NOTICE OF AGENCY'S FINAL DECISION

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Case Nam[redacted]

ALJ: Somerville Decision Date: 1/29/19

Case No.: DHMH-MCP-15-17-19798

Agency Case No. (if applicable): _____

Document Name (CRS): _____

Please check one:

_✓_ AFFIRMED

_____ AFFIRMED w/ comment

_____ MODIFIED

_____ REVERSED

_____ OTHER _____

If not affirmed in its entirety, please append a copy of the Agency's Final Decision.

Signature Appears on Original

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[redacted]	*	**BEFORE WILLIAM SOMERVILLE,**
v.	*	**AN ADMINISTRATIVE LAW JUDGE**
MARYLAND DEPARTMENT OF	*	**OF THE MARYLAND OFFICE**
HEALTH	*	**OF ADMINISTRATIVE HEARINGS**
	*	**OAH No. DHMH-MCP-15-17-19798**

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PROPOSED[1] DECISION

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STATEMENT OF THE CASE

On May 16, 2017, the Department of Health and Mental Hygiene (DHMH or MDH),[2] issued a determination denying for lack of medical necessity reimbursement from the Medical Assistance (MA) program for treatment of a certain patient (Patient) at [redacted] (Hospital), an acute care hospital, during the dates of service from [redacted] 2017 through [redacted] 2017. On June 6, 2017, the Hospital filed a memorandum with the Office of Health Services at DHMH and the Office of Health Services treated that document as a request for hearing to challenge the DHMH's determination. On June 22, 2017, the matter was referred to the Office of Administrative Hearings (OAH) for a hearing.

[1] The regulatory scheme contemplates a "proposed decision" in this category of administrative case. Code of Maryland Regulations (COMAR) 10.09.92.13 (referring to COMAR 10.09.36.09); COMAR 10.09.36.09D(1) (thirty days to file exceptions).

[2] On July 1, 2017, DHMH was renamed the Maryland Department of Health (MDH). I will refer to the Agency as DHMH or MDH, as appropriate.

I held a hearing on November 2, 2018, at the Administrative Law Building in Hunt Valley, Maryland. [redacted], Associate General Counsel, represented the Hospital. Michael McCarthy, Assistant Attorney General, represented the MDH.

The Administrative Procedure Act, the Procedures for Hearings before the Secretary of Health, and the Rules of Procedure of the OAH govern procedure in this case. Md. Code Ann., §§ 10-201 through 10-226 (2014 & Supp. 2018); COMAR 10.01.03; and COMAR 28.02.01.

ISSUE

Did the MDH properly deny for lack of medical necessity reimbursement to the Hospital from the MA Program for inpatient treatment of the Patient, during the period from [redacted] 2017 through [redacted] 2017?

SUMMARY OF THE EVIDENCE

Exhibits

I admitted the following exhibits offered by the Hospital:

1. CV of Robert S. Tano, M.D.
2. Memorandum, 5-1-2017
3. Medical records, Bates stamped 1 through 112

I admitted the following exhibits offered by the MDH:

1. CV of Sherry L. Mills, M.D.
2. Administrative review document, 5-16-2017

Testimony

Robert S. Tano, M.D., testified on behalf of the Hospital, and was qualified to offer opinions in the field of "quality assurance and utilization review." Sherry L. Mills, M.D., testified on behalf of MDH, and was qualified to offer opinions in the field of "general medicine" and "utilization review."

FINDINGS OF FACT

Based upon demeanor evidence, testimony, and other evidence, I find the following facts by a preponderance of the evidence:

1. On [redacted] 2016, the Patient, an MA recipient, was admitted to the Hospital, an acute care facility. The Patient was 92 years old, was ventilator dependent, C-diff positive, and experiencing renal failure. She was eventually intubated.

2. On [redacted] 2016, the Patient's family had a palliative care consultation or conference about the Patient. The Patient's medical history was noted, as follows:

> Patient is a 92-year-old female with a past medical history of [redacted] in 1980s, [redacted] two times in 2011 and 2014 with no functional deficit, hypertension, type 2 diabetes mellitus. Patient also has a history of [redacted] radiation and chemo. Patient admitted for SOB[3] and found to have pneumonia. She is currently on antibiotics and still requires 1.5L NC. Nephrology has been following her for [redacted] and [redacted] attributed to [redacted] diet, and hydrations status. Per niece patient has had four hospitalizations over the last year, including two in [redacted] Previous admissions were for UTI and [redacted] Palliative care team was consulted to discuss goals of care. (Hosp. Ex. 3, p. 53.)

The Patient's frailty was discussed and the Hospital staff talked about CPR, intubation, and lowering the Patient's code status.[4] (Hosp. Ex. 3, p. 57-58.)

3. On [redacted] 2017, after the Patient had been intubated, extubated, and re-intubated a few times over the previous few days, the Patient's code status was changed to "No resuscitation or CPR efforts if cardiac or respiratory arrest occurs. Provide all other therapy, including therapies to prevent cardiac or respiratory arrest." Heart failure had been added to the list of diagnoses. (Hosp. Ex. 3, pp. 61 - 62.)

4. On [redacted] 2017, Hospital palliative care staff again met with the Patient's family. They spoke about weaning the Patient from the intubated ventilator support and how the

[3] "Shortness of breath."
[4] "Code status" addresses how much effort a patient wants expended to keep the patient alive if a life-threatening condition were to arise.

most recent attempt failed. The plan on which the family agreed was to extubate the Patient at 2:00 p.m. on the next day and move the Patient to a "waiting room" on the sixth floor for a last meeting with family members. (Hosp. Ex. 3, p. 67.) The Patient's code status was lowered to "Comfort Measures Only." (Hosp. Ex. 3, p. 69.) To transport the Patient anywhere, at that time, was potentially life threatening based on her medical frailty.

5. On [redacted] 2017, the Patient was palliatively extubated at 2:00 p.m. (Hosp. Ex. 3, p. 1.) The Patient was given oxygen through a nose tube. She received palliative measures and hospice care. She was given [redacted] for pain. She was moved to the sixth floor room and met with her family and her dog. She would linger in that state until eight days later when she would die.

6. On [redacted] 2017, a physician accurately noted in the Patient's chart that the Patient's family and health care team had previously discussed the Patient's DNR and DNI[5] code status and palliative care. All had agreed that palliative and comfort measures should be used thereafter. (Hosp. Ex. 3, p. 19.)

7. On [redacted] 2017, the Patient's physician accurately noted that the Patient's need for continued hospitalization was "continue comfort/palliative care" and goals were "comfort at end of life." A barrier to safe discharge was "still requiring palliative care" and "on IV [redacted]." (Hosp. Ex. 3, p. 23.)

8. On [redacted] 2017, the Patient's care was essentially the same. The Patient's chart accurately noted the reason for continued hospitalization was "rapidly declining status, comfort care req[uires] IV meds." (Hosp. Ex. 3, p. 32.)

9. On [redacted], 2017, the Patient was ventilator dependent (and had been extubated on [redacted] 2017), non-verbal, not oriented, suffering multi-organ failure, and on

[5] "Do Not Resuscitate" and "Do Not Intubate."

palliative care. Goals of care were to control pain and anxiety and provide comfort measures. With regard to the possibility of discharge, the Patient had an extremely poor prognosis and was terminally ill. (Hosp. Ex. 3, p. 36.) The Patient was approved for "charity home hospice" but a physician accurately held the opinion, as noted in the chart, that the Patient was "not currently stable for transfer home with hospice." (Hosp. Ex. 3, pp. 52 and 87.) On that day, the Patient's niece told the Patient "that it would be ok if [the Patient] transitioned on." (Hosp Ex. 3, p. 88.)

10. On [redacted] 2017, the Patient's condition remained the same as the previous day. (Hosp. Ex. 3, p. 39.) Her family asked that she be given a dose of [redacted] to help with pain caused by [redacted] Care being given was palliative care to help control pain and anxiety. (Hosp. Ex. 3, p. 43.)

11. On [redacted] 2017, the Patient's condition was unchanged. With regard to discharge, the Patient's chart accurately noted "Patient has an extremely poor prognosis as is terminally ill; exploring hospice options." (Hosp. Ex. 3, p. 46.)

12. On [redacted], 2017, the Patient continued not to be alert. Her family asked that her [redacted] dose be lowered and care providers complied. Goals of care were to control pain and anxiety and offer comfort measures. At 9:10 p.m. a physician examined the Patient and declared her to be dead.

13. Sometime before May 1, 2017, the Hospital requested reimbursement from the MA program, or billed, for "acute hospital care" provided to the Patient from [redacted] 2016 through [redacted] 2017. The Hospital did not ask for "administrative days" type of reimbursement.

14. Thereafter, the DHMH's utilization review agent denied seven reimbursement days, [redacted] through [redacted] 2017, for lack of medical necessity.

15. On May 1, 2017, a company hired by the Hospital to advocate for reimbursement sent a letter to the DHMH, in essence, pleading the Hospital's case and requesting further review. (Hosp. Ex. 2.)

16. On May 16, 2017, the DHMH reviewer again denied seven days, from [redacted] 2017 through [redacted] 2017. The program reviewer determined "the level of care received by the patient during the denied period could have been provided at a LLOC[6] (Hospice) and did not require an acute [hospital] setting; therefore the decision to deny the days [redacted]17 through [redacted]17 should be upheld." The DHMH notified the Hospital of its determination on that day. (MDH Ex. 2.)

17. On June 6, 2017, the Hospital, by an employee, filed a request for hearing to challenge the determination.

DISCUSSION

Burdens

COMAR 10.01.03.16B(5) provides the following:

> (5) In a proceeding in which a party seeks payment from the Department . . . the party seeking payment or contesting recoupment has the burden of going forward and the burden of persuasion.

In the instant case, I conclude that the Appellant bears the burdens of production and persuasion. COMAR 10.01.03.16B(5). To prevail, the Hospital must prove by a preponderance of the evidence that it is entitled to reimbursement from the MA Program for the medical services rendered to the Patient in the Hospital, an acute care facility, during the period from [redacted] 2017 through [redacted] 2017. Md. Code Ann., State Gov't § 10-217 (2014) (standard of proof).

[6] "Lower level of care."

With regard to a preponderance of the evidence, a trier of fact can properly accept all, some, or none of the evidence offered. *Sifrit v. State*, 383 Md. 116, 135 (2004); *Edsall v. Huffaker*, 159 Md. App. 337, 341-43 (2004).

Arguments of the Parties

The Hospital argues that although only palliative comfort care was provided to the Patient on and after [redacted] 2017, the Patient was not stabile for transfer to a lower-level health care facility. The Hospital could not, in good conscience, send the Patient to a nursing facility for hospice care or send the Patient home. The Hospital argues that having the dying Patient remain in an acute hospital setting for the last week of her life, under these circumstances, qualifies as rendering care that was "medically necessary."

The MDH argues that the comfort care given to the Patient, on and after [redacted] 2017, was not an acute hospital level of care, and could have been provided at a lower level of care facility. The Hospital, however, asked for acute level of care reimbursement. The MDH argues that the MA program will not pay for acute hospital level of care if that level has not been provided, or if the level of care that was provided could have been provided in a lower level of care setting.

Analysis

In the instant case, in order to prevail, the Hospital must show that the care provided to the Patient during the days in issue was care that was medically necessary. COMAR 10.09.92.04B.

The MDH only reimburses acute hospital providers though the MA program for services that are "medically necessary" or "necessary" as administrative days. The pertinent program regulation, COMAR 10.09.92.04B, provides:

B. The [MA] Program covers the following hospital services:
(1) Medically necessary emergency services as defined in COMAR 10.09.36.01, including triage, related ancillary services, and when necessary, observation stays of a participant who presents to a hospital emergency department;
(2) Medically necessary services performed in an outpatient department of a hospital;
(3) Medically necessary services performed at a freestanding medical facility;
(4) Medically necessary inpatient hospital services meeting the following criteria:
(a) Inpatient days, including preoperative days, determined to be medically necessary by the Department or its designee;
(b) Admissions from an emergency department resulting in a medically necessary inpatient stay; and
(c) Elective admissions that the Department or its designee determines to be medically necessary;
(5) Inpatient stays determined to be medically necessary due to an emergent condition by the Department or its designee for a nonqualified alien;
(6) Administrative days determined to be necessary by the Department or its designee
. . . .

COMAR 10.09.92.07C(3) restricts requests for payment for services under the "administrative day" category, as follows:

(3) A hospital is not eligible for administrative day reimbursement if the days have already been billed as acute days.

"Acute level of care," "administrative day," and "medically necessary" are defined in COMAR 10.09.92.01B, which sets forth definitions, as follows:

(2) "Acute level of care" means care in which a patient is treated:
(a) For a brief but severe episode of illness, for conditions that are the result of disease or trauma; and
(b) During recovery from surgery.
. . .

(4) "Administrative day" means a day of medical services delivered to a participant who no longer requires an acute level of care.
. . .

(20) "Medically necessary" means that the service or benefit is:
(a) Directly related to diagnostic, preventative, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
(b) Consistent with standards of good medical practice;
(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and
(d) Not primarily for the convenience of the participant, family, or provider.

COMAR 10.09.92.01B(2), (4), (20).

On [redacted] 2017, the Patient's code status was lowered to comfort care only. (Finding of Fact 4.) On [redacted] 2017, the Patient was palliatively extubated at 2:00 p.m. and taken to the sixth floor of the Hospital for a final meeting with family. (Finding of Fact 5.) She was not given treatment thereafter to cure any condition; she was treated for her symptoms only. (Findings of Fact 5, 6, 7, 9, 10, and 12.) The Patient was not being treated for a severe illness but was being treated for comfort. From some point on [redacted] 2017, until the end, the Patient was not being given an acute level of care in the acute hospital. COMAR 10.09.92.01B(2).

The Hospital eventually billed the service or treatment during that time as acute hospital services, and not as administrative days. (Finding of Fact 13.) The Hospital cannot now call those days in issue "administrative days" for reimbursement purposes. COMAR 09.10.92.07C(3).

It appears, however, that by applying the MDH's MA program reimbursement rules to the facts and circumstances of this particular case, the comfort services that were rendered in the last week of the Patient's life qualify as "medically necessary inpatient hospital services." COMAR 10.09.92.04B(4). Both of the opinion-offering witnesses recognized that to discharge the Patient to a lower level of care on or after [redacted] 2017, involved transporting the Patient to her home or to a hospice facility. That transport would not be without significant, possibly life-threatening barriers. (Finding of Fact 4.) One barrier was the fact that the Patient was on an I.V. [redacted] drip. Other medicines would have had to be substituted. Another barrier was the fact that the Patient was fragile, possibly too fragile for transport.[7] Thus, the inpatient services that the Patient received in the Hospital during the days in issue were "medically necessary"

[7] One witness opined that the Patient was too fragile to transport safely and that "it was just not done." The other opined that the Patient was fragile, but that it still could be done. I conclude that, despite the opinion of the MDH's witness to the contrary, the Hospital had no intention to discharge the Patient to a lower-level-of-care facility unless the Patient was stable, and unless safe to do so.

because the palliative services were "directly related to . . . palliative . . . treatment of an illness . . . or health condition." COMAR 10.09.92.01B(20)(a). There was no allegation or argument that the treatment the Patient received was not "good medical practice." COMAR 10.09.92.01B(20)(b). The treatment was "the most cost-efficient service" that could be provided "*without sacrificing effectiveness [of that palliative treatment], or access to it.*" COMAR 0.09.92.01B (20)(c) (emphasis added). Finally, there was no allegation or argument that the treatment was primarily for the convenience of the MA participant, family, or provider. COMAR 10.09.92.01B(20)(d).

I conclude on the facts and circumstances of this case, that transporting the Patient in her fragile condition would have sacrificed effectiveness of treatment or access to it. COMAR 10.09.92.01B(20)(c). I conclude that the Hospital has met its burdens.

CONCLUSIONS OF LAW

I conclude as a matter of law that [redacted] has shown by a preponderance of the evidence that the inpatient treatment of the Patient between [redacted] 2017 and [redacted] 2017 at an acute care hospital was medically necessary. COMAR 10.09.92.01B(20). I conclude therefore that MDH improperly denied payment from the MA Program to [redacted] for the medical services the Patient received at the Hospital between [redacted] 2017 and [redacted] 2017. COMAR 10.09.92.04B.

PROPOSED ORDER

I **PROPOSE** that the final decision maker:

ORDER that the request of [redacted] for payment for the Patient's stay at an acute care hospital between [redacted] 2017 and [redacted] 2017, be **GRANTED**.

Signature Appears on Original

January 29, 2019
Date Decision Mailed

William J.D. Somerville III
Administrative Law Judge

WS/emh
177756

RIGHT TO FILE EXCEPTIONS

Any party adversely affected by this proposed decision has the right to file written exceptions with the Secretary of the Maryland Department of Health within thirty days of the date of the Administrative Law Judge's (ALJ) decision. COMAR 10.09.92.13 (referring to COMAR 10.09.36.09); COMAR 10.09.36.09D(1) (thirty days from ALJ's decision). The Secretary will review timely exceptions before rendering the final agency decision. Md. Code Ann., State Gov't §§ 10-216, 10-220, 10-221 (2014); COMAR 10.01.03.01A (other specific procedural regulations apply); 18F. The Office of Administrative Hearings is not a party to any review process.

Copies Mailed To:

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[redacted]

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