

2004

IHC Health Systems, Inc. d/b/a LDS Hospital v. Utah Department of Health, Division of Health Care Financing : Brief of Petitioner

Utah Court of Appeals

Follow this and additional works at: https://digitalcommons.law.byu.edu/byu_ca2



Part of the [Law Commons](#)

Original Brief Submitted to the Utah Court of Appeals; digitized by the Howard W. Hunter Law Library, J. Reuben Clark Law School, Brigham Young University, Provo, Utah; machine-generated OCR, may contain errors.

Douglas Turek; The Turek Law Firm; Attorney for Petitioner.

Rex W. Olsen; Utah Department of Health; Attorney for Respondent.

Recommended Citation

Legal Brief, *IHC Health Systems v. Utah Department of Health*, No. 200440487 (Utah Court of Appeals, 2004).
https://digitalcommons.law.byu.edu/byu_ca2/5479

This Legal Brief is brought to you for free and open access by BYU Law Digital Commons. It has been accepted for inclusion in Utah Court of Appeals Briefs by an authorized administrator of BYU Law Digital Commons. Policies regarding these Utah briefs are available at http://digitalcommons.law.byu.edu/utah_court_briefs/policies.html. Please contact the Repository Manager at hunterlawlibrary@byu.edu with questions or feedback.

NO. 200440487-CA

IN THE UTAH COURT OF APPEALS

IHC HEALTH SYSTEMS, INC. d/b/a LDS HOSPITAL,

Petitioner,

VS.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE FINANCING,

Respondent.

On Petition for Review From the Agency Decision
Rendered by the Utah Department of Health
Division of Health Care Financing
Agency Decision No. 03-224-22

UTAH COURT OF APPEALS
BRIEF

BRIEF OF PETITIONER

UTAH
DOCUMENT
K F U
50
.A10

DOCKET NO. 200440487-CA

Rex Olsen
UTAH DEPARTMENT OF HEALTH
288 North, 1460 West
P.O. Box 143101
Salt Lake City, Utah 841114
(801)-538-9914 - Telephone
(801)-538-6099 - Fax

Douglas Turek
THE TUREK LAW FIRM, PLLC
25231 Grogan's Mill Road, Suite 110
The Woodlands, Texas 77380
(281) 296-6920 - Telephone
(281) 296-0733 - Facsimile

ATTORNEY FOR RESPONDENT

ATTORNEY FOR PETITIONER

ORAL ARGUMENT REQUESTED

FILED
UTAH APPELLATE COURTS

AUG 27 2004

NO. 200440487-CA

IN THE UTAH COURT OF APPEALS

IHC HEALTH SYSTEMS, INC. d/b/a LDS HOSPITAL,

Petitioner,

VS.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE FINANCING,

Respondent.

On Petition for Review From the Agency Decision
Rendered by the Utah Department of Health
Division of Health Care Financing
Agency Decision No. 03-224-22

BRIEF OF PETITIONER

Rex Olsen
UTAH DEPARTMENT OF HEALTH
288 North, 1460 West
P.O. Box 143101
Salt Lake City, Utah 841114
(801)-538-9914 - Telephone
(801)-538-6099 - Fax

Douglas Turek
THE TUREK LAW FIRM, PLLC
25231 Grogan's Mill Road, Suite 110
The Woodlands, Texas 77380
(281) 296-6920 - Telephone
(281) 296-0733 - Facsimile

ATTORNEY FOR RESPONDENT

ATTORNEY FOR PETITIONER

ORAL ARGUMENT REQUESTED

LIST OF PARTIES

Pursuant to Rule 24(a)(1), Petitioner provides the Court with a list of all parties to the Agency Proceeding:

A. Parties:

Petitioner: IHC Health Systems, Inc. d/b/a LDS Hospital

Respondent: Utah Department of Health,
Division of Health Care Financing

B. Attorneys:

For Petitioner: Douglas Turek
The Turek Law Firm, PLLC
25231 Grogan's Mill Road, Suite 110
The Woodlands, Texas 77380

For Respondent: Rex Olsen
Utah Department of Health
288 North, 1460 West
P.O. Box 143101
Salt Lake City, Utah 841114

C. Interested Parties:

Patient: Keyontae Pittman

Patient's Mother: Tawnee Chamberlain

Medicaid HMO: Molina Healthcare of Utah, Inc.

TABLE OF CONTENTS

LIST OF PARTIES	ii
TABLE OF CONTENTS	iii
TABLE OF AUTHORITIES	v
STATEMENT OF JURISDICTION	2
STATEMENT OF ISSUES	3
DISPOSITIVE LEGAL AUTHORITY	5
STATEMENT OF THE CASE	7
I. NATURE OF THE CASE	7
II. COURSE OF PROCEEDINGS	7
III. DISPOSITION AT THE AGENCY LEVEL	8
IV. STATEMENT OF THE RELEVANT FACTS	8
A. <i>The Birth and Treatment of Keyontae Pittman</i>	8
B. <i>Keyontae Pittman’s Coverage from IHC Health Plus</i>	10
C. <i>Keyontae Pittman’s Coverage Through the Molina Medicaid HMO</i>	11
ARGUMENT AND AUTHORITIES	13
SUMMARY OF ARGUMENTS	13
I. THE UTAH DEPARTMENT OF HEALTH ERRED IN UPHOLDING MOLINA’S REFUSAL TO PAY FOR THE TREATMENT OF KEYONTAE PITTMAN FROM AUGUST 19, 2002 THROUGH OCTOBER 29, 2002	13

<i>A.</i>	<i>It was Impossible for LDS Hospital to Meet the Authorization Requirements</i>	13
<i>B.</i>	<i>LDS Hospital Reasonably Treated Keyontae Pittman as having IHC Health Plus</i>	14
1.	<u>Keyontae Pittman’s Mother Presented with IHC Health Plus</u>	14
2.	<u>From the Information Obtained by LDS Hospital, Pittman Was Covered by IHC Health Plans During His Treatment</u>	15
a.	LDS Hospital Verified Coverage on August 21, 2002	15
b.	Reverifying Coverage at the End of the Temporary Coverage Period Would Not Have Helped	15
c.	LDS Hospital Did Not Discover that IHC Health Plans Was Not Covering Pittman Until December 18, 2002	16
3.	<u>IHC Health Plus Made Payments on Pittman’s Accounts That Were Later Reversed</u>	17
4.	<u>Keyontae Pittman’s Mother did not Refuse Coverage until October 25, 2002</u>	17
<i>C.</i>	<i>There has been No Evidence Presented that Pittman’s Treatment was Inappropriate or Unnecessary</i>	18
<i>D.</i>	<i>All of Pittman’s Prior Bills were Paid Without Authorizations</i>	18
CONCLUSION		19
CERTIFICATE OF FILING AND SERVICE		21
ADDENDUM		
Department of Health Order Adopting ALJ Recommendation		tab 1
ALJ Recommendation		tab 2

TABLE OF AUTHORITIES

Cases

<i>First Nat’l Bank v. Count Bd. of Equalization</i> ,	4
799 P. 2d 1163 (Utah 1990)	
<i>Grace Drilling Co. v. Board of Review</i> ,	4
776 P. 2d 63 (Utah Ct. App. 1989)	
<i>Morton Int’l, Inc. v. Utah Stater Tax Comm’n</i> ,	3
814 P.2d 581 (Utah 1991), <i>cert. denied</i> ,	
843 P. 2d 516 (Utah 1992).	
<i>United States v. Communications, Inc. v. Public</i>	4
<i>Serv. Comm’n</i> , 882 P. 2d 141 (Utah 1994).	

Rules

Utah Rule of Appellate Procedure 24	2, 3, 5, 7, 13,
Utah Administrative Rule 414-1-13	5, 19

Statutes

Utah Code Ann. § 63-46b-16	2
Utah Code Ann. § 78-2a-3	2

Other Authorities

Utah Medicaid Provider Manual, Section 1, 4-4	5, 19
Utah Medicaid Provider Manual, Section 1, 5	5, 19

NO. 200440487-CA

IN THE UTAH COURT OF APPEALS

IHC HEALTH SYSTEMS, INC. d/b/a LDS HOSPITAL,

Petitioner,

VS.

UTAH DEPARTMENT OF HEALTH,
DIVISION OF HEALTH CARE FINANCING,

Respondent.

On Petition for Review From the Agency Decision
Rendered by the Utah Department of Health
Division of Health Care Financing
Agency Decision No. 03-224-22

BRIEF OF PETITIONER

TO THE HONORABLE JUSTICES OF THE UTAH COURT OF APPEALS:

Pursuant to the Utah Rules of Appellate Procedure, IHC Health Systems, Inc. d/b/a LDS Hospital (“LDS Hospital”), files this brief respectfully asserting that the decision upholding the denial of payment for the treatment of Keyontae Pittmen from August 19, 2002 through October 29, 2002 was in error; thus, it should be reversed.

STATEMENT OF JURISDICTION

Pursuant to Rule 24 (a)(4), Petitioner asserts that the Utah Court of Appeals has jurisdiction over this appeal under Utah Code Ann. § 78-2a-3 (2)(a) and Utah Code Ann. § 63-46b-16, as this is an appeal from a final decision from a formal adjudicative proceeding of the Utah Department of Health, Division of Health Care Financing.

STATEMENT OF ISSUES

Pursuant to Rule 24 (a)(5), Petitioner asserts that the sole issue before this Court is whether the Respondent erred in upholding the decision to deny payment for the treatment of Keyontae Pittman from August 19, 2002 through October 29, 2002. This error was caused by the following:

1. The Department erroneously interpreting and applying the law relating to reimbursement of LDS Hospital;
2. The Department determining facts that are not supported by substantial evidence;
3. The Department abused its discretion in denying payment to LDS Hospital; and
4. Responding acted arbitrarily and capriciously in denying payment to LDS Hospital.

Since this error has prejudiced LDS Hospital, this court has the ability to grant the relief requested. *See Utah Code Ann.* §63-46b -16(4)(d), (g), (h)(1) and (3).

This issue was preserved at the Agency level as reflected at pages 1, 27-29 and 114-118 of the Appellate Record. *See App. Rec., pp. 1, 27-29, and 114-118.*

For the error in interpreting and applying the law relating to reimbursement for LDS Hospital, the Department's decision will be upheld only if it is concluded to be not erroneous, i.e. the correction-of-error standard. *Morton Int'l, Inc. v. Utah Stater Tax Comm'n*, 814 P.2d 581 (Utah 1991), *cert. denied*, 843 P. 2d 516 (Utah 1992). For the other three errors, the Department's decision will be upheld if there is substantial evidence once the appellate court

reviews the whole record. *Grace Drilling Co. v. Board of Review*, 776 P. 2d 63 (Utah Ct. App. 1989); *First Nat'l Bank v. Count Bd. Of Equalization*, 799 P. 2d 1163 (Utah 1990); *United States v. Communications, Inc. v. Public Serv. Comm'n*, 882 P. 2d 141 (Utah 1994).

DISPOSITIVE LEGAL AUTHORITY

Pursuant to Rule 24 (a)(6), Petitioner asserts that there is no constitutional provision, statute, ordinance, rule, or regulation whose interpretation is determinative of this appeal.

There is, however, authority that is of central importance to the Department's Decision and which are listed below in relevant part:

1. Utah Administrative Rule R414-1-13:

By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

2. Utah Medicaid Provider Manual, Section 1, 4-4:

Each managed care plan specifies which services require prior authorization (PA) and the conditions of authorization. When a provider contacts Medicaid to request PA for services to a patient covered by a managed care plan, Medicaid must refer the provider to that plan. Medicaid cannot authorize PA requests for services for patients enrolled in managed care plans, unless the services are not included under the Medicaid contract with the plan.

Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client's plan, Medicaid cannot pay for the service. If the provider fails to follow the plan's procedures for authorization, the managed care plan may also refuse to pay for the service.

3. Utah Medicaid Provider Manual, Section 1, 5:

“VERIFYING MEDICAID ELIGIBILITY: a Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient's eligibility, EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan. Emergency Services or the

Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client's Medicaid Identification Card at the Interim Verification of Eligibility (form 695). The provider may wish to copy the card to substantiate the Medicaid claim. Information is also available through Medicaid Online, ACCESSNOW, and Medicaid Information.

STATEMENT OF THE CASE

Pursuant to Rule 24(a)(7), Petitioner provides the following statement of this case:

I. NATURE OF THE CASE

This is a healthcare provider claim. LDS Hospital is seeking reimbursement from Molina Healthcare of Utah, Inc. (“Molina”), serving as a Utah Medicaid HMO, for the treatment of Keyontae Pittman from August 19, 2002 through October 29, 2002. Molina has denied payment, which was upheld by Respondent, The Utah Department of Health, Division of Health Care Financing (“the Department”).

II. COURSE OF PROCEEDINGS

LDS Hospital treated Keyontae Pittman (“Pittman”), as required by his emergency medical conditions, for more than three months from July 22, 2002 through October 29, 2002. *See App. Rec.*, pp. 27-79 and 114-118.

Once Molina denied payment for the treatment of Pittman from August 19, 2002 through October 29, 2002, LDS Hospital appealed that denial through the Molina procedures until those avenues of appeal were exhausted. *See App. Rec.*, p. 2.

LDS Hospital then filed an appeal with the Department. *See App. Rec.*, p. 1. This appeal proceeded through a formal adjudicative proceeding. In Recommended Decision No. 03-224-22, the Administrative Law Judge entered on April 26, 2004 a recommendation to uphold the payment denial. *See App. Rec.*, pp. 191-197. The Department adopted this recommendation in full on May 18, 2004. *See App. Rec.*, pp. 189-190.

Most recently, LDS Hospital filed a Petition for Review with this Court on June 10, 2004 seeking review of the May 18, 2004 decision of The Department. *See App. Rec.*, pp. 199-200.

III. DISPOSITION AT THE AGENCY LEVEL

The Administrative Law Judge recommended that Molina's denial of payment be upheld for the treatment of Pittman from August 19, 2001 through October 29, 2001. *See App. Rec.*, pp. 191-197. The Administrative Law Judge's recommendation was adopted by the Department. *See App. Rec.*, pp. 189-190.

IV. STATEMENT OF THE RELEVANT FACTS

Pursuant to Rule 24(a)(7), Petitioner provides the following facts relevant to the issues before this Court:

A. The Birth and Treatment of Keyontae Pittman

Tawnee Chamberlain was admitted to LDS Hospital for active labor. Her daughter, Keyontae Pittman, was born on July 22, 2002 with serious and life-threatening medical conditions. *See App. Rec.*, pp. 27-77.

Pittman was treated from July 22 through July 26, 2002 at LDS Hospital. *See App. Rec.*, p. 27. During this stay, Pittman was an emergent care patient. *See App. Rec.*, pp. 33-34. The charges for the services rendered to Keyontae Pittman during this time amounted to \$22,311.51. *See App. Rec.*, p. 31. These charges have been paid in full by Molina. *See App. Rec.*, p. 31.

On July 26, 2002, Keyontae Pittman was transferred to Primary Children's Medical Center for specialized procedures. *See App. Rec., pp. 36-45.* She was treated at Primary Children's until July 30, 2002, when she was returned to LDS Hospital. *See App. Rec., pp. 36 and 47.* The charges at Primary Children's Hospital were \$16,789.68. *See App. Rec., p. 36.* Molina has paid for all of these charges. *See App. Rec., p. 36.*

Pittman was again treated at LDS Hospital from July 30, 2002 through August 14, 2002. *See App. Rec., pp. 47-54.* At this time, Pittman was still an emergent care patient. *See App. Rec., pp. 53-54.* The charges for his treatment at LDS Hospital at this time were \$16,054.32. *See App. Rec., p. 47.* Molina paid the total charges for this treatment. *See App. Rec., p. 47.*

On August 14, 2002, Pittman was again transferred to Primary Children's for specialty procedures. *See App. Rec., pp. 56-67.* Pittman was treated at Primary Children's until August 19, 2002. *See App. Rec., p. 56.* The charges for the treatment during this time were \$21,546.36. *See App. Rec., p. 56.* Molina paid in full for these charges. *See App. Rec., p. 56.*

Finally, from August 19, 2002 until October 29, 2002, Pittman was again treated as an emergent care patient at LDS Hospital. *See App. Rec., pp. 69-76.* During this period of approximately seventy (70) days, Keyontae Pittman's charges for treatment were \$222,986.20. *See App. Rec., p. 69.* Molina has denied payment for these charges. *See App. Rec., pp. 2 and 69.*

The treatment of Keyontae Pittman by LDS Hospital and Primary Children's Hospital can be summarized in the following chronology:

- July 22 through July 26, 2002 at LDS Hospital;
- July 26, 2002 through July 30, 2002 at Primary Children's Hospital;
- July 30, 2002 through August 14, 2002 at LDS Hospital;
- August 14, 2002 through August 19, 2002 at Primary Children's Hospital; and
- August 19, 2002 until October 29, 2002 at LDS Hospital.

See App. Rec., pp. 31-34, 36-45, 47-54, 56-67, and 69-76.

It is undisputed that LDS Hospital saved Pittman's life through this course of treatment.

B. Keyontae Pittman's Coverage from IHC Health Plus

At the time of her admission at LDS Hospital, Tawnee Chamberlain was enrolled in the IHC Health Plus through her employer, Vancott, Bagley, Cornwall, and McCarthy. *See App. Rec., pp. 134 and 136.* LDS Hospital verified Ms. Chamberlain's coverage with IHC Health Plus and was told that she was an active participant. *See App. Rec., pp. 32 and 70.*

After the birth of Keyontae Pittman, LDS Hospital continued to verify newborn's coverage. *See App. Rec., pp. 32 and 70.* LDS Hospital checked Pittman's IHC Health Plus coverage on August 20, 2002 and discovered that she had not been added. *See App. Rec., p. 70.* LDS Hospital again checked the newborn's coverage on August 21, 2002 and was told

that the she had been added under the mother's IHC Health Plus coverage. *See App. Rec., p. 70.*

Based on this information, LDS Hospital listed IHC Health Plans as the primary insurance carrier on the account for Keyontae Pittman. *See App. Rec., p. 70.* Further, LDS Hospital fulfilled the required authorization procedures for IHC Health Plus. *See App. Rec., pp. 70.*

LDS Hospital was not notified until December 18, 2002 that the newborn, Keyontae Pittman, was, in fact, not covered by IHC Health Plus. *See App. Rec., p. 70.* This was a result of Tawnee Chamberlain refusing coverage for both herself and her child on October 24, 2002. *See App. Rec., p. 136.* Because of this refusal of coverage, the IHC Health Plans coverage was retroactively terminated back through the birth of Pittman. *See App. Rec., p. 136.*

This change in coverage for Pittman occurred on October 24, 2002, only 5 days before his discharge. *See App. Rec., pp. 69 and 136.* In fact, IHC Health Plans made payments for the treatment of Keyontae Pittman which were reversed when the coverage error was discovered. *See App. Rec., pp. 31, 36, 47, and 51.*

C. Keyontae Pittman's Coverage Through the Molina Medicaid HMO

Pittman was certified for Utah Medicaid under the Molina Medicaid HMO on August 26, 2002. *See App. Rec., p. 21.* This certification occurred 7 days after Pittman was admitted

for the final time to LDS Hospital. *See App. Rec., p. 69.* This certification created retroactive Medicaid coverage back to July 1, 2002. *See App. Rec., p. 121.*

The Department has paid for the treatment of Keyontae Pittman from July 22, 2002 through August 18, 2002. *See App. Rec., pp. 31, 36, 47, and 56.* The Department has denied payment for the treatment of Pittman from August 19, 2002 through October 29, 2002. *See App. Rec., pp. 2, 189-190, and 191-196.* There is no dispute that Utah Medicaid would be responsible for the charges from August 19, 2002 through October 29, 2002, if not for the authorization issue. *See App. Rec., pp. 2 and 191-196.*

ARGUMENT AND AUTHORITIES

I. THE UTAH DEPARTMENT OF HEALTH ERRED IN UPHOLDING MOLINA'S REFUSAL TO PAY FOR THE TREATMENT OF KEYONTAE PITTMAN FROM AUGUST 19, 2002 THROUGH OCTOBER 29, 2002

Pursuant to Rule 24 (a)(8), Petitioner presents the following summary of its arguments.

- Pittman did not have Medicaid coverage at his admission or within 48 hours of admission so that authorization was impossible;
- Pittman's mother presented with IHC Health Plus coverage so that was reasonably relied on by LDS Hospital;
- The Department has offered no evidence to support that any of the Treatment of Pittman was improper or unnecessary ; and
- Pittman's other two LDS Hospital admissions were paid for by the Department without authorization.

Pursuant to Rule 24(a)(9), each of these arguments are addressed more fully below.

A. It was Impossible for LDS Hospital to Meet the Authorization Requirements

The Department denied LDS Hospital's claim for the treatment of Keyontae Pittman from August 19, 2002 through October 29, 2002 because LDS Hospital failed to obtain pre-authorization and/or failed to obtain authorization within 48 hours of admission. *See App. Rec.*, pp. 2, 189-90, and 191-196. However, it would have been impossible for LDS Hospital to fulfill these authorization requirements because Pittman was not made eligible for Utah Medicaid until August 26, 2002. *See App. Rec.*, p. 121. Pittman's coverage was applied retroactively back to July 1, 2002. *See App. Rec.*, p. 121.

Obviously, LDS Hospital could not have known to authorize through Utah Medicaid before August 26, 2002 because there was no coverage. *See App. Rec.*, p. 121.

If LDS Hospital had even known to try to obtain authorization for Pittman with Utah Medicaid on August 19, it would have been told that Pittman was not covered. *See App. Rec.*, p. 121. However, there was nothing to indicate that Molina should be checked at the August 19, 2002 admission and nothing to indicate that authorization was needed with Molina. *See App. Rec.*, p. 70. Medicaid was not added as a payer on Pittman's account until January 22, 2003. *See App. Rec.*, p. 70.

B. LDS Hospital Reasonably Treated Keyontae Pittman as having IHC Health Plus

To the contrary, LDS Hospital treated Pittman as being covered by IHC Health Plus. *See App. Rec.*, pp. 69-70. This treatment by LDS Hospital was reasonable because: 1) Pittman's mother presented at the delivery with IHC Health Plus; 2) LDS Hospital verified coverage with IHC Health Plus on August 20; 3) IHC Health Plus made payments on Pittman's accounts which were later reversed; and 4) Coverage was not refused on Pittman until October 25, 2002. As will be shown below, there was no reason for LDS Hospital not to pursue payment through IHC Health Plus.

1. Keyontae Pittman's Mother Presented with IHC Health Plus

At the time of her admission, Tawnee Chamberlain presented that she was covered by IHC Health Plus. *See App. Rec.*, pp. 31-32. Typically, in this situation there is a temporary coverage period for the newborn. In this case, there was a 90 day temporary

coverage period for Pittman. *See App. Rec., p. 129.* LDS Hospital understood that both Tawnee Chamberlain and Pittman had coverage through IHC Health Plus through December 18, 2002. *See App. Rec., p. 70.*

2. From the Information Obtained by LDS Hospital, Pittman Was Covered by IHC Health Plans During His Treatment

LDS Hospital was more than diligent in gathering information about Pittman. All of the information gathered by LDS Hospital indicated that Pittman was covered by IHC Health Plus. This information, as supported by the record, is discussed more fully below.

a. LDS Hospital Verified Coverage on August 21, 2002

The Department has argued that LDS Hospital did not continue checking, after Pittman's birth, to determine if Pittman had been added to IHC Health Plan. However, LDS Hospital checked coverage on August 20 and 21, 2002. *See App. Rec., p. 70.* On August 20 there is a note that says "note Will said baby must be add right away will let Joyce know so she can tell parents." *See App. Rec., p. 70.* There is another note on August 21, 2002, where the LDS Hospital representative indicated "check Health Plus System and the baby has been added." *See App. Rec., p. 70.* As of August 21, 2002, LDS Hospital was informed that Pittman had been added to IHC Health Plans. *See App. Rec., p. 70.*

b. Reverifying Coverage at the End of the Temporary Coverage Period Would Not Have Helped

The Department has argued that LDS Hospital should have checked Keyontae Pittman's eligibility for IHC Health Plans after 30 days from his birth, because that is the

period that was temporarily covered for newborns. The simple answer is that eligibility was checked, as outlined above, on August 20 and 21, 2002. *See App. Rec.*, p. 70. Further, this argument is not based on the facts of the IHC Health Plans coverage. The contract between IHC Health Plans and Tawnee Chamberlain's employer, Vancott, Bagley, Cornwall, & McCarthy¹, indicates that the temporary coverage period for newborns was up to 90 days, not 30. *See App. Rec.*, p. 129. The temporary period, therefore, did not run until approximately October 20, 2002, or 90 days after Pittman's birth. *See App. Rec.*, p. 69. This was less nine (9) days from Pittman's final discharge from LDS Hospital. *See App. Rec.*, p. 69.

There is no way that LDS Hospital could have known that Keyontae Pittman did not have coverage through IHC Health Plans until, at the earliest, between 4 and 9 days before his discharge.

c. LDS Hospital Did Not Discover that IHC Health Plans Was Not Covering Pittman Until December 18, 2002

Regardless of when Pittman's IHC Health Plus coverage was denied, LDS Hospital did not discover that Pittman was not covered by IHC Health Plans until December 18, 2002. *See App. Rec.*, p. 70.

¹Vancott, Bagley, Cornwall, and McCarthy was the employer of Tawnee Chamberlain, Keyontae Pittman's mother. It is through her employment with Vancott, Bagley that Chamberlain obtained the health insurance coverage from IHC Health Plans. *See App. Rec.*, pp. 134 and 136.

3. IHC Health Plus Made Payments on Pittman's Accounts That Were Later Reversed

After LDS Hospital treated Pittman and billed IHC Health Plus, there were payments made on his accounts. *See App. Rec., pp. 31, 36, 47, and 56.* These payments were made in August and September of 2002. *See App. Rec., pp. 31, 36, 47, and 56.* These payments were made for the treatment of Pittman from July 22, 2002 through August 18, 2002. *See App. Rec., pp. 31, 36, 47, and 56.*

After Tawnee Chamberlain refused coverage for Pittman through IHC Health Plus, these payments were reversed in January of 2003.. *See App. Rec., , pp. 31, 36, 47, and 56.*

4. Keyontae Pittman's Mother did not Refuse Coverage until October 24, 2002

Tawnee Chamberlain, Keyontae Pittman's mother, initially enrolled her under IHC Health Plus on October 8, 2002. *See App. Rec., p. 134.* Tawnee Chamberlain cancelled the coverage for Pittman o October 24, 2002. *See App. Rec., p. 136.*

Apparently, even Pittman's mother was not sure whether she was going to elect coverage under IHC Health Plus until October 24, 2002. *See App. Rec., pp. 134 and 136.* However, with the prospect of personally paying almost \$200 a month in additional premiums for her child, Tawnee Chamberlain elected not to continue the child's coverage with IHC Health Plans. *See App. Rec., p. 136 and 138-139.*

C. There has been No Evidence Presented that Pittman's Treatment was Inappropriate or Unnecessary

It is undisputed that LDS Hospital saved Pittman's life through its course of treatment, including the treatment from August 19, 2002 through October 29, 2002. While The Department has denied payment for this treatment because of lack of authorization, it has come forward with no evidence that it would have in any way altered the course of treatment of Pittman during that time period.

The only time this issue has been raised was as a sidenote in one letter to the ALJ. The policy behind Medicaid coverage is to ensure that the Utah citizens who cannot afford health coverage are covered. LDS Hospital upheld its part of that system by treating Pittman. Since there has been no indication that the course of treatment for Pittman was either improper or unnecessary, the The Department should uphold its part of the system by paying for the treatment.

D. All of Pittman's Prior Bills were Paid Without Authorizations

Molina's original denial letter to LDS Hospital, in the second paragraph, states: "[t]he claim dated 7/30/02 – 8/14/02 will be paid because the baby appeared to be covered by IHC Health Plans at that time and LDS Hospital would not have known to authorize with Molina Healthcare." *See App. Rec., p. 2.* That was true until December 18, 2002. *See App. Rec., p. 70.* The Department is still denying payment. Since this lack of knowledge was sufficient to have the earlier bills to be paid, it should be sufficient. The only difference is that the denied bill was for \$222,986.20.

CONCLUSION

In conclusion, the Department has erred in upholding the denial of payment by Molina for the treatment of Keyontae Pittman from August 19, 2002 through October 29, 2002. Specifically, the Department incorrectly interpreted R414-1-13, the Utah Medicaid Provider Manual, and Contract between Petitioner and Respondent as requiring authorization, under the facts presented above. Further, the Department erred by holding that, under the facts presented above, LDS Hospital should have known to authorize with Molina. This decision by the Department reflects an abuse of discretion and arbitrary and capricious action, and an action that is not supported by substantial evidence.

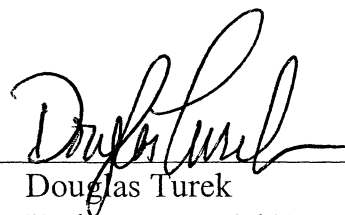
For these reasons, Petitioner respectfully requests that this Court order that LDS Hospital be paid the contractually required amount for the treatment of Keyontae Pittman from August 19, 2002 through October 29, 2002, with total charges of \$222,986.20.

Petitioner respectfully requests that it receive all other relief to which it is entitled.

Respectfully submitted,

THE TUREK LAW FIRM, PLLC

By: _____

A handwritten signature in black ink, appearing to read "Douglas Turek", written over a horizontal line.

Douglas Turek

Utah Bar No.: 9649

25231 Grogan's Mill Road, Suite 110

The Woodlands, Texas 77380

(281) 296-6920 - Telephone

(281) 296-0733 - Facsimile

ATTORNEY FOR PETITIONER

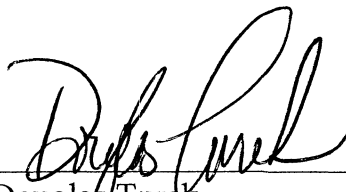
Douglas Turek
The Turek Law Firm, PLLC
25231 Grogan's Mill Rd., Ste. 110
The Woodlands, Texas 77380
(281)-296-6920 - Telephone
(281)-296-0733 - Fax

CERTIFICATE OF FILING AND SERVICE

I, Douglas Turek, certify that on August 27, 2004 I served a copy of the attached Brief of Petitioner upon Rex Olsen, the counsel for the respondent in this matter, by mailing it to him via First class mail, return receipt requested, with sufficient postage prepaid to the following address:

Rex Olsen
Utah Department of Health
288 North, 1460 West
P.O. Box 143101
Salt Lake City, Utah 841114
(801)-538-9914 - Telephone
(801)-538-6099 - Fax

(Certified Mail - Return Receipt Requested)



Douglas Turek

DT lam
D:\DTurek\TurekLawFirm\LITIGATION\IHC 1009 00\PITTMAN 1009 11\APPEAL\XBRIEF-PETITIONER 001 wpd
August 26, 2004

Tab 1



OLENE S. OLIVER
Governor

GAYLE F. McKEACHNIE
Lieutenant Governor

State of Utah
Utah Department
of Health

Scott D. Williams, M.D., M.P.H.
Executive Director

A. Richard Melton, Dr. P.H.
Deputy Director

Allen Korhonen
Deputy Director

Michael J. Deily
Division Director
Division of Health Care Financing

IHC HEALTH PLANS (PITTMAN))
Petitioner)
)
vs.)
)
UTAH DEPARTMENT OF HEALTH)
DIVISION OF HEALTH CARE FINANCING,)
Respondent.)

FINAL AGENCY ORDER
Case No. 03-224-22

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6576.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R410-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

I hereby adopt Recommended Decision No. 03-224-22 in its entirety.

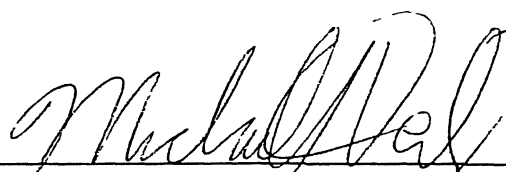
RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Final Agency Order is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Order.

A copy of this Final Agency Order shall be sent to Petitioner or representative at the last known address by certified mail, return receipt requested.

DATED this 18 day of May 2004

BY: 
Michael Deily, Director
Division of Health Care Financing
UTAH DEPARTMENT OF HEALTH

Tab 2

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

IHC HEALTH PLANS (PITTMAN)	:	
Petitioner,	:	
vs.	:	RECOMMENDED DECISION
	:	
UTAH DEPARTMENT OF HEALTH,	:	Case No. 03-224-22
DIVISION OF HEALTH CARE	:	Margaret J. Clark
FINANCING,	:	Administrative Law Judge
Respondent.	:	

Pursuant to Utah Administrative Code R410-14, and 26, Chapter 18, and Title 63, Chapter 46b, a telephonic prehearing conference for the above-captioned case was held on September 2, 2003. Participating were: Douglas Turek, Attorney for LDS Hospital; Darlene Bensen, Barbara Christensen, and Craig Devashrayee for the Division of Health Care Financing; and Margie Rogers, and Shauna Abbatiello for Molina Healthcare of Utah. A second in-person prehearing was held on January 5, 2004 with Darlene Bensen, Barbara Christensen, Craig Devashrayee present for the Division of Health Care Financing (DHCF); Margie Rogers, and Shauna Abbatiello for Molina Health Care; and Emily Fisher for LDS Hospital. DHCF was represented by Rex W. Olsen, Assistant Attorney General. Douglas Turek, Attorney for LDS Hospital, participated by telephone.

Since there were no disputed issues of material facts, a Recommended Decision is hereby issued without a hearing based upon the parties' pleadings, pursuant to Utah Administrative Code R410-14-4.

A Recommended Decision was submitted to Michael Deily, Director of Health Care Financing, on February 11, 2004. Mr. Deily issued an Interim Remand Order asking the parties to brief the timeliness issue raised by Mr. Turek in his letter dated March 18, 2004. Mr. Deily has directed this presiding officer to issue a recommended decision, striking the untimely information submitted by DHCF and issuing a decision based upon the remaining admissible evidence.

BACKGROUND

Keyontae Pittman was born on July 22, 2002, with complications. The treatment of Keyontae was in five stages:

1. July 22, through July 26, 2002, at LDS Hospital (LDSH);
2. July 26, 2002, through July 30, 2002, at Primary Children's Medical Center (PCMC);
3. July 30, 2002, through August 14, 2002, at LDSH;
4. August 14, 2002, through August 19, 2002, at PCMC;
5. August 19, 2002, until October 29, 2002, at LDSH.

Molina Healthcare (Molina) paid for all treatment except the last stage from August 19, 2002, until October 29, 2002.

ISSUE

WAS MOLINA CORRECT IN DENYING PAYMENT TO LDS HOSPITAL FOR KEYONTAE PITTMAN'S HOSPITAL STAY FROM AUGUST 19, 2002, THROUGH OCTOBER 29, 2002?

FACTS

1. Petitioner, Baby K.P., ("the baby") was born prematurely on July 22, 2002, at LDS Hospital ("LDSH") with serious and life-threatening medical conditions, including a hole in her heart (LDSH Exhibits A, B, C, D, and E).
2. The baby was treated in five stages beginning at her birth, on July 22, 2002. The fifth stage, the only one for which payment is an issue, began with the baby's hospitalization at LDSH on August 19, 2002, ending on October 29, 2002.
3. IHC Care Plus was the mother's primary insurance through her employment with the law firm of Vancott, Bagley Cornwall, and McCarthy. Eligibility for IHC Plus Plans began July 1, 2002.
4. The baby's mother added the baby to the IHC Health Plans on October 8, 2002 [see LDSH Exhibit D].

5. The baby's mother signed an IHC Health Plans "employee change form" on October 24, 2002, deleting the baby from IHC coverage [see LDSH Exhibit E].
6. Since the mother added the baby to IHC Care Plus plans within 90 days of its birth, the baby would have been covered for 90 days after its birth [See LDSH Exhibit C, p. 2], had it not been deleted.
7. On July 22, 2002, LDSH called IHC Plans (rather than Molina), to determine coverage. LDSH was informed that the baby had not yet been added to the mother's policy and that the mother needed to add the baby "right away." [see Molina's Exhibit 2, a letter from Emily Fisher, LDSH, appealing to Molina].
8. LDSH did not coordinate with Molina or obtain a prior authorization from Molina for the baby's last hospital stay.
9. On July 17, 2003, Molina denied payment for lack of inpatient authorization for the baby's last admission to LDSH from August 19, 2002, until October 29, 2002.
10. There was no dispute between the parties that, although the services provided were medically necessary, the admission was not urgent or emergent.

RECOMMENDED CONCLUSIONS OF LAW

I recommend that Molina's decision to deny payment for the baby's last admission to PCMC from August 19, 2002, until October 29, 2002 be UPHeld based upon Utah Administrative Rule R414-1-13, the Utah Medicaid Provider Manual Section 1, Subsections 4 and 5, and LDS's contract with Molina.

REASONS FOR PRESIDING OFFICER'S DECISION

I recommend that Molina's decision to deny payment for the baby's last admission to PCMC from August 19, 2002, until October 29, 2002 be UPHeld based upon the fact that LDS is a Utah Medicaid provider. As such, the following law applies to LDSH.

Utah Administrative Rule R414-1-13, entitled, "Provider and Client Agreements," provides in relevant part:

- (2) By signing a provider agreement with the Department, the provider agrees to follow the terms incorporated into the provider agreements, including policies and

procedures, provider manuals, Medicaid Information Bulletins, and provider letters.

Pursuant to the above cited rule, LDS Hospital, as a Medicaid Provider, is bound to follow all Utah Medicaid policies and procedures that are contained in the Utah Medicaid Provider Manual.

(1) Utah Medicaid Provider Manual Section 1, 4-4, states that, “Each managed care plan specifies that the provider must follow the plan’s procedures for authorization in order to receive reimbursement since information as to what plan the client must use is available to providers; [see Molina’s Exhibit 5; emphasis added];

(2) Utah Medicaid Provider Manual, Section 1, Subsection 5 [see Molina’s Exhibit 1 (January 16, 2004 document)] states in relevant part: “VERIFYING MEDICAID ELIGIBILITY: a Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient’s eligibility, EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance [emphasis added]. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client’s Medicaid Identification Card at the Interim Verification of Eligibility (form 695). The provider may wish to copy the card to substantiate the Medicaid claim. Information is also available through Medicaid Online, ACCESSNOW, and Medicaid Information.

The Utah Medicaid Provider Manual, Section 1, Subsection 4-4 is entitled “Managed Care Plans and Prior Authorization.” That Section provides as follows:

Each managed care plan specifies which services require prior authorization (PA) and the conditions of authorization. When a provider contacts Medicaid to request PA for services to a patient covered by a managed care plan, Medicaid must refer the provider to that plan. Medicaid cannot authorize PA requests for services for patients enrolled in managed care plans, unless the services are not included under the Medicaid contract with the plan.

Because information as to what plan the client must use is available to providers, the provider must follow the plan’s procedures for authorization in order to receive reimbursement. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client’s plan, Medicaid cannot pay for the service. If the provider fails to follow the plan’s procedures for authorization, the managed care plan may also refuse to pay for the service [emphasis added].

Section 5 of the Utah Medicaid Provider Manual, under “General Information,” provides:

A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient’s eligibility EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program, assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance [emphasis added]. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client’s Medicaid identification Card or the Interim Verification of Eligibility (form 695)....”

A contract setting forth IHCS Responsibilities [see Molina’s Exhibit 6, September 3, 2003 document], states in relevant part: “Compliance with Quality and Utilization Management Program: IHCHS agrees to notify AFC [now called “Molina”] of any urgent or emergent hospital admission by the second working day after such admission (Monday through Friday 8:00a.m. to 5:00 p.m. Mountain Standard Time).

Molina’s Exhibit 7, (September 3, 2003 document), is a copy of an amendment, effective April 1, 2002, adding LDSH to an agreement allowing Molina Medicaid members to assess Molina at a discounted rate. Under a Section, entitled, “IHCHS, RESPONSIBILITIES” paragraph G states:

Compliance with Quality and Utilization Management Program: IHCHS agrees to provide clinical information as authorized by the Member to the AFC [now Molina] when the Member has reached an outlier status during a hospital stay. Outlier status is defined as the recommended average length of stay by Millman and Robertson, and shall apply to all IHCHS facilities. 5 IHCHS agrees to notify AFC of any urgent or emergent hospital admission by the second working day after such admission (Monday through Friday 8:00 a.m. to 5:00 p.m. Mountain Standard Time). A clinical review of any emergent or urgent admission will be provided upon request within two (2) working days of the request. The information in the clinical review will include: date of service, reason for admission, primary diagnosis, diagnostic testing, abnormal lab values and medication review.

LDSH contended that it “acted reasonably, considering all the facts known to it at the time.” However, even excluding the untimely evidence that LDSH’s own admission records indicate it knew from July 22, 2002, that the baby’s secondary coverage was Utah Medicaid through Molina, the Utah Administrative Code, the Utah Medicaid Provider Manual and LDSH’s contract with Molina require that providers take the responsibility of verifying the client’s coverage each time and before services are rendered, following whatever requirements are applicable to that particular plan.

In Primary Children’s Hospital (Daugaard) v Utah Department of Health, 993 P.2d 882 (Utah

Ct. App.1999) the petitioner hospital discovered that the database of Respondent Department of Health, Division of Health Care Financing, (the Medicaid agency), indicated that the petitioner patient was no longer eligible for Medicaid. Because of this, the petitioner did not submit a request for prior authorization. The petitioner hospital, not knowing that respondent had resumed the petitioner patient's coverage later in the day, performed a bone marrow transplant and requested a retroactive prior authorization. DHCF denied the request and petitioners appealed. The Court of Appeals reversed the decision because: (1) it determined that based upon prior practice with DHCF, the provider had never been required to request a prior authorization when DHCF's system showed no eligibility; (2) a section of the administrative rule for transplants authorized retroactive prior authorizations for unusual circumstances, which the court determined were met; and (3) because DHCF advised the provider who relied upon it to its detriment, that the patient's Medicaid eligibility had lapsed when in fact it had not.

The present case is distinguishable from the Primary Children's Hospital/Daugaard because there is no estoppel issue. Neither DHCF nor Molina did anything to mislead LDSH.

Furthermore, the law is clear. A contrary decision would have the effect of nullifying R414-1-13, the Utah Medicaid Provider Manual, and the contract between LDSH and Molina for a reduced cost of care for LDSH. The contract between LDSH and Molina was an arm's length transaction between two sophisticated parties and should be upheld.

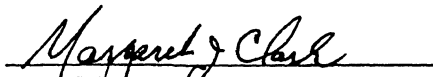
RECOMMENDED AGENCY ACTION

I recommend that Molina Healthcare of Utah's decision be UPHELD.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represent the results of that review, will be released simultaneously by the Department of Health, Division of Health Care Financing.

DATED this 26 day of April 2004


Margaret J. Clark
Administrative Law Judge