DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD

ORDER OF MEDICARE APPEALS COUNCIL
REMANDING CASE TO ADMINISTRATIVE LAW JUDGE

In the case of	**Claim for**
*** o/b/o A.B. (deceased) (Appellant)	Hospital Insurance Benefits (Part A)
**** (Beneficiary)	**** (HIC Number)
Blue Cross Blue Shield of Georgia (Contractor)	**** (ALJ Appeal Number)

The Administrative Law Judge (ALJ) issued a decision dated March 12, 2009, which concerned Medicare coverage for inpatient hospital services provided to the beneficiary on February 13, 2008, in connection with her dentist's extraction of six teeth while she was hospitalized.[1] The ALJ denied coverage for the

[1] The ALJ's decision refers to the services as "services in conjunction with an inpatient hospital stay," under Medicare Part A. This characterization is consistent with the appellant's testimony at the hearing as to her understanding of the services. The medical records indicate that the beneficiary was an inpatient on the date of service at issue (February 13, 2008), as well as on consecutive days both prior to and following the date of service. However, there are parts of the record that refer to the services as "Part B" or "outpatient" services, apparently in error. *See, e.g.,* Medicare Summary Notice, Exh. 1 at 15. This inpatient dental services case is unusual in that the beneficiary's dental surgery was performed while the beneficiary was already a hospital inpatient rather than having been admitted for the specific dental procedure. Thus, this case likely involves coverage and payment issues under the Part A prospective payment system. The ALJ should consult with the Medicare Administrative Contractor in determining the exact coverage and payment issues on remand.

The primary purpose of the remand the Council orders in this case is to join the hospital as a party and to ascertain the specific nature of the particular services at issue, which were billed for $2,590. This is discussed on pages 4-9, below. While the services were rendered when the beneficiary was an inpatient, it is not clear whether these services, which were purportedly related to a dental procedure, are covered and/or separately payable services.

services, and found the beneficiary liable for the noncovered charges. The appellant has asked the Medicare Appeals Council to review this action.

The Council reviews the ALJ's decision *de novo.* 42 C.F.R. § 405.1108(a). The Council will limit its review of the ALJ's action to the exceptions raised by the party in the request for review, unless the appellant is an unrepresented beneficiary. 42 C.F.R. § 405.1112(c). The appellant's request for review will be made a part of the record as Exhibit (Exh.) MAC-1.

The Council hereby vacates the hearing decision and remands this case to an ALJ for further proceedings, including notice to the provider, Wills Memorial Hospital (which was not notified of and did not participate previously in the ALJ hearing process), and a new decision. *See* 42 C.F.R. §§ 405.1108(a), 405.1128(a).

The ALJ's Decision and the Appellant's Request for Review

The ALJ denied Medicare coverage for $2590 in charges claimed by the hospital purportedly in connection with dental services performed at the hospital in its operating room by the beneficiary's dentist, on February 13, 2008. Dec. at 1-2, 5; *see also* Exh. 4 at 7-9, Exh. 1 at 9 and 15. The ALJ's denial is based on two erroneous assumptions: first, that these charges were definitely for the dental services themselves, as opposed to possibly for related hospital inpatient services; and second, that when a dental procedure is performed in the hospital, Medicare requires that the procedure itself be necessary because of the individual's underlying condition and medical status (not that the hospitalization for the procedure be necessary because of the individual's underlying condition and medical status). Dec. at 5. *See* Section 1862(a)(12) of the Social Security Act (Act), and 42 C.F.R. § 411.15(i) (providing for Medicare coverage when the hospitalization is required because of the individual's underlying condition and medical status). As noted above, the ALJ also found the beneficiary responsible for the noncovered charges. Dec. at 5.

The appellant, the daughter of the deceased beneficiary, acting on her behalf, advances the following contentions in this appeal:

- The $2,590 charge at issue here is for medical services that the hospital provided on February 13, 2008, when the beneficiary's dentist extracted six teeth in the hospital

operating room. The beneficiary's family has paid the dentist's bill for the teeth extraction, in the amount of $672.00. *See* Exh. 1 at 10.

- The beneficiary was in the hospital and her condition made it impossible, both physically and medically, for her to go to the dentist's office to have the teeth extracted. Because of her physical and medical condition, the hospital costs in connection with the teeth extraction should be covered by Medicare.

- The ALJ's decision mentions the letter from the beneficiary's physician, saying she could not leave the hospital, but says nothing about the letter from her dentist, saying it would have been impossible to transport her to his office. *See* Exh. 2 at 2.

- The ALJ's decision states that there was no evidence that an underlying condition existed to warrant the teeth extraction. However, the beneficiary had an infection and was losing weight rapidly because her teeth hurt too much to eat.

- The beneficiary was 75 years old when this occurred, not 72 as the ALJ's decision states. Additionally, she was transferred from *** Memorial Hospital to *** Regional Medical Center on April 21, 2008 (not discharged from *** on that date), and then discharged to hospice care on April 26, 2008.

Exh. MAC-1.

Additional Factual Background

The following factual summary is based on the written record and the testimony of the beneficiary's daughter (the appellant) at the ALJ hearing in January 21, 2009. It appears from the record that the hospital did not receive notice of the hearing and an opportunity to participate. For that reason, parts of this factual summary must be viewed as preliminary and tentative, subject to revision if the hospital advances any additional, probative evidence at the supplemental hearing the Council orders upon remand.

The beneficiary was admitted as an inpatient to *** Memorial Hospital on February 1, 2008, because of malaise and fatigue, a

high white blood cell count, a need for intravenous (IV) antibiotics, and a need for further testing. Testimony of the beneficiary's daughter at the ALJ Hearing in January 21, 2009 (ALJ Hearing Testimony); *see also* Exh. 2 at 23-25 (History and Physical prepared at admission, listing an impression of sepsis (white blood cell count 22,000), hypovolemic hyponatremia, atrial fibrillation with rapid ventricular response, weight loss, and a history of vaginal bleeding).

At that time the beneficiary was not eating because her teeth hurt. ALJ Hearing Testimony. She had six decayed and broken teeth, and reddish gums. *Id.* In addition, the beneficiary's physician and dentist thought that she might have an infection in her mouth or jaw causing or contributing to her sepsis. Exh. 1 at 16. Her dentist came to the hospital and examined her, and her dentist and doctor agreed that the six teeth needed to be removed. Exh. 1 at 16; Exh. 2 at 2; ALJ Hearing Testimony.

The beneficiary's dentist and doctor also agreed that given her underlying medical condition and clinical status, her teeth needed to be removed at the hospital. *Id.* She needed to continue on IV antibiotics; her heart needed to be monitored closely (given her atrial fibrillation and a previous heart failure); she was non-ambulatory and incontinent; and she had deep vein thrombosis yet could not take a blood thinner (given a past life-threatening bleed due to duodenal ulcers while on Coumadin) and had an IVC filter in place. *See, e.g.,* Exh. 1 at 16, Exh. 2 at 1 and 2. Based on this uncontroverted evidence in the written record (including parts of the written record submitted by the hospital), the Council finds that the beneficiary needed to have the extraction of her teeth performed at the hospital on an inpatient basis.[2] The services were, in fact, provided while the beneficiary was a hospital inpatient on February 13, 2008.

After the dental procedure, the beneficiary was discharged from the hospital approximately twelve days later. Exh. 1 at 6. Her

[2] As explained below in the Analysis, the fact that the beneficiary required inpatient status for dental services, based on her underlying medical condition and clinical status means that the expenses for inpatient hospital services in connection with the dental procedure are covered by Medicare. Section 1862(a)(12) of the Act; 42 C.F.R. § 411.15(i); MBPM, Chapter 1, Section 70 (except for fees for physicians' services). As noted above, the ALJ erred in stating that her underlying medical condition and clinical status had to warrant the dental surgery itself. Therefore, the Council makes no finding as to whether her underlying medical condition warranted the dental surgery.

family paid the dentist's bill of $672 for the tooth extractions. Exh. 1 at 10. The hospital billed Medicare for her inpatient stay, and for $2590 in charges for supplies and services provided on February 13, 2008, purportedly in connection with the dental procedure in the operating room (Exh. 1 at 9). The inpatient stay was covered by Medicare, but the $2590 in charges was denied. ALJ Hearing Testimony; Exh. 1 at 15. The hospital's billing office had assigned the HCPCS code of D2934 to $2550 worth of the charges when billed to Medicare. The D2934 code is used to bill for a prefabricated steel crown for a primary tooth. However, nothing in the written record indicates that the beneficiary received a crown of any type. On this point, the beneficiary's daughter testified at the hearing that her mother had not received a crown, and that she (the daughter) had been in touch with an employee of the billing office at *** Memorial Hospital, explaining the ongoing Medicare appeal. ALJ Hearing Testimony. According to the beneficiary's daughter, the hospital employee responded that she had listed the D2934 (dental crown) code because it was the only code she knew for a dental procedure. *Id.*

However, the record does not establish that the outstanding charges were specifically for dental services. The beneficiary's dentist separately billed the beneficiary for his services for the dental procedure, and the beneficiary (or her estate) has paid this bill. Exh. 1 at 10. The outstanding charges may be charges for hospital inpatient services in connection with the teeth extraction in the operating room, though this is not clear. At the ALJ hearing, the beneficiary's daughter testified that it was her understanding the $2590 that the hospital billed was for the operating room and the services and supplies the hospital provided for the dentist during the surgery.

As noted above, the hospital itself did not participate in the ALJ hearing, as it appears not to have been notified. This omission will need to be addressed upon remand.

Applicable Law

The Social Security Act provision excluding dental services from coverage contains the following exception:

> [No payment may be made for] expenses for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting

> teeth, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such dental services if the individual, because of his underlying medical condition and clinical status, or because of the severity of the dental procedure, requires hospitalization in connection with the provision of such services.

Section 1862(a)(12) of the Social Security Act (emphasis added).

This exception is repeated in the federal regulation on point:

> The following services are excluded from coverage:
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> * * *
>
> (i) *Dental services* in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, *except for* inpatient hospital services in connection with such dental procedures when hospitalization is required because of –-
>
> (1) The individual's underlying medical condition and clinical status; or
>
> (2) The severity of the dental procedures.

42 C.F.R. § 411.15(i) (emphasis in original; footnote omitted).

The Medicare Benefit Policy Manual (MBPM), under this exception, allows for coverage of all ancillary services "such as x-rays, administration of anesthesia, use of the operating room, etc." However, it does not allow for coverage of "the medical services of physicians furnished in connection with noncovered dental services," including those, for example, of an anesthesiologist, radiologist, or pathologist. CMS Pub. 100-2, MBPM, Chapter 1, Section 70.[3]

Analysis

Pursuant to the foregoing provisions of applicable law, inpatient hospital services in connection with the provision of dental services are covered if the beneficiary, because of her underlying medical condition and clinical status, requires

[3] The ALJ erred in stating that Chapter 14, Section 150, and Chapter 16, Section 140, of the Medicare Benefit Policy Manual are applicable in this case. These provisions apply to dental services (and ancillary services) rendered on an outpatient basis. All of the services in this case were rendered on an inpatient basis.

hospitalization in connection with the provision of such services. In this case, as stated above, based upon the uncontroverted evidence in the written record, the Council finds that the beneficiary needed to have the extraction of her teeth performed by the dentist at the hospital on an inpatient basis, because of her underlying medical condition and clinical status. Therefore, the $40 worth of supplies that the hospital billed for on February 13, 2008, in connection with the dental procedure are covered by Medicare.[4] In addition, it is possible that the $2550 charge that the hospital also billed for that same date would have been considered to be for a covered Medicare service if it had been billed correctly, rather than as a crown that was apparently never provided.[5]

The Council concludes that Medicare will not cover the $2550 the hospital billed for a putative crown. The Medicare adjudication process is not intended to make adjustments, or order the parties to make adjustments, in claims and coding. A party must submit any necessary adjustments in claims and coding to the contractor. *See* Pub. 100-4, Medicare Claims Processing Manual, Chapter 1, *General Medicare Billing Requirements,* Sections 130 *et seq.* The hospital has not done so here, even though it knew or had reason to know that its billing and coding were incorrect. Therefore, unless the hospital demonstrates on remand that it provided a crown, the $2550 claim coded D2934 is denied.

If the $2550 charge was not for the provision of a crown, then it is likely that the charge was for other items or services related to the dental surgery. The charge may have been for the operating room or other hospital-based services, which would presumably be covered under the DRG[6]-determined rate for the

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[4] The Council notes, however, that these charges may not be separately payable by Medicare, as they may be subsumed within the payment the hospital has received under the prospective payment system for the beneficiary's inpatient stay, as discussed in further detail in conjunction with the $2550 charge below.

[5] However, if some part of that $2550 in hospital charges was for physicians' fees, including for example, an anesthesiologist or radiologist, then it would not be covered. *See* Pub. 100-2, MBPM, Chapter 1, Section 70. It is not clear from the record in this case whether any part of that $2550 in hospital charges represents physicians' fees. This will need to be determined, if possible, by the ALJ on remand.

[6] "Diagnosis-Related Groupings" or "DRGs" are used to determine the appropriate payment rate per discharge for most hospital inpatient stays under Medicare Part A. Thus, rather than services being paid on a line-item or cost-reimbursement basis, most inpatient services are paid at a flat rate which considers such factors as the beneficiary's age, diagnoses, and extent

inpatient stay. Or the services may have been billed for the services of independent physicians, such as anesthesiologists or radiologists, who furnished services to the beneficiary in conjunction with the dental surgery. In such case, the services would be separately billable to the beneficiary as services ancillary to a dental procedure. See CMS Pub. 100-2, MBPM, chapter 1, section 70. The nature of these services must be ascertained on remand in order to determine whether they have already been covered by any DRG-related payment made to the hospital, or whether they were the separate responsibility of the beneficiary and can be billed to her estate.

On remand, the ALJ will need to make findings as to each party's respective liability for the $2550 in noncovered costs. In order to make these findings, the ALJ will need to determine whether any part of the $2550 in charges billed by the hospital represents charges for physicians' fees not included in the DRG payment. If the hospital does not produce documentation as to the bases for this $2550 in charges, or the hospital does not participate upon remand, then the testimony of the beneficiary's daughter at the January 21, 2009 hearing is uncontroverted, and the Council has found it credible. Her testimony at the hearing was that she understood the charges to be for the operating room and the services that the hospital provided for the dentist during the dental procedure. ALJ Hearing Testimony. In such case, this item on the bill would likely have been covered by the DRG payment, which the ALJ should confirm with the fiscal intermediary on remand. Moreover, if the $2550 in charges includes only amounts for the operating room and hospital services during the teeth extraction which should have been included in the hospital's inpatient billing, then the services have been already covered (though they may not be separately payable). In such case, the beneficiary is not liable for any additional payment.

However, if the $2550 includes charges for physicians' fees or other expenses related to dental services that are not covered under the DRG-related payment to the hospital, then the beneficiary may be liable for that amount. Section 1879, which provides for a limitation on liability, does not apply unless coverage for services was denied as not medically reasonable and necessary under section 1862(a) of the Act. Under this set of facts, the hospital would have already received coverage for the

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of expected treatment. *See* Section 1886(d) of the Social Security Act. The Council presumes that the inpatient services in this case were paid under this system.

part of the $2550 that represents inpatient hospital services, but not for separately-billable physicians' fees. In such case, the beneficiary would be liable for that part that represents physicians' fees.

Remand Instructions

On remand, the ALJ will take the following actions:

1) Provide each of the parties in this case, the appellant and the *** Memorial Hospital, with notice and an opportunity for a supplemental hearing in the case.

   a) Provide each party with a copy of the CD recording of the January 21, 2009 hearing, and a copy of the written record, at least twenty days before the supplemental hearing.

   b) Inform each party in writing that the documents and testimony already in the record in this case will remain a part of the record. Also inform each party that any further documents or testimony they submit will also be made a part of the record.

   c) Provide each party with a written notice of the proposed time and date for the supplemental hearing no fewer than twenty days before the hearing. Advise each party in the written notice that the issues to be addressed at the supplemental hearing will include, but not be limited to:

      (i) What specific hospital services, supplies, and/or other items are represented or referred to in the $2550 bill the hospital submitted to Medicare for services to the beneficiary on February 13, 2008 (and which the hospital coded as D2934)? A copy of this bill is in the written record as Exh. 1 at 9.

      (ii) Whether any of these specific February 13, 2008 charges totaling $2550 were for fees or costs for physicians' services (including, for example, radiologist's services, anesthesiologist's services) which are not encompassed in the DRG payment for the beneficiary's inpatient stay?

(iii) What documentary or written evidence is available in support of the hospital's responses to Questions (i) and (ii), above?

2) Based on the parties' statements and/or submissions, and the legal authorities and the determinations set forth in this Council decision, issue a new ALJ decision in this case, including but not limited to determinations of the applicability of liability and waiver *vel non* pursuant to Sections 1879 and 1834(j)(4) of the Act.

3) As noted in the Council's decision, above, if the hospital does not respond with probative information and documents as to Questions (i) through (iii) above, then the ALJ should consider the testimony of the beneficiary's daughter at the January 2009 hearing uncontested, and find that this $2550 represents charges for hospital inpatient services, including use of the hospital operating room, in connection with the dental extractions performed by the beneficiary's dentist on February 13, 2008.[7]

The ALJ may take any specific steps provided by the regulations in 42 C.F.R. §§ 405.1000 to 405.1063 and not inconsistent with this order, and any further action not inconsistent with this order.

MEDICARE APPEALS COUNCIL

/s/ Susan S. Yim
Administrative Appeals Judge

/s/ Gilde Morrisson
Administrative Appeals Judge

Date: August 13, 2009

[7] If the hospital determines that the $2550 in charges are subsumed in the DRG payment received for the beneficiary's inpatient stay, as contemplated above, the hospital should consider withdrawing the charges at issue and request that the request for hearing be withdrawn by the beneficiary's estate and be dismissed by the ALJ.