BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

TAYLOR REGIONAL HOSPITAL,	:	
	:	**Docket No.: OSAH-DCH-PROP-**
Petitioner,	:	**1328857-116-WOODARD**
	:	
v.	:	**Agency Reference No.: P13-017**
	:	
DEPARTMENT OF COMMUNITY HEALTH,	:	
	:	
Respondent.	:	
	:	

INITIAL DECISION

I. Introduction

Petitioner appealed Respondent's decision to deny its claim for Medicaid coverage of an open cholecystectomy that Petitioner performed on August 23, 2011, for patient "L.F." An administrative hearing was conducted on March 26, 2013, by telephone. Appearing for Petitioner (hereafter "Taylor Regional" or "Petitioner") were the following employees: Susan Smith, RN, Case Manager; Dawn Warnock, Director, Health Information Services; and Deanna Floyd, Business Office Manager. Appearing for Respondent were Theresa Sroufe, Team Leader of Precertification Team, Georgia Medical Care Foundation ("GMCF"); and Candace Morgan, Program Specialist for Hospital Services, Department of Community Health (hereafter "DCH" or "Respondent"). Respondent was represented by Malcolm L. H. Wells, Esq.

For the reasons set forth below, Respondent's denial of Petitioner's claim for the open cholecystectomy is hereby **AFFIRMED**.

II. Findings of Fact

1.

The patient was scheduled for an outpatient laproscopic cholecystectomy at Taylor Regional, a Medicaid provider in Hawkinsville, Georgia, on August 16, 2011. The procedure was later rescheduled to August 23, 2011. During surgery, the procedure

was converted to an open cholecystectomy after the discovery of inflammatory tissue and adhesions that made the laproscopic procedure unsafe. The patient was eligible for Medicaid at the time of admission. (Testimony of Susan Smith; Exhibits R-2 & R-3).

2.

When a Medicaid recipient is scheduled in advance for surgery or other treatment at a Medicaid-participating hospital, the hospital is required to obtain a precertification number from Respondent. If it is determined during the procedure that a patient's status requires a change from outpatient to inpatient, Respondent is required to inform Medicaid. The change in procedure, from laproscopic to open, may also require a new authorization code and must be verified with Medicaid as a separate matter. Respondent allows the hospital to request a change to the precertification authorization for the procedure and/or status within thirty (30) days of the beginning date of the episode of care. (Testimony of Candace Morgan; Exhibit R-1).

3.

Respondent has assigned responsibility for evaluating and issuing precertification numbers to its agent, the Georgia Medical Care Foundation ("GMCF"). Respondent allows providers to request precertification numbers through GMCF by fax, writing, a change request link on the website, and, in certain circumstances, by phone. Another method of communication is the GMCF "Contact Us" inquiry on its website. However, GMCF does not treat the "Contact Us" inquiry as a correct venue for requests for reconsideration. (Testimony of Theresa Sroufe; Exhibit R-5).

4.

Susan Smith, RN, is the Case Manager who handled the precertification process for Taylor Regional. Smith called GMCF on August 25, 2011, and explained that the patient was scheduled for an outpatient laproscopic cholecystectomy but, during surgery, the procedure was changed to an open cholecystectomy. Smith was informed that no further action was required on her part to change the preauthorization code for the procedure because the preauthorized procedure and the eventual procedure are in the

same family of codes ("FOC"). However, Smith did not mention anything to GMCF regarding a status code upgrade from outpatient to inpatient. (Testimony of Theresa Sroufe; Exhibit R-2).

5.

On September 21, 2011, Medicaid informed Smith that the claim was denied for reasons relating to the outpatient to inpatient status change. At that point, Smith attempted to update the status code from outpatient-to-inpatient. Smith was unable to process the change because thirty (30) days had passed since the original date of service, August 16, 2011.[1] Moreover, the August 25, 2011 inquiry was made through GMCF's "Contact Us" service, which is not the correct venue for a status upgrade from an outpatient to an inpatient code. (Testimony of Susan Smith; Testimony of Theresa Sroufe).

6.

On October 17, 2011, Petitioner requested a status change from outpatient to inpatient for the August 23, 2011 procedure by filing a new claim as per GMCF's instructions. Respondent denied the request because the request was untimely. Petitioner appealed four times and was denied each time by Respondent before requesting an Administrative Review. (Testimony of Susan Smith; Exhibit R-3).

III. Conclusions of Law

1.

Petitioner appealed the denial of its Medicaid claim. Therefore, the burden of proof is on Petitioner. Ga. Comp. R. & Reg. r. 616-1-2-.07. Respondent was required to present its evidence first at the hearing, but this did not shift the burden of proof from Petitioner. The standard of proof is by a preponderance of the evidence. Ga. Comp. R. & Reg. r. 616-1-2-.21.

2.

Ga. Comp. R. & Reg. r. 616-1-2-.21 states as follows:

[1] At this point, Petitioner had not notified GMCF that the date of surgery had changed to August 23, 2011.

> (1) In a hearing conducted under this Chapter, the Administrative Law Judge shall make an independent determination on the basis of the competent evidence presented at the hearing. Except as provided in Rule 29 [regarding remands to the Referring Agency], the Administrative Law Judge may make any disposition of the matter available to the Referring Agency . . . .
> . . . .
>
> (3) The hearing shall be de novo in nature, and the evidence on the issues in a hearing shall not be limited to the evidence presented to or considered by the Referring Agency prior to its decision.

3.

Respondent has issued general guidelines for Medicaid recipients and providers in *Part I, Policies and Procedures for Medicaid/Peach Care for Kids,* and specific guidelines for hospitals in *Part II, Policies and Procures for Hospital Services ("Hospital Services Manual").* These policies are not formally promulgated as rules and regulations, and the Administrative Law Judge took official notice at the hearing of the policies in effect in October and November 2010.

4.

Section 801 of the *Hospital Services Manual* states in pertinent part as follows:

> Services That Require Precertification
> As a condition of reimbursement, the Division [of Medical Assistance of the Department of Community Health] requires that inpatient hospital admissions and certain outpatient procedures be prior approved or pre-certified. Precertification pertains to medical necessity and appropriateness of setting only; the patient must be eligible at the time the service is rendered. The purpose of the program is to ensure that medically necessary quality health-care services be provided to eligible Medicaid members in the most cost effective setting. Precertification does not guarantee reimbursement. The medical record must substantiate the medical necessity, including the appropriateness of the setting for the services provided and billed to the Division.

As not all medical conditions can be known in advance of a procedure, Respondent has issued special guidelines in Section 802 for changes to precertification of urgent procedures and the emergency admission of a patient:

> When precertification . . . has been obtained for an outpatient procedure and during the procedure, it is determined that additional or a different procedure is necessary . . . the additional or different procedure will be considered an urgent procedure. The hospital's request for an update of the precertification file will be considered timely if received within thirty days of the date of the procedure.
>
> When precertification . . . has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary . . . the admission should be considered an emergency. The hospital's request for an update of the precertification file should be considered timely if received within thirty days of the beginning date of the episode of care.

Section 801 of the *Hospital Services Manual* concludes with the following warning:

> FAILURE TO OBTAIN THE REQUIRED CERTIFICATION WILL RESULT IN DENIAL OF REIMBURSEMENT.

(Emphasis contained in the original).

5.

There is no issue that Petitioner contacted Respondent in a timely manner to seek an authorization code change for the open laproscopic procedure during the August 25, 2011 call to GMCF. However, Petitioner did not submit a status change request to update from an outpatient-to-inpatient setting status at that time. The required status change request did not occur until October 17, 2011, which was after the thirty (30) timeframe set forth by Medicaid. Therefore, Respondent properly denied Petitioner's claim.

IV. Decision

IT IS HEREBY ORDERED that Respondent's decision to deny precertification for services provided by Petitioner on August 23, 2011 is **AFFIRMED**.

SO ORDERED, this 15th day of April, 2013.

M. Patrick Woodard, Jr.
Administrative Law Judge