

BACKGROUND

Prior to the beneficiary's hospitalization for the dental surgery, he had undergone a coronary bypass with placement of 3 stents subsequent to having a myocardial infarction (MI). Exh. 2 at 5. He also had a history of hypertension, cholesterol embolization to his legs and left arm, type II diabetes and congestive heart failure. *Id.* Given the above conditions, the beneficiary's physicians determined that the dental surgery that he required to extract his mandibular and maxillary left two molars should be performed in *** Regional Medical Center rather than in a physician's office, so that his cardiac condition could be monitored during the procedure. Exhibit 2 at 2 and 56-58.

The beneficiary presented to the hospital's Same-Day Surgery area as an outpatient on April 25, 2007, for the dental surgery. *Id.* at 5-8. As indicated below, the medical record indicates that the beneficiary was not admitted to the hospital an inpatient at any point in his hospital stay:

The patient presented to Same-Day Surgery area and later he was taken to the operating room where the above surgery under general anesthesia was well tolerated. He was then taken to the recovery room and then back to the Same Day Surgical area where he was discharged later in satisfactory condition.

Id. at 5.

Initially and upon redetermination Cahaba GBA found the services were not covered. Exh. 1 at 99. At reconsideration, the Qualified Independent Contractor (QIC) again denied coverage on the basis that Medicare does not cover dental services performed in a hospital setting on an outpatient basis. *Id.* at 2. Both Cahaba GBA and the QIC found the beneficiary responsible for the non-covered services.

Following a November 12, 2008, telephone hearing, the ALJ found that the services provided to the beneficiary on April 25, 2007, were reimbursable under Medicare Part A. The ALJ concluded:

[The] medical record and testimony clearly indicate [that] the services at issue were medically reasonable

and necessary, if not imperative to treat the beneficiary.... [The} services at issue were not routine dental services that took place by chance in a hospital setting. Rather, due to the beneficiary's underlying medical history and complications . . . it was medically necessary to extract teeth 15 and 18 in a hospital setting.

The inpatient hospital services provided by the appellant to the beneficiary on April 25, 2007, are covered and payable under Part A of Title XVIII of the Social Security Act (Act), and were not otherwise excluded under Section 1862(a)(1) of the Act.

Dec. at 7-8.

In its referral to the Council, CMS notes that the Medicare statute does not cover "services in connection with the care, treatment, filling, removal, or replacement of teeth" under § 1862(a)(12) of the Act. Exh. MAC-1 at 5. CMS further notes that the statute provides 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 patient's underlying medical condition or the severity of the procedure is such that hospitalization is required." *Id.* CMS does not dispute that the beneficiary's medical condition required that the extraction take place in a hospital setting. *Id.* at 6. However, CMS contends that the ALJ erred in finding coverage for the services at issue because the beneficiary was not admitted as an inpatient, and, therefore, did not meet the conditions for payment of the hospital charges under § 1862(a)(12) of the Act. *Id.*

The appellant has responded to the agency referral. It argues that the beneficiary's medical condition warranted extraction of the teeth in a hospital setting, and that the prior denials of coverage, which analyzed whether the beneficiary was an inpatient, focused on "form over substance." Exhibit MAC-2 at 5-7. The appellant summarizes its position by stating that the ALJ was "correct in examining in depth the nature of the services rendered and the intent of the doctors and patient." *Id.*

As explained in detail below, the Council finds that the ALJ erred in finding that the hospital services were covered. The Council has reached this conclusion because the Medicare statute

does not permit payment for outpatient hospital services provided in conjunction with outpatient dental surgery.

APPLICABLE LAW

Section 1862(a)(12) of the Social Security Act (Act) precludes Medicare coverage:

Where such expenses are 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.

(Emphasis added.) As noted above, payment may only be made for Medicare Part A inpatient hospital services provided in connection with the dental services, and not the dental services themselves.

CMS has implemented the above exclusion in regulations found at 42 C.F.R. § 411.15(i).

The regulation provides that dental services are excluded from coverage --

except for inpatient hospital services in connection with such dental procedures when the hospitalization is required because of -

- (1) The individual's underlying medical condition or clinical status; or
- (2) The severity of the dental procedures.

The Medicare Benefit Policy Manual (MBPM), CMS Pub. 100-02, Chap. 1, § 10 defines an inpatient as a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally a person is considered an inpatient if formally admitted as an inpatient with the expectation that he will remain at least overnight and occupy a bed even though it later develops that he can be discharged or

transferred to another hospital and does not actually use a hospital bed overnight.

In contrast, a hospital outpatient is defined as a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. See MBPM, Chap. 6, § 20.1.

When a patient is hospitalized for a dental procedure and the dentist's service is covered under Part B, the inpatient hospital services furnished are covered under Part A. . . . Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with noncovered dental services are not covered. MBPM Chap. 1, § 70

DISCUSSION

As explained above, the Medicare statute limits coverage of services related to the care of the teeth and related structures to coverage of inpatient hospital services that are provided, when necessary, when a beneficiary is hospitalized as an inpatient to undergo a dental procedure. However, in no circumstances does Medicare cover the Part B services for the dental procedure itself, nor does it cover the hospital charges if the beneficiary is admitted to the hospital as an outpatient.

The Council notes that CMS has not disputed that the beneficiary's medical status precluded dental surgery in an office setting, nor has it contended that it was inappropriate to admit him to the hospital to undergo the surgery. Rather, it contends that because he was admitted to the hospital as an outpatient, the statute does not allow coverage for the hospital services. As a result, the sole issue before the Council is whether the beneficiary was an "inpatient" or "outpatient" of the hospital during his dental surgery and subsequent period in the recovery room.

As discussed above, Medicare defines a hospital inpatient as a person admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. MBPM Chap. 1, § 10. An examination of the hospital record reveals that the ALJ erred in finding the hospital services were provided under Medicare Part A. See Exh. MAC-1 at 6-8; See also Dec. at 8. Both the Operative Record and Medical/Surgical Sheet indicate that the beneficiary was discharged from the Same Day Surgical area

without being admitted to the *** Regional Medical Center as an inpatient. Exh. 2 at 5-8. Further, both the Medicare Part B Summary Notice and the hospital's itemized bill reflect that the hospital services were billed under Medicare Part B as outpatient services. Exh. 1 at 114-118, 135.

In summary, the Council does not disagree with the ALJ's general conclusion that the beneficiary had a medical condition that required that his teeth be extracted in a hospital setting. However, the ALJ erred in concluding that the beneficiary was admitted to the hospital as a Medicare Part A inpatient. Rather the beneficiary was admitted and received treatment as an outpatient. Therefore, the hospital services he received in connection with his dental surgery are excluded from coverage under section 1862(a)(12) of the Act.

LIABILITY

Finally, because the ALJ found coverage for the services at issue, the ALJ did not discuss liability for the services at issue. See Dec. at 8. The Council finds that the beneficiary's estate is responsible for the hospital services because the services were excluded from coverage under section 1862(a)(12) of the Act, and, therefore, the estate's responsibility for the services may not be waived.

DECISION

Following a careful consideration of the record, it is the decision of the Medicare Appeals Council that the hospital services provided to the beneficiary on April 25, 2007, are not covered by Medicare and that the beneficiary's estate is responsible for the hospital charges. Accordingly, the ALJ's decision is reversed.

MEDICARE APPEALS COUNCIL

/s/ M. Susan Wiley
Administrative Appeals Judge

/s/ Clausen J. Krzywicki
Administrative Appeals Judge

Date: April 10, 2009