STATE OF NORTH CAROLINA | IN THE OFFICE OF ADMINISTRATIVE HEARINGS

COUNTY OF WAKE | 13 DHR 18151

REX HOSPITAL INC. Petitioner	)	
v.	)	FINAL DECISION
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE Respondent	)	

THIS CAUSE came on for hearing before the undersigned Administrative Law Judge Donald W. Overby on December 4-5, 2014, in Raleigh, North Carolina.

APPEARANCES

For Petitioner:

Tracy M. Field
WOMBLE CARLYLE SANDRIDGE & RICE, PLLC
271 17th Street, NW, Suite 2400
Atlanta, GA 30363

Christopher W. Jones
WOMBLE CARLYLE SANDRIDGE & RICE, PLLC
PO Box 831
Raleigh, NC 27602

For Respondent:

Neal T. McHenry
Assistant Attorney General
N.C. Dept. of Justice
9001 Mail Service Center
Raleigh, North Carolina 27699-9001

Rajeev K. Premakumar
Assistant Attorney General
N.C. Dept. of Justice
9001 Mail Service Center
Raleigh, North Carolina 27699-9001

ISSUE

Whether the Department exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; acted arbitrarily or capriciously; or failed to act as required by law or rule as required by N.C. Gen. Stat. § 150B-23

Whether the Department was entitled to recoup $2,635.30 in overpayments from Petitioner, which were identified in an audit with Program Integrity case number 513000050?

APPLICABLE STATUTES AND RULES

42 U.S.C. §§ 1396a - 1396v
42 C.F.R. Parts 455 and 456
N.C. Gen. Stat. § 150B-22 *et seq.*
10A N.C.A.C. 22F *et seq.*
21 N.C.A.C. 64 .0101 *et.seq.*
N.C. State Plan for Medical Assistance

EXHIBITS

Petitioner's Exhibits 1-5 were admitted into evidence.
Respondent's Exhibits 1-13, 15-19 were admitted into evidence.

WITNESSES

For Petitioner:	Joan B. Crowson, RN, MSN, CCM
For Respondent:	Laurence H. Raney, M.D. Judy Diamond, RN

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact. In making the findings of fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to the demeanor of the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable, and whether the testimony is consistent with all other believable evidence in the case. From the sworn testimony of witnesses, the undersigned makes the following:

FINDINGS OF FACT

1. At all times material to this matter, Petitioner, Rex Hospital, Inc. ("Petitioner"), was an enrolled provider of Acute Inpatient Hospital Services in the North Carolina Medicaid Program.

2. This matter involves an audit of Petitioner conducted by Health Management Systems ("HMS") on or about March, 2013 (Program Integrity Case No. 513000050). (Rsp. Ex. 3). HMS offices are located in Texas, but the reviewing contractors are from across the country.

3. Respondent contends that the admission to inpatient status in the case under review was not medically necessary and observation status would have been appropriate as determined by the reviewing physician (Rsp. Exs. 10 and 15, T pp. 111, 117). Respondent contends that the medical records did not justify admission to inpatient status. (Rsp. Ex. 5).

4. To initiate the audit, an initial record request letter was sent to the Petitioner. (Rsp.'s Ex. 3, T p. 41).

5. As a result of the audit, HMS identified an overpayment of $2,635.30, which was identified as Program Integrity Case No. 513000050. (Rsp. Ex. 5).

6. On June 5, 2013 HMS notified Petitioner of the audit results for Program Integrity Case No. 513000050 via mail and requested that Petitioner send in a check for the overpayment within thirty (30) days or file a Request for Reconsideration within fifteen (15) days. (Rsp. Ex. 5).

7. There is no contention that Petitioner failed to adequately comply with internal grievance and review requirements.

8. Petitioner filed a timely appeal for the one (1) inpatient admission to this Court and the case was set for hearing on December 4-5, 2014, by Order dated October 22, 2014.

9. The audits were conducted by nurse reviewers employed by HMS entering data from each patient's chart into the Interqual admission criteria software. (Rsp. Exs. 8 and 13, T pp. 46-49).

10. There is little to no evidence about the company HMS. The inference is that its business—perhaps sole business—is to provide post-payment reviews such as those at issue herein across the entire country.

11. Interqual is a nationally accepted criteria screening tool used by hospitals to help initially determine if a patient meets in-patient criteria.

12. Judy Diamond is an Appeals Team Lead Coordinator for HMS. Ms. Diamond testified on behalf of Respondent. She has an Associate's Degree in Nursing; has been a nurse for 18 years; is licensed as a nurse in the State of California; and oversees HMS audits in numerous states. (Ex. 18, T p. 22) Ms. Diamond received minimal training in the use of Interqual from HMS but uses the program on a daily basis. (T pp. 24-25) She receives regular updates and the manual is updated

annually but she does not receive particular on-going or yearly training on Interqual and is not and has not ever been tested on Interqual.

13. By her testimony, she has completed thousands of Interqual reviews determining whether a hospital stay met Interqual's criteria for an inpatient stay. (T pp. 25, 30) Ms. Diamond is familiar with and uses DMA's policies and manuals. (T p. 23).

14. Ms. Diamond was accepted as an expert in the administration of Interqual Level of Care Criteria and her testimony is to be given the weight the trier of fact deems appropriate. (T p. 34)

15. Upon receipt of the medical records from a hospital, the HMS nurse reviewer selects the version of Interqual to use based upon the date of admission and the category of treatment and then would check the appropriate boxes in the screening tool depending upon the nurse's review of the records. (T p. 30).

16. According to Ms. Diamond, the process that HMS uses is that the nurse reviewer reviews the records and completes the Interqual clinical assessment based upon the date of service. (T p. 42) If the Interqual criteria are met justifying in-patient treatment, then it is a non-finding and no recoupment is sought. (T p. 42) If the Interqual criteria are not met, then the file is sent back to a supervisor for assignment to a licensed physician to review. (T p. 42) If the physician finds that the admission to inpatient setting was medically necessary despite not meeting Interqual guidelines, the admission is entered as a non-finding and no recoupment is sought. (T pp. 42-43) If, on the other hand, the physician finds that admission to inpatient setting was not medically necessary, HMS seeks recoupment for the admission to a setting that is not medically necessary. (T p. 43).

17. Ms. Diamond did not identify the nurse reviewer in this case, and thus it is not known whether the nurse is licensed in North Carolina or anywhere else. She generally has no knowledge of the credentials or experience of the nurse reviewers nor how a particular nurse applies the Interqual assessment. In essence, she generally knows nothing about most nurses other than the name, an identifying number and which state the nurse is licensed in. (T pp. 55, 59)

18. Ms. Diamond acknowledges that each nurse reviewer also prepares a written summary. (T. pp. 61-62) The summary is the reviewing nurse's assertion of what was important from the file, not part of the Interqual assessment. The summary is forwarded to the reviewing physician who may or may not use the summary. No reviewing nurse appeared and testified in this hearing.

19. Ms. Diamond was not aware if an "inter-rater" was used by reviewing nurses to assure accuracy and reliability between the different professionals using the Interqual. (T. p. 58)

20. Ms. Diamond had no role in reviewing this file except and until to provide testimony in this contested case. She was not the reviewing nurse and has no underlying knowledge of anything about the particular files but is offering her opinion on the application of Interqual.

21. Laurence H. Raney, M.D. was called to testify by the Respondent. Dr. Raney is Board Certified in Emergency Medicine. He received his MD from the University of Florida in 1983 and

is a member of the American College of Emergency Physicians, the American Academy of Emergency Medicine and the Air Medical Physicians Association. (Rsp. Ex. 18, T. pp. 72-77).

22. Dr. Raney has never practiced medicine of any kind in North Carolina. Dr. Raney has never served on a hospital utilization management committee. Through researching UNC Hospital and the community in which it resides, Dr. Raney was able to familiarize himself with the community standard of care at UNC Hospital and determined that the standard of care was similar to a hospital at which he previously worked. (T pp. 76-77).

23. Dr. Raney was admitted by the Court to testify as an expert in emergency medicine and hospital admissions. His testimony is to be given the weight the trier of fact deems appropriate. (T p. 108).

24. Dr. Raney had no role in reviewing this file except and until to provide testimony in this contested case. He was not the reviewing physician and has no underlying knowledge of anything about the particular files but is offering his opinion on the admission review process and his review of the particular files in preparation for this hearing.

25. Any claims for patients which were found to not meet the Interqual admission criteria were subsequently reviewed by a licensed physician. (Rsp. Exs. 10 and 15, T pp. 38, 67, 79-80).

26. For the patient admission at issue from the audit, Respondent contends the inpatient admission did not meet the Interqual criteria for an inpatient admission and thus would appropriately be forwarded to a physician for review. (Rsp. Exs. 8 and 13, T pp. 47-49, 55-56)

27. According to Dr. Raney, once the case is before the physician for review, the doctor does not review the Interqual criteria, but does a whole new clinical review. The Interqual is in essence the first line tool which gets the particular case file to the doctor level for review. There is no prohibition to the doctor looking at the Interqual criteria.

28. According to Dr. Raney, the physician to whom this review was forwarded was a North Carolina licensed physician.

29. He has little to no knowledge of the credentials or experience of the physician reviewer nor how that particular doctor reviewed the file nor whether the doctor reviewed the Interqual assessment. In essence, he knows very little about that doctor or how he reviewed the files at issue. No North Carolina doctor was called to present evidence in this matter.

30. The Respondent contends that the audit found that Petitioner failed to comply with the DMA Hospital Provider Manual (last revised November 1999) which was in effect at the time that services examined by the audit were rendered for the patients involved. (Rsp. Ex. 2).

31. The Respondent's argument relies in large part on the Hospital Provider Manual. The Manual states that "[m]edically necessary and non-experimental inpatient hospital services are available to all eligible Medicaid recipients without limitation on length of stay." (Rsp. Ex. 2, p. 63).

32. The Hospital Provider Manual states that "[t]he Medicaid program will pay the cost of inpatient services that have been determined to be covered by the program and are medically necessary." (Rsp. Ex. 2, p. 64).

33. The Hospital Provider Manual also states that when "an entire hospital stay or any portion of an inpatient hospital stay is denied, the charges for that denied stay . . . will not be covered by Medicaid." (Rsp. Ex. p. 128).

34. Finally, the Hospital Provider Manual states that "[p]atients who are admitted to observation status do not qualify as inpatients, even when they stay past midnight." (Rsp. Ex. 2, p. 128).

35. Nothing has been presented to this Tribunal which elevates the Provider Manual to the status of rule. If such exists by way of exemption, or otherwise, it has not been produced. Absent such authority it would seem that the DMA Hospital Provider Manual would be relegated to the same status as the Adult Medicaid Manual which "merely explains the definitions that currently exist in federal and state statutes, rules and regulations" and that "[v]iolations of or failures to comply with the MAF [Medicaid] Manual [are] of no effect" unless the act or omission in question amounts to a "failure to meet the requirements set out in the federal and state statutes and regulations." Joyner v. N. Carolina Dep't of Health & Human Servs., 214 N.C. App. 278, 288-89, 715 S.E.2d 498, 505-06 (2011)

36. The underlying question to be resolved is whether or not Petitioner used acceptable medical standards within the community it serves in making the determination on in-patient versus observation status. The paramount question is whether or not the services rendered were medically necessary.

37. After the reconsideration review, the alleged overpayments for the inpatient admission at Rex Hospital of one patient remained contested between the parties, with the one admission having a total value of $2,635.30. The alleged overpayment is for patient D.D.

38. Petitioner did not challenge the accuracy of the $2,635.30 total figure at the hearing of this case.

39. Joan B. Crowson, RN, MSN, CCM is currently employed as an assistant director of utilization management with the Petitioner UNC Hospital. Ms. Crowson testified for the Petitioner and was admitted as an expert in utilization management and the use of Interqual and hospital admissions. (Pt. Ex. 2; T p. 186). She offered testimony concerning Rex Hospital as well.

40. Part of Ms. Crowson's duties are to make sure that the nurses at the various locations for utilization management within the UNC Hospitals system are reviewing in accordance with the Code of Federal Regulations. Interqual is an integral part of utilization management. Ms. Crowson and the other UM nurses are trained every year and tested every year on Interqual. Ms. Crowson has personally been using Interqual since 1997, having reviewed possibly as many as hundreds of thousands of cases. (T p. 176)

41. Ms. Crowson assisted Rex Hospital for a period of time while Rex was without a director. Further she has assisted as Rex and UNC Hospitals try to merge their electronic medical records. Thus Ms. Crowson has knowledge of Rex Hospital's utilization management program. She has worked closely with the UM managers at Rex. According to Ms. Crowson, the Rex UM program is very similar to that of UNC Hospitals. (T. p. 230)

42. According to Ms. Crowson, Rex does not have "resident" doctors rotating in and out of the hospital and it does not have psychiatry and therefore the UM system at UNC may be somewhat more involved. (T. p. 231)

43. While Ms. Crowson is more familiar with the UNC Hospital process than with that of Rex Hospital, she is aware that every hospital in the state of North Carolina is required to comply with the Code of Federal Regulations and the federal code requires a utilization plan. (T pp. 210, 223). Ms. Crowson even drafted the utilization management plan for UNC Hospitals. (T. p. 212)

44. Ms. Crowson is not a doctor to make the determination of admittance; however, as a member of the UM committee at UNC Hospital which reviews admissions, she has a function that is part of the decision as to the appropriateness of an admission.

45. While Ms. Crowson observed that the services which were planned for or provided to any patient admitted to an inpatient setting could have been done in an observation setting, she also stated that <u>any</u> service could be provided while in observation, including intensive care services. (T p. 247). Thus, in theory, every admission could be an "observation;" however, that would not be in keeping with the federal regulatory guidelines.

46. The fact that any service could be provided while in observation raises what is perhaps the underlying, but unspoken issue, which is whether or not this is a monetary and not a medical issue. Medicaid will pay the cost if the hospital stay is in-patient but the cost becomes the patient's responsibility if it is an observation setting. Rhetorically, if money is not at least partially driving the bus, then why does it matter so long as the patient is receiving proper care? Also, it is very important to note that the patient has zero input into the decision-making. The patient just knows that he or she spent a night in the hospital and does not know the wrangling of the decision-making until they get a bill. In other words, the decision does not necessarily affect the treatment received by the patient, but it does affect what happens in billing. (T. p. 218)

47. Ms. Crowson testified about the process used by the hospitals. The decision-making would not have reached the doctor level of review if the question about Interqual had not already been addressed. She testified that in each instance the process was followed correctly and thus the patient's records would have gone through the Interqual process. Respondent's witness Dr. Raney had stated that the doctors did not consult the Interqual reports anyway.

48. Ms. Crowson makes clear that any cases which did not meet criteria for admission at the nurse review/Interqual level are the ones that are reviewed by another doctor other than just the decision of the admitting physician. (T. p. 229)

49. If the reviewing physician and the admitting doctor are not in agreement after the initial physician review, then yet another independent physician is consulted for the review. In the hospital scheme of review, it takes two doctors to override the admitting decision of the attending physician. (T. p. 246)

50. Petitioner has complied with the federal regulatory guidelines for hospital admissions.

Based upon the foregoing Findings of Fact, this Tribunal makes the following

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings, and this tribunal has jurisdiction of the parties and of the subject matter at issue.

2. Respondent bears the burden of proof in this matter pursuant to N.C. Gen. Stat. §108C-12.

3. The test established by N.C. Gen. Stat. § 150B-23 is whether or not the agency "(1) Exceeded its authority or jurisdiction; (2) Acted erroneously; (3) Failed to use proper procedure; (4) Acted arbitrarily or capriciously; or (5) Failed to act as required by law or rule."

4. It is undisputed that Petitioner is a hospital providing Acute Inpatient Hospital Services to Medicaid recipients.

5. The federal enabling authority comes from 42 CFR 456 *et. seq.* and especially Subpart C, §§456.50 *et. seq.*, which specifically deals with utilization controls for hospitals.

6. 42 CFR 456.4 places the responsibility for monitoring the utilization control program with the state agency, the Respondent. Among other requirements, the state agency must "take all necessary corrective action to ensure the effectiveness of the program; [and] establish methods and procedures to implement this section."

7. 42 CFR 456.5 requires the state agency to have written criteria for evaluation of the appropriateness and quality of the Medicaid services rendered. Such criteria has not been produced for this contested case hearing.

8. 42 CFR 456.6 requires the Respondent to have an agreement with another agency wherein that subordinate agency "is responsible for establishing a plan for the review by professional health personnel of the appropriateness and quality of Medicaid services." An assumption may be that it is Health Management Systems, but there is scant evidence to that effect—only that HMS conducted the audit.

9. 42 CFR 431.107 requires the State Medicaid Plan to provide for an agreement between the State Medicaid agency and each provider. This requirement is echoed in 42 CFR 456.101 which further requires the hospital which provides inpatient care to have a utilization review plan "that provides for review of each beneficiary's need for the services that the hospital furnishes him."

10. 42 CFR 456.105 requires each hospital to establish a committee to perform the utilization review as required. 42 CFR 456.122 requires the committee to have written criteria to assess the needs for admission. Further it requires the committee to have "more extensive written criteria" for cases which have shown to be associated with high costs, or frequently are associated with the furnishing of excessive services, or are associated with attending physicians whose care is frequently found to be questionable.

11. There is no contention, and thus no evidence, that either the hospital or the individual doctors have been shown to have been associated with high costs, or that they are frequently associated with furnishing excessive services, or that the individual doctors care has frequently been found to be questionable.

12. 42 CFR 456.105 provides the hospital's committee with more specific details of the review to be conducted. If the hospital committee agrees that admission is warranted, then a date for review of that decision is assigned. If the committee does not think the criteria has been met, then the committee or a subgroup of the committee which includes at least one physician reviews the case. If the decision of the committee continues to be that admission is not warranted, then the attending physician is given an opportunity to present his reasons justifying admission. If the attending does not present further information, then the committee's decision stands. If, however, the attending physician does present further information, then at least two physicians are required to review and overturn the decision of the attending doctor.

13. The hospital fully complied with these federal requirements. (Pet. Ex. 3) While there is less direct evidence concerning Rex that UNC Hospital, because of the holding in this contested case, the dearth of evidence is of no consequence in that the Respondent has failed to carry its burden of proof.

14. N.C. Gen. Stat. 108A, Part 6, §§ 108A-54 *et. seq*. and entitled Medical Assistance Program, is the North Carolina enabling statutes for the Medicaid program. N.C. Gen. Stat. § 108A-54 authorizes the Respondent to adopt rules to implement the state Medicaid program. (Emphasis added)

15. N.C. Gen. Stat. § 108A-54.1B(a) more specifically authorizes the Respondent to adopt both temporary and permanent rules "to implement or define the federal laws and regulations, the North Carolina State Plan of Medical Assistance" and more particularly "the audits and program integrity." (Emphasis added) N.C. Gen. Stat. § 108A-54.1B(d) acknowledges that some plans and waivers which have been approved by CMS for the North Carolina Medicaid program have the same force and effect as properly promulgated rules. There is no evidence or argument presented to this Tribunal which identifies the hospital recoupment cases as being within such plan or waivers.

16. Armed with the authority to enact rules, the Respondent should have clear and concise rules which apply to this action to recoup monies paid to participating hospitals and, if such exists, it has not been provided in the course of this contested case. N.C. Gen. Stat. § 108A-54.2 applies to "policy" and does not help Respondent's position.

17. Respondent relies exclusively in its argument on rules found within 10A NCAC 22F. Subchapter 22F is entitled Program Integrity, and it is the subchapter dealing with program integrity for the entirety of Medicaid, not just the hospitals.

18. 10A NCAC 22F .0101, entitled Scope, specifically states that "[T]his Subchapter shall provide methods and procedures to ensure the integrity of the Medicaid program."(Emphasis added). In other words, if methods and procedures exist, they should be found in this subchapter.

19. Interestingly 10A NCAC 22F .0101 cites three General Statutes and one federal regulation as the authority for this rule. The first statute cited is N.C. Gen. Stat. § 108A-25(b) which states that a program of medical assistance is to be established and shall be administered by the county departments of social services. There is no evidence that the counties have had any role at all in the process with which this contested case is concerned.

20. The remaining two references to general statutes are N.C. Gen. Stat. § 108A-63 and N.C. Gen. Stat. § 108A-64, both of which refer to provider fraud. There has not been even an inference that provider fraud is involved in this case.

21. 10A NCAC 22F .0103 also requires the Respondent to develop methods and procedures for broadly dealing in practically any manner with cases involving "fraud, abuse, error, overutilization or the use of medically unnecessary or medically inappropriate services." The rule goes further and states that "the Division shall institute methods and procedures to recoup improperly paid claims."

22. Also, interestingly, 10A NCAC 22F .0103 refers to the same three statutes and the same federal regulation as 10A NCAC 22F .0101, which do not apply to this contested case based on the evidence presented. There is no evidence county departments of social services have been involved in this contested case.

23. 10A NCAC 22F .0301 defines "provider abuse." The assertion by Respondent, presumably, is that the hospital cases fit within this definition because the questioned charges were "not necessary" and that the hospital failed "to provide and maintain within accepted medical standards for the community . . . medically necessary care and services." (Emphasis added) However, as before, the authority for 10A NCAC 22F .0301 does not apply to the evidence as presented in this contested case.

24. 10A NCAC 22F .0601(a) provides for restitution for improper payments, but also lacks authority from the North Carolina General Assembly that is applicable to this contested case.

25. 10A NCAC 22F .0403 explains the process after utilization review has determined a patient has had an excessive length of stay, but there is nothing about how the determination for excessive stay is made. This rule likewise refers to N.C. Gen. Stat. § 108A-25(b) which requires the county departments to be involved.

26. Since all references by Respondent to rules refer to Subchapter 22F, and that subchapter does not authorize action as sought in this contested case, the Respondent has failed to show that

it has statutory or promulgated rule authority to do what it proposes to do in this contested case, i.e., recoup money paid to the hospital.

27. If there is any other statutory or rule authority, Respondent has failed to present such authority to this Tribunal.

28. Respondent relies in part on the DMA Hospital Provider Manual (revised November 1999). Nothing has been presented to this Tribunal which elevates the Provider Manual to the status of rule. If such exists by way of exemption, or otherwise, it has not been produced. Absent such authority it would seem that the DMA Hospital Provider Manual would be relegated to the same status as the Adult Medicaid Manual as addressed in Joyner v. N. Carolina Dep't of Health & Human Servs, which states

> The principal authority upon which DHHS relied in . . . was the North Carolina Adult Medicaid Manual, which is an "internal instructional reference for DHHS employees in the application of DHHS policy and interpretation of the federal Medicaid requirements." . . . Although the provisions of the Medicaid Manual are clearly entitled to some consideration in attempts to understand the rules and regulations governing eligibility for Medicaid benefits, we have previously stated that the Medicaid Manual "merely explains the definitions that currently exist in federal and state statutes, rules and regulations" and that "[v]iolations of or failures to comply with the MAF [Medicaid] Manual [are] of no effect" unless the act or omission in question amounts to a "failure to meet the requirements set out in the federal and state statutes and regulations [.]" *(Internal cites omitted)*
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> Joyner v. N. Carolina Dep't of Health & Human Servs., 214 N.C. App. 278, 288-89, 715 S.E.2d 498, 505-06 (2011)

29. It is also noted that the DMA Hospital Provider Manual, page 43, refers to a provision in the Administrative Code that has long since been repealed.

30. It is not known if Respondent is attempting to bootstrap the contract between Petitioner and Respondent into this argument. It was introduced as an exhibit, but there is no argument or reference to the contract in this case. However, assuming *arguendo* that such were the case, it would be without merit. In the contract, paragraph 3(e) makes reference to practically anything that has been reduced to writing and might remotely have relevance, including the kitchen sink. Mere reference to a writing in a contract does not rise to the level of enforceability unless the receiving party has a semblance of real notice. Further the contract requires that the contract is governed by the litany so long as it is "consistent with and expressly or implicitly authorized" and there is zero evidence of any of the contractual terms. Therefore the contract has no control in this case.

31. *Even if* it is assumed that the proper authority exists for these reviews, nothing has been presented to this Tribunal which shows the process followed to get to OAH. There is no evidence of how it was determined that these particular cases were chosen, how many cases were reviewed in total, were these cases merely randomly selected or what prompted the audit. Many unanswered

questions of the process exist. With no evidence, one cannot determine what is the proper procedure as required in N.C. Gen. Stat. § 150B-23, much less whether or not it was followed.

32. *Even if* it is assumed that the proper authority exists and that the proper procedure was followed, the Respondent does not prevail on the facts of this case.

33. This contested case is not just about a comparison of Dr. Raney's testimony and Ms. Crowson's testimony; however, assuming yet again that it was, neither of Respondent's witnesses participated in an active role in the initial reviews as compared to Ms. Crowson's very direct involvement of all of the hospitals process and reviews.

34. If there is a comparison to be made, then it would be Dr. Raney's much removed review of the patient's file as opposed to the admitting physician's opinion plus that of at least one reviewing doctor, possibly two.

35. The Eleventh Circuit Court of Appeals has discussed this to a degree, and while not controlling in this district it is certainly instructive. In Moore ex rel. Moore v. Reese, 637 F.3d 1220, 1223 (11th Cir. 2011), the Court of Appeals also dealt with the extent to which a state Medicaid agency may review the treating physician's determination of medical necessity.

36. The Court found in essence that neither the state agency nor the admitting physician necessarily prevails over the other:

> In sum, the Medicaid Act does not give the treating physician unilateral discretion to define medical necessity so long as the physician does not violate the law or breach ethical duties any more than it gives such discretion to the state so long as the state does not refuse to provide a required service outright. It is a false dichotomy to say that one or the other, the state's medical expert or the treating physician, must have complete control, or must be deferred to, when assessing whether a service or treatment is medically necessary under the Medicaid Act.
> Moore ex rel. Moore v. Reese, 637 F.3d 1220, 1259-60 (11th Cir. 2011)

37. *Even if* the comparison was or should be Dr. Raney's testimony versus the admitting doctor and/or the first line reviewing doctor, for the Respondent at best it would be substantially equal. In other words there has not been enough evidence to carry the burden of proof.

38. Respondent's evidence has shown at the very best that it did basically the exact same process the hospital did on the dates of admission except the State comes back with a different result. While the federal regulations require the individual states to have some form of quality and utilization management, this seems like Monday morning quarterbacking at its worse.

39. Based on the testimony and evidence presented in this contested case hearing, the hospital had a more extensive review at the time of the admissions than the Respondent has had after the fact. And in so doing, the hospital fully complied with the federal regulations and their own policy that was approved by the state.

40. Based on the testimony and qualifications of the parties' respective witnesses, the Court finds that the weight of the evidence supports Petitioner's contention that inpatient admission was medically necessary for this patient.

41. Ms. Crowson's testimony is given more credibility because she was actually more directly involved in the process under review even though she is employed with UNC Hospitals and not directly with Rex. Giving Dr. Raney and Ms. Diamond the weight deemed appropriate by the finder of fact, they are giving their opinions from afar and in hind-sight and are not given as much credibility as Ms. Crowson.

42. The underlying foundation for this entire process is the monetary considerations in order to protect and safeguard Medicaid monies so that the money is not wasted but rather spent on those in actual need. The very first section of 42 C.F.R. § 456 acknowledges such:

> (1) Methods and procedures to safeguard against unnecessary utilization of care and services. Section 1902(a)(30) requires that the State plan provide methods and procedures to safeguard against unnecessary utilization of care and services.
> (2) Penalty for failure to have an effective program to control utilization of institutional services. Section 1903(g)(1) provides for a reduction in the amount of Federal Medicaid funds paid to a State for long-stay inpatient services if the State does not make a showing satisfactory to the Secretary that it has an effective program of control over utilization of those services.
>
> 42 C.F.R. § 456.1

43. This and other parts of that section of the federal requirements show that the State can be penalized for not exercising proper control over the hospitalizations. The penalty is monetary. The references within the quote in paragraph 42 above are to requirements in sections of the Social Security Act.

44. This swirl of decision-making is made without any input from the patient. The patient has no idea of how these decisions may affect him or her. They are not asked if they would rather go home or if they want to be on "observation" and remain in the hospital even though it will cost them money if the in-patient is being denied.

45. Rhetorically, the question becomes is this a monetary decision or truly a medical decision. According to Ms. Diamond, HMS is the entity that seeks recoupment—not the Respondent DHHS, the single state agency responsible for Medicaid in the State of North Carolina. It could be an easy jump to make that HMS has monetary incentive and thus the close calls become monetary decisions from the Respondent's perspective; however, there is not sufficient evidence from which to conclude such is the case, and the issues in this case are framed solely about the medical decisions.

46. In this contested case, the Petitioner did what was required of them by the federal regulations.

47. With regard to the patient at issue in the case, the Respondent has failed to prove that it was not medically necessary to admit the patient to inpatient status. Stated in the positive, the patient was properly admitted into the hospital as an inpatient. The patient should not have instead been admitted to observation.

48. Respondent failed to meet its burden of showing by a preponderance of the evidence that DMA's identification of the payment as having been an improper overpayment and any subsequent action to recoup such payment was proper. Respondent failed to meet its burden of proof to show that the hospital failed to provide and maintain within accepted medical standards for the community medically necessary care and services.

49. As required in N.C. Gen. State §150B-23, Respondent exceeded its authority or jurisdiction; acted erroneously; failed to use proper procedure; and failed to act as required by law or rule.

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned makes the following:

DECISION

The decision by Respondent DMA to recoup $2,635.30 from Petitioner is not supported by the evidence and hereby is **REVERSED**.

NOTICE

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of Wake County or in the Superior Court of the county in which the party resides. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law Judge's Final Decision.** In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision. N.C. Gen. Stat. §150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. §150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

IT IS SO ORDERED.

This the 29th day of May, 2015.

DONALD W. OVERBY
Administrative Law Judge Presiding