48 – 49.
4 Ex. E, pp. 75 – 101; Ex. F, pp. 19 – 35; Dr. Raman's testimony.
5 Ex. E, p. 104.
6 Ex. E, pp. 120, 122, 125.
7 Ex. F, p. 13.
8 Ex. F, pp. 14 – 17.
9 Ex. E, pp. 127 -157; Ex. F, pp. 1 – 14; Dr. Raman's testimony.
10 *See* November 6, 2020 letter from Heart of Care, filed on November 9, 2020.
11 Ex. E, pp. 159 – 163 refers to the date of discharge being June 2, 2020. However, Comagine's correspondence refers to the date of discharge being June 3, 2020. *See* footnote 1 above.

B. The Medical Claims and their Disposition

Hospital A submitted Medicaid claims for the entirety of Ms. G's hospital stay. Those claims were given to Comagine Health for its third-party review, to determine if Ms. G's hospital stay was medically necessary.

Eric Raman, M.D. is a physician reviewer with Comagine Health, which performs third party reviews of Alaska Medicaid claims for medical necessity. He is a practicing hospitalist, has been a clinical instructor for the University of Washington medical school, and has a fellowship in hospital medicine. Both he and other Comagine reviewers examined the Medicaid claims submitted by the hospital for Ms. G's stay, including her medical records.[12] He concluded that two portions of Ms. G's hospital stay were not medically justified. Specifically, she was stable as of May 10, and did not receive any active treatment until there was a decision on May 17 that she should have the extraventricular drain, and then was recovered from that procedure by May 24, 2020. She was not receiving a hospital level of care between May 11 through May 16 and from May 25 onward. Dr. Raman opined that Ms. G did not require a medical inpatient level of care during those two time periods, due to her not receiving any active treatment or interventions.[13]

Comagine subsequently notified Ms. G that Medicaid did not consider the entirety of her hospital stay as being medically necessary, and that Medicaid would not pay for her hospital stay from May 11 through May 16, and May 25 through June 3, 2020.[14]

C. The Hearing

Ms. G requested a hearing to challenge the denial of payment for the two portions of her hospital stay. That hearing was held on November 24, 2020. Ms. G did not participate. Instead, her brother T Q, who holds her power of attorney, along with his wife D Q, represented Ms. G's interests and testified. Laura Baldwin, a fair hearing representative with the Division represented the Division. Dr. Raman testified for the Division.

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12 *See* Ex. G; Dr. Raman's testimony.
13 Dr. Raman's testimony.
14 Ex. D.

III. Discussion

The Medicaid program will only pay for medically necessary treatments.[15] The salient issue is whether Hospital's A billing for Ms. G's hospital stay should be partially denied as being medically unnecessary. Because Ms. G's hospital stay was a new service, she has the burden of proof by a preponderance of the evidence to show that her stay was medically necessary.[16]

The undisputed facts are that Ms. G was medically fragile and could not reside on her own, nor could she return to her previous assisted living home due to her intensive care needs. However, the question is whether she required a hospital inpatient level of care during her entire hospital stay. The Division has argued that Hospital A billed for and kept her at a full level of care during her entire stay, but that she instead should have been moved to a swing bed status during a portion of her stay. A swing bed is described by the Centers for Medicare and Medicaid Services as follows:

> The swing-bed concept allows a hospital to use their beds interchangeably for either acute-care or post-acute care. A "swing-bed" is a change in reimbursement status. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.[17]

Alaska Medicaid pays hospitals for its patients differently depending on whether they are full care inpatients or swing bed patients. The difference is considerable. Hospital A's Medicaid inpatient daily payment rate for the applicable period, January 1, 2020 through June 30, 2020 was $3,603.45.[18] The swing bed daily payment rate was considerably less, $802.66.[19]

This decision will not address whether Hospital A should have moved Ms. G to a swing bed status or whether the claims should be paid at the swing bed rate.[20] Instead, the only issue presented is whether Ms. G required a hospital inpatient level of care during May 11 through 16, and May 25 through June 3. The evidence in this case consisted primarily of the hospital records and Dr. Raman's testimony.

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15 *See* 7 AAC 105.100(5) and 7 AAC 105.110(1) and (2).

16 7 AAC 49.135.

17 CMS *State Operations Manual Appendix T – Regulations and Interpretive Guidelines for Swing Beds in Hospitals* Interpretive Guideline § 482.58 (SOM - Appendix T (cms.gov) date accessed December 24, 2020).

18 Official notice is taken of the Alaska Medicaid payment rates. Those rates are available online at Current Medicaid Payment Rates (alaska.gov) (dated accessed December 18, 2020).

19 Official notice is taken of the Alaska Medicaid swing bed payment rate. That rate is available online at Medicaid Swing Bed Rate for Calendar Year 2020 (alaska.gov) (date accessed December 18, 2020).

20 Hospital A has appeal rights, which it has apparently availed itself of. *See* Ex. D.

The federal courts have held that an individual's physician's treating opinion regarding whether a treatment is necessary is presumed to be correct:

> The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment.[21]

In general, more weight is given to a treating physician's opinion than the opinions of those who do not treat a claimant.[22] An examining physician's opinion is "entitled to greater weight than the opinion of a nonexamining physician."[23] An administrative law judge must provide "clear and convincing" reasons for rejecting the uncontradicted opinion of either a treating or examining physician.[24] Even when a treating or examining physician's opinion is contradicted, that opinion "can only be rejected for specific and legitimate reasons that are supported by substantial evidence in the record."[25] "The opinion of a nonexamining physician cannot by itself constitute substantial evidence that justifies the rejection of the opinion of either an examining physician *or* a treating physician."[26]

Utilizing the above test, because there is no direct evidence from any of Ms. G's treating or examining physicians (such as testimony, affidavit, or letter), it is necessary to review both the hospital records and Dr. Raman's testimony. A review of the hospital records, as recited in the facts above, corroborates Dr. Raman's credible testimony that for the designated portions of Ms. G's hospital stay, she was essentially observed and not provided any active medical treatment other than maintenance. For instance, despite the fact she was experiencing tachycardia, she was not provided any active cardiology treatment. This constitutes clear and convincing evidence that rebuts any implicit inference that Ms. G's entire hospital stay was medically necessary. Instead, the evidence shows that the designated portions of her hospital stay was caused by the fact that there was not an appropriate non-hospital placement for Ms. G: her needs were too intensive for her previous assisted living home, and she required a skilled nursing facility level of care, *i.e.,* a nursing home or other placement that provided a nursing facility level of care, supervision, and oversight, as compared to ongoing acute medical care.

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21 *Weaver v. Reagen*, 886 F.2d 194, 200 (8th Cir. 1989).
22 *Lester v. Chater*, 81 F.3d 821, 830 (9th Cir. 1996).
23 *Id.* at 830 – 831.
24 *Id.*
25 *Id.* at 830 – 831.
26 *Id. at 831.*

As a result, there is substantial evidence showing that Ms. G's inpatient stay during May 11 through 16 and May 25 through June 3, 2020 was not medically necessary: the Medicaid program's denial of the hospital's claims for those dates is upheld.

Ms. G should be aware that under 7 AAC 105.270(a) and 7 AAC 105.280, the provider can request an appeal to challenge the denial or a reduction in a claim. The record shows that Hospital A has availed itself of its appeal rights. This is the provider's only remedy and the "recipient is under no obligation to pay the provider for the service" unless the "recipient fail[ed] to furnish a recipient identification card, recipient identification number, or other evidence of Medicaid eligibility before receiving the service." [27] However, Ms. G may have some limited copayment obligation to Hospital A.[28]

IV. Conclusion

The Division's decision to deny Medicaid coverage for Ms. G's inpatient hospital stay at Hospital A for the time periods of May 11 through May 16 and May 25 through June 3, 2020 is AFFIRMED.

Dated: December 30, 2020

Signed
Lawrence A. Pederson
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 12th day of January, 2021.

By: *Signed*
Name: Lawrence A. Pederson
Title: Administrative Law Judge

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]

[27] 7 AAC 145.005(d). It should be noted that "[b]y providing a service to a Medicaid recipient and billing the department for that service, a provider agrees to comply with applicable department regulations." 7 AAC 145.005(g).

[28] 7 AAC 145.005(d). The copayment requirements are listed in 7 AAC 05.610.