BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

CRISP REGIONAL HOSPITAL,	:	
Petitioner,	:	**Docket No.:**
	:	**OSAH-DCH-PROP-1450910-40-Brown**
v.	:	
	:	**Agency Reference No: P13-182**
DEPARTMENT OF COMMUNITY HEALTH,	:	
Respondent.	:	

John C. Cotton, Esq.,
For Petitioner

Roy Griffis, Esq.,
For Respondent.

FILED
OSAH
DEC 23 2014

Kevin Westray, Legal Assistant

INITIAL DECISION

I. INTRODUCTION

Crisp Regional Hospital requested a hearing to dispute the decision of Respondent, the Department of Community Health (hereinafter "DCH"), to deny Medicaid reimbursement for inpatient services provided to a Medicaid-eligible patient (hereinafter "the Beneficiary"). The hearing on this matter took place on October 20, 2014 before the undersigned Administrative Law Judge of the Office of State Administrative Hearings. The evidentiary record remained open until November 10, 2014 to allow the parties to file Proposed Findings of Fact and Conclusions of Law. For the reasons indicated below, DCH's action is **AFFIRMED.**

II. FINDINGS OF FACT

Medicaid Reimbursement for Inpatient Hospital Services

1.

DCH is the state agency responsible for administering Georgia Medicaid, a cooperative state/federal program created through Title XIX of the Social Security Act. Through Medicaid, DCH compensates enrolled providers for covered services furnished to eligible members. DCH

administers Medicaid pursuant to a State Plan approved by the Center for Medicare and Medicaid Services (CMS), the entity responsible for administering Medicaid at the federal level.

2.

Medicaid reimburses providers for inpatient hospital services under a "hybrid diagnosis related group [DRG] prospective payment system." The DRG system classifies inpatient hospital services into groups based on a number of factors, including principal diagnosis, secondary diagnosis, age, and presence of complications. Each hospital service or group is identified by a DRG code, which has an associated payment amount established by DCH. The initial claim for which a provider seeks reimbursement is called an "inlier" claim. An enrolled provider that has an unusually costly admission, or cost outlier, during a reimbursement year may obtain additional reimbursement for that admission under circumstances prescribed in DCH's Policy Manuals. *Exhibits R-3, R-4.*

3.

Provider claims are processed through an electronic system called the Georgia Medicaid Management Information System (GAMMIS). GAMMIS is administered by HP Enterprises, DCH's fiscal agent. It "adjudicates" claims pursuant to DCH reimbursement policy via an algorithm. If a provider's claim qualifies as an outlier, the claims processing system will issue a report of claim adjudication, called a Remittance Advice, with Edit Code 4399, whereupon the provider may submit a written request and supporting documentation to HP Enterprise for outlier review. Providers cannot obtain outlier reimbursement without first obtaining a Remittance Advice with a 4399 edit code. *Exhibits R-3, R-4.*

Utilization Review Notes

4.

Providers enrolled in Georgia Medicaid must meet federal and state requirements for control of utilization of inpatient services. This includes implementation of Utilization Review Plans. The purpose of utilization review is "to evaluate the necessity, appropriateness, and efficiency of the use of medical services." As part of utilization review, the attending physician, or another authorized representative must document that inpatient services continue to be medically necessary and appropriate. Additionally, the case manager must review the patient's record and document whether the patient meets "severity of illness" or "intensity of service" (SI/IS) criteria in Utilization Review Notes. Failure to document SI/IS criteria in Utilization Review Notes may result in denial of reimbursement. *Exhibits R-2, R-3, R-4.*

Crisp Regional Hospital's Claim

5.

Petitioner Crisp Regional Hospital (hereinafter "Crisp Regional") is a Medicaid-enrolled provider and operates a hospital in Cordele, Georgia. Crisp Regional adopted a Utilization Review Plan on December 21, 2011 with an effective timeframe of two years. *Exhibit R-2.*

6.

Crisp Regional provided inpatient hospital services to the Beneficiary from December 15, 2011 to March 12, 2012. *Exhibits R-5, P-4, P-7.*

7.

The Beneficiary was initially admitted to Crisp Regional's facility as a "self-pay." However, after her admission, the Beneficiary applied for, and obtained, retroactive Medicaid coverage. *Exhibit P-7.*

8.

Crisp Regional initially applied for inlier DRG coverage for inpatient services provided to the Beneficiary. On or about January 7, 2013, Crisp Regional obtained payment for its inlier claim in the amount of $27,560.49. The Remittance Advice issued to Crisp Regional included Edit Code 4399, indicating that Crisp Regional could pursue outlier reimbursement. *Exhibit P-1.*

9.

After Crisp Regional received the above-described Remittance Advice, Tish Eady, Crisp Regional's Hospital Biller, began compiling the documentation required to obtain outlier reimbursement. Eady submitted Crisp Regional's claim and supporting documentation (the "claim packet") to HP Enterprises for outlier payment consideration on or about January 25, 2013. *Exhibits P-2, P-3.*

10.

Pursuant to DCH's outlier reimbursement policies, Crisp Regional's claim packet included Utilization Review Notes generated for the Beneficiary while she was an inpatient. Crisp Regional's Utilization Review forms include a space where appropriate personnel may indicate that the patient "[m]eets I/S Criteria." On all of the Utilization Review Notes completed during the Beneficiary's stay at Crisp Regional, this space was left blank. Additionally, many of the entries in the Utilization Review Notes are undated or do not include a signature. *Exhibit R-5.*

11.

DCH notified Crisp Regional that its claim was denied on or about February 19, 2013. The Initial Denial Letter sent to Crisp Regional provided that Crisp Regional's claim was being denied because the "Utilization Review Notes documenting severity of illness and intensity of

service criteria [were] missing." DCH included the following notation under the box which read "The following additional information is required to complete the review process":[1]

> Part II of DCH Policies and Procedures for Hospital Services Manual, Appendix L indicates . . . Utilization review notes must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of your DRG outlier request . . . Appendix L further states . . . Hospital utilization review programs must include review of the medical necessity for admission the appropriateness of services and the medical necessity for continued stay . . . MET or NOT MET MUST BE DOCUMENTED on the Utilization Review Notes.

Exhibit P-4.

12.

Eady interpreted the Initial Denial Letter to mean that DCH did not receive the Utilization Review Notes along with the rest of the documentation submitted for outlier consideration. Accordingly, she sent a second claim packet, which was identical to the first, to DCH on or about March 1, 2013. *Exhibit P-5*; *Testimony of Tish Eady.*

13.

After reviewing Crisp Regional's claim packet a second time, DCH issued a Final Denial Letter to Crisp Regional on April 1, 2013. The Final Denial Letter provided that Crisp Regional's outlier claim was being denied for the following reason:

> The Utilization Review Notes not completely filled to indicate "Met" or "Not Met".
>
> - Part II, of the DCH Policies and Procedures for Hospital Services manual, Appendix L, indicates "Utilization review notes must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay. Failure to document the SI/IS criteria in the utilization review notes may result in the denial of your outlier request."

[1] This box was not checked. *See Exhibit P-4.*

- Appendix L further states, "Hospital utilization review programs must include review of the medical necessity for admission, the appropriateness of services and the medical necessity for continued stay." "Met" or "Not Met" must be documented on the Utilization Review Notes.

Exhibit P-6.

14.

After it was notified that its claim for outlier reimbursement had been denied, Crisp Regional's Case Manager reviewed the Utilization Review notes and amended them by handwriting "Y" or "N" to indicate whether the Beneficiary met intensity of service criteria for each date. Crisp Regional then submitted these "corrected" Utilization Review notes to DCH's Customer Service and Resolution Unit on or about April 8, 2013. *Exhibit P-7, P-8.*

15.

DCH submitted Crisp Regional's claim and supporting documentation to Georgia Medical Care Foundation (GMCF), its peer review organization, for an Administrative Review. Based upon GMCF's review, DCH affirmed its original determination to deny Crisp Regional's claim. DCH informed Crisp Regional of its determination in a letter dated March 18, 2014.[2] *Exhibit P-9.*

16.

On or about April 11, 2014, Crisp Regional submitted a hearing request and the matter was referred to the Office of State Administrative Hearings. *Exhibit P-10.*

III. CONCLUSIONS OF LAW

1.

Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to

[2] GMCF did not review the corrected Utilization Review Notes submitted by Crisp Regional. However, as Davilyn Ariail, Medical Claims Outlier Review Team Leader for GMCF, explained in her testimony, this would not alter DCH's determination because whether a patient meets SI/IS criteria must be documented at the time such notes are generated. *Testimony of Davilyn Ariail.*

meet the costs of necessary medical care and services. 42 U.S.C. §§ 1396 *et seq.*; *Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011). Participation is voluntary, "but once a state opts to participate it must comply with federal statutory and regulatory requirements." *Id.* All states have opted to participate and, thus, each must designate a single state agency to administer its Medicaid plan. *Id.*; 42 C.F.R. § 431.10(a), (b)(1). Georgia has designated DCH as the "single state agency for the administration" of Medicaid. O.C.G.A. § 49-2-11(f) (2014).

2.

Hospitals are reimbursed for inpatient services based on a hybrid diagnosis-related group ("DRG") prospective payment system. DEP'T OF CMTY HEALTH, PART II POLICIES AND PROCEDURES FOR HOSPITAL SERVICES [hereinafter HOSPITAL SERVICES MANUAL], App'x C, § 2. Claims for inpatient services may be reimbursed for operating cost based on one of three payment calculations: (1) inlier DRG; (2) outlier DRG; and (3) cost-to-charge ratio. *Id.* In order to receive outlier reimbursement, the provider must submit Utilization Review Notes with its claim. *Id. at* APP'X L (Reimbursement for Outlier Cases). These Utilization Review Notes "must indicate the severity of illness/intensity of service (SI/IS) that was met for medical necessity of the hospital stay." *Id.* "Failure to document the SI/IS criteria in the utilization review notes may result in the denial of [the Provider's] DRG outlier request . . . ." *Id.*

3.

From the plain language of the relevant policy manual provision, it does not appear that Crisp Regional failed to abide by the prerequisites for outlier reimbursement merely by failing to place a "Y" or "N" in the appropriate space on the Utilization Review form. In other words, the relevant provision does not render a provider's failure to "check a box" fatal as long as the provider otherwise "indicate[s] the severity of illness/intensity of service (SI/IS) that was met . . .

." However, in the present case, Crisp Regional not only failed to mark the Utilization Review Notes, but also to include any affirmative indication that severity of illness or intensity of service criteria were met and thereby failed to adhere to the prerequisites for outlier reimbursement. Accordingly, DCH's determination to deny Crisp Regional's claim was correct.

IV. DECISION

IT IS HEREBY ORDERED that DCH's action is **AFFIRMED**.

SO ORDERED, this 23rd day of December, 2014.

Barbara A. Brown

BARBARA A. BROWN
Administrative Law Judge