BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

SOUTHERN REGIONAL MEDICAL CENTER, **Petitioner,** **v.** **DEPARTMENT OF COMMUNITY HEALTH,** **Respondent.**	**Docket No.:** [redacted] [redacted]**-OSAH-DCH-PROP-31-Howells** **Agency Reference No.:** [redacted]

FILED
07-11-2023
OFFICE OF STATE ADMINISTRATIVE HEARINGS

INITIAL DECISION

Petitioner Southern Regional Medical Center ("Southern Regional") requested a hearing to contest the final decision of the Department of Community Health ("DCH") that there was an overpayment regarding two admissions of one patient in the amount of $13,070.17. The hearing was conducted via video conference on June 9, 2023. David E. Grisham, Esq. represented Southern Regional. Kevin Spainhour, Esq. represented DCH. For the reasons that follow, DCH's determination of an overpayment is **AFFIRMED**.

Findings of Fact

1.

On May 9, 2018, at 8:42 p.m., B[redacted] M[redacted], a nursing home resident, arrived at the emergency room of Southern Regional. The reason for her visit was "AMS" or altered mental status, as stated on the Patient Registration form and the emergency department records. (Ex. R-1, part 1, pp. 9, 98-104.) When she arrived, she was comatose, but breathing on her own. (Id.) At 10:21 p.m., her temperature was reported as 96.7 degrees Fahrenheit. (Id. at p. 24.)

2.

The emergency department record listed the following diagnosis codes:

Diagnosis Code	Name
A41.9	SEPSIS, UNSPECIFIED
I63.9	CEREBRAL INFARCTION, UNSPECIFIED
G93.40	ENCEPHALOPATHY, UNSPECIFIED
J18.1	LOBAR PNEUMONIA, UNSPECIFIED ORGANISM
E87.1	HYPO-OSMOLALITY AND HYPONATREMIA
K92.2	GASTROINTESTINAL HEMORRHAGE, UNSPECIFIED
I13.0	HYP HRT & CHR KDNY DIS W HRT FAIL AND STG 1-4/UNSP CHR KDNY
N17.9	ACUTE KIDNEY FAILURE, UNSPECIFIED
D62	ACUTE POSTHEMORRHAGIC ANEMIA
I48.0	PAROXYSMAL ATRIAL FIBRILLATION
Z66	DO NOT RECUSSITATE
N18.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED
E11.22	TYPE 2 DIABETES MELLITUS W DIABETIC CHRONIC KIDNEY DISEASE
I50.9	HEART FAILURE, UNSPECIFIED
G20	PARKINSON'S DISEASE
F03.90	UNSPECIFIED DEMANTIA WITHOUT BEHAVIORAL DISTURBANCE
I25.10	ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS
Z79.82	LONG TERM (CURRENT) USE OF ASPIRIN
Z88.0	ALLERGY STATUS TO PENICILLIN
I69.30	UNPSECIFIED SEQUELAE OF CEREBRAL INFARCTION
Z95.1	PRESENCE OF AORTOCORONARY BYPASS GRAFT
Z79.899	OTHER LONG TERM (CURRENT DRUG THERAPY
Z82.49	FAMILY HX OF ISCHEM HEART DIS AND OTH DIS OF THE CIRC SYS

(Ex. 1, part 1, p. 99.)

3.

Ms. M[redacted] was admitted to the hospital as of May 10, 2018. She underwent diagnostic tests and received treatment. It was determined that Ms. M[redacted] had suffered a massive cerebrovascular accident (i.e., a stroke). She had left lower lobe pneumonia, and she was anemic which was due to a gastrointestinal bleed. Additionally, she had hyponatremia (i.e., her sodium level was low) and evidence of possible sepsis. (Ex. R-1, part 1, pp. 19.) Her treatment included transfusion of packed red blood cells, administration of an intravenous antibiotic (Levaquin), and other medications. (Id. at pp. 12, 437-39, 455-58, 460-485.)

4.

Ms. M[redacted] was discharged from the hospital on May 17, 2018, at approximately 6:30 p.m.[1] (Ex. 1, part 2, p. 551.) Her discharge diagnoses were: (1) Altered Mental Status; (2) GI bleed; (3) History of CVA with residual deficit; (4) Ischemic stroke; (5) Atrial fibrillation; (6) CVA (cerebral vascular accident); and (7) Chronic renal insufficiency. (Ex. 1, part 1, pp. 12-13.) At the time of her discharge, Ms. M[redacted]'s attending physician considered her to be appropriate for hospice care; however, at the time, her family did not consent to hospice care. Ms. M[redacted] was discharged to the nursing home. (Id. at p. 12.)

5.

Ms. M[redacted] returned to the Southern Regional Emergency Department via ambulance on May 18, 2018, at approximately 10:09 a.m. The reason for her visit was difficulty breathing. (Ex. 1, part 2, p. 920.) According to the History and Physical Report, Ms. M[redacted] was in acute respiratory failure due to aspiration pneumonia. She was also diagnosed as having Sepsis. (Id. at p. 925.) Her temperature on admission was 102 degrees Fahrenheit. (Id. at 949.)

6.

The emergency department record listed the following diagnosis codes:

Diagnosis Code	Name
A41.9	SEPSIS, UNSPECIFIED ORGANISM
J96.01	ACUTE RESPIRATORY FAILURE WITH HYPOXIA
I50.33	ACUTE ON CHRONIC DIASTOLIC (CONGESTIVE) HEART FAILURE
G93.40	ENCEPHALOPATHY, UNSPECIFIED
J18.9	PNEUMONIA, UNSPECIFIED ORGANISM
E44.0	MODERATE PROTEIN-CALORIE MALNUTRITION
E87.2	ACIDOSIS
I69.959	HEMIPLGA FOLLOWING UNSP CEREBBASC DISEASE AFF UNSP SIDE
Z68.31	BODY MASS INDEX (BMI) 31.0-31.9, ADULT
Z66	DO NOT RECUSSITATE

[1] The last temperature recorded was 99.6, on May 17, 2018, at 2:25 p m. (Ex. 1, part 1, p. 403.)

D64.9	ANEMIA, UNSPECIFIED
E87.6	HYPOKALEMIA
E83.42	HYPOMAGNESEMIA
E83.39	OTHER DISORDERS OF PHOSPHORUS METABOLISM
I11.0	HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
E11.40	TYPE 2 DIABETES MELLITUS WITH DIABETIC NEUROPATHY, UNSP
G20	PARKINSON'S DISEASE
I48.91	UNSPECIFIED ATRIAL FIBRILLATION
I25.10	ATHSCL HEART DISEASE OF NATIVE CORONARY ARTERY W/O ANG PCTRS
Z95.1	PRESENCE OF AORTOCORONARY BYPASS GRAFT
E03.9	HYPOTHYROIDISM, UNSPECIFIED
F03.90	UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE
Z88.0	ALLERGY STATUS TO PENICILLIN
E11.69	TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION
J20.9	ACUTE BRONCHITIS, UNSPECIFIED

(Ex. 1, part 2, p. 957.)

7.

At the time of this readmission, the family had not consented to a Do Not Resuscitate Order. For that reason, Ms. M[redacted] was intubated and placed on mechanical ventilation. (Id. at 935.) She was admitted to the ICU, given intravenous antibiotics (Levaquin and Vancomycin), antihypertensives, and anti-failure medications. (Id. at p. 922.) At one point during Ms. M[redacted]'s hospital stay, her attending physician questioned whether her fever was neurogenic in nature, due to her previous CVA (i.e., stroke).[2] Because of this, her antibiotics were placed on hold. (Id. at p. 1203.)

[2] Ms. M[redacted]'s blood cultures were negative, her urine cultures were probably contaminated, and it appears no sputum cultures were taken. (Ex. 1, part 3, pp. 1285, 1387-1454.) Her chest X-rays showed as follows: May 19, 2018 – "lungs are clear"; May 21, 2018 – "Left basilar consolidation with small left pleural effusion, slightly progressed compared to prior exam. New mild opacification at right lung base, probably atelectasis"; May 22, 2018 –"bibasilar infiltrates [] small left pleural effusion [] no pneumothorax"; May 23, 2018 – "small left pleural effusion. Lungs are otherwise clear and expanded"; May 24, 2018 – "no acute infiltrates, effusions or pneumothoraces." (Ex. 1, part 3, pp. 1261-70.)

8.

On May 23, 2018, Ms. M[redacted]'s family agreed to a Do Not Resuscitate Order. (Id. at p. 1224.) Ms. M[redacted] was discharged to the inpatient hospice unit on May 24, 2018. (Id. at p. 922.) The last temperature recorded prior to her discharge was 99.5 degrees Fahrenheit, at 8:00 a.m. on May 24, 2018. (Id. at 1246.) According to Ms. M[redacted]'s attending physician, the reason for her admission on May 18, 2018 was "metabolic encephalopathy/acute hypoxic respiratory failure." (Id.) Ms. M[redacted]'s discharge diagnoses were as follows: acute hypoxic respiratory failure - requiring intubation on vent; febrile illness - improved; anemia; hypokalemia, hypomagnesemia, hypophosphatemia – corrected; lactic acidosis – resolved; history of CVA with residual weakness; history of hypertension – stable; acute on chronic diastolic congestive heart failure; Type 2 diabetes mellitus; diabetic neuropathy; history of Parkinson's disease; history of atrial fibrillation; history of coronary artery disease status post CABG; moderate protein calorie malnutrition; DNR status; poor prognosis. (Ex. 1, part 2, p. 922.)

9.

Myers and Stauffer serves as the Recovery Audit Contractor for Georgia's Medicaid Program. It conducted a review of selected claims paid to Southern Regional which were submitted in 2018 and which involved readmissions of patients with the same or related diagnoses within three days of discharge. John Lott is a Program Manager at Myers and Stauffer. He performed the claims analysis for that audit. (Ex. 1, part 1, p. 1; Testimony of John Lott.)

10.

Pursuant to Georgia Medicaid policy, when a patient is readmitted within three days of discharge for the same or a related problem, it must be considered one admission.[3] When that

[3] Southern Regional is a participating provider in the Medicaid Program. (Ex. 1, part 1, pp. 1-3.) DCH has adopted policy and procedure manuals that govern the Medicaid program generally and hospital services specifically, including

happens, the claims are combined and put through an algorithm to be regrouped and repriced. To determine if the problems were the same, the auditor looks at the principal diagnosis submitted by the provider. If the principal diagnoses are an exact match, then the problems are determined to be the "same." If the first three digits of the principal diagnosis match, then the problems are determined to be "related." When the first three digits of the principal diagnosis do not match, relatedness is determined by a review of all submitted diagnoses and procedures by the clinical team. Here, Southern Regional submitted the exact same principal diagnosis code of A41.9 (Sepsis) for Ms. M[redacted]'s May 10, 2018 through May 17, 2018 admission and for her May 18, 2018 through May 24, 2018 readmission. When these admissions were combined and regrouped, it was determined that Southern Regional received an overpayment in the amount of $13,070.17.[4] (Ex.1, part 1, pp. 1, 6; Testimony of John Lott.)

11.

Dr. Barbara Biggs is the Medical Director at Myers and Stauffer. She completed a relatedness review of Ms. M[redacted]'s two hospital admissions. She noted that Southern Regional submitted the same principal diagnosis of Sepsis for both admissions. In Dr. Biggs' opinion, the two admissions were related because Ms. M[redacted] was determined to be septic during both admissions. She attributes the sepsis to left lower lobe pneumonia which she contends was present during both admissions. Dr. Biggs is not convinced that the second admission is due to a second separate incidence of aspiration. Notwithstanding, she acknowledged that during Ms. M[redacted]'s

Part II, Policies and Procedures for Hospital Services ("Hospital Services Manual"). (Ex. 2.)

[4] The Initial Findings Letter and Notice of Overpayment was sent to Southern Regional on November 11, 2022. The original audit involved five patients. (Ex. 1, part 1, p. 1-7.) Southern Regional disagreed with the Initial Findings and submitted a response. After reviewing the response, Myers and Stauffer rescinded the findings as to some of the patients but maintained the findings as to B[redacted] M[redacted]. (See February 10, 2023 Final Decision Letter, attached to OSAH Form 1 in court file.) Southern Regional subsequently requested an administrative hearing. (See March 3, 2023 Hearing Request, attached to OSAH Form 1 in court file.)

first admission she had suffered a new CVA. She also notes that during both admissions Ms. M[redacted] was diagnosed with encephalopathy which is a change in brain function typically from a progressive illness. Nevertheless, when Ms. M[redacted] was readmitted on May 18, 2018 with shortness of breath, Dr. Biggs acknowledged that the shortness of breath could have been caused by pneumonia or a decreased inability to handle secretions due to her previous CVA. (Testimony of Dr. Biggs.)

12.

Dr. Sridhar Reddy testified on behalf of Southern Regional. In his opinion, the two admissions were for discreet problems. He believes the second admission was caused by aspiration which in turn caused the need for mechanical ventilation. He attributes the aspiration to the nursing home's failure to follow aspiration precautions. He acknowledged, however, that a CVA can cause a decreased gag reflex which can lead to aspiration. (Testimony of Dr. Reddy.)

Conclusions of Law

1.

The Georgia Medical Assistance Act of 1977 (O.C.G.A. §§ 49-4-141 et seq.) affords a provider participating in the state Medicaid program the opportunity to request an administrative hearing in order to appeal a determination by the Department regarding the amount of Medicaid reimbursement due to the provider. O.C.G.A. § 49-4-153(b)(2). The administrative hearing is *de novo* and this Court must make an independent determination on the basis of the evidence presented at the hearing. See GA. COMP. R. & REGS. r. 616-1-2-.21(1), (3). See also Longleaf Energy Assocs., LLC v. Friends of the Chattahoochee, Inc., 298 Ga. App. 753, 769 (2009), *cert. denied*, 2009 Ga. LEXIS 809 (Sept. 28, 2009) (ALJ must consider the applicable facts and law anew, without according deference or presumption of correctness to the decision of the agency).

2.

The relationship between the Petitioner and the Department is a contractual one. See Pruitt Corp. v. Dept. of Commty. Health, 284 Ga. 158, 160 (2008). The Petitioner, as a participating provider in the Medicaid program, is required to abide by the Department's policy manuals. "Providers of services are not required to participate in a state's Medicaid program, but if they do choose to participate, they must agree to accept payment in accordance with the state plan provisions." Briarcliff Haven, Inc. v. Dept of Human Resources, 403 F. Supp. 1355, 1362-63 (N.D. Ga. 1975).

3.

The policy at issue here is as follows: "Readmission for the same or related problem within three (3) days of discharge is considered the same admission." Section 904, Hospital Services Manual. Here, Southern Regional submitted the exact same principal diagnosis code of A41.9 (Sepsis) for the first admission and the second admission which was within approximately 16 hours of her discharge. Southern Regional argues that these were two discreet incidences of sepsis.

4.

As an initial matter, Southern Regional's argument seems unlikely. When Ms. M[redacted] arrived at the emergency room of Southern Regional on May 9, 2018, with altered mental status, her temperature was 96.7 degrees Fahrenheit. While she did develop a fever during that admission, she was also discharged back to the nursing home on May 17, 2018, with a last recorded temperature of 99.6.

5.

When Ms. M[redacted] returned to the Southern Regional's emergency room on May 18, 2018, she had a temperature of 102 degrees Fahrenheit. Thus, if she was septic during the first admission, it is more likely than not that the sepsis continued.

6.

Notwithstanding, it seems more likely that Ms. M[redacted] was not septic during her second admission and that her respiratory difficulty was related to her previous CVA. During her second admission, Ms. M[redacted]'s attending physician noted that her fever may have been neurogenic. Ms. M[redacted]'s blood cultures were negative, her urine culture was probably contaminated, and no sputum cultures were taken. Ms. M[redacted]'s chest X-rays did not clearly indicate pneumonia. She had intermittent fever throughout her second admission and she still had fever when she was transferred to hospice, despite having received antibiotics.

7.

Dr. Reddy opined that Ms. M[redacted]'s respiratory difficulty on May 18, 2018 was due to aspiration and that the cause of the aspiration was because aspiration precautions were not followed when she was discharged to the nursing home. No evidence was presented that the nursing home failed to follow aspiration precautions. Dr. Reddy did, however, acknowledge that a CVA can cause a decrease in the gag reflex which can lead to aspiration. Dr. Biggs also testified that Ms. M[redacted]'s shortness of breath during her second admission could be related to her previous CVA and a decreased ability to handle secretions.

8.

Therefore, if Ms. M[redacted] was septic during her first admission and her second admission it was more likely a continuation. If her difficulty breathing and subsequent mechanical ventilation

was due to aspiration, then it is likely that the aspiration was related to her previous CVA. In either event, the two admissions should be considered the same admission.

Decision

For the foregoing reasons, DCH's determination of an overpayment is **AFFIRMED**.

SO ORDERED, this 11th day of July, 2023.

Stephanie M. Howells
Administrative Law Judge