Department of Health and Human Services
Maine People Living Safe, Healthy and Productive

Paul R. LePage, Governor Ricker Hamilton, Commissioner

Department of Health and Human Services
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IN THE MATTER OF:

Charles Palian, DMD)
c/o Joshua D. Hadiaris, Esq.)
Norman Hanson & DeTroy, LLC) **FINAL DECISION**
PO Box 4600)
Portland, ME 04112-4600)

This is the Department of Health and Human Services' Final Decision.

The Recommended Decision of Hearing Officer Thackeray, mailed June 5, 2018 and the responses and exceptions filed on behalf of Charles Palain, DMD have been reviewed.

I hereby adopt the findings of fact and I accept the Recommendation of the Hearing Officer that for the review period of 9/1/2010 to 12/31/2013, the Department has correctly established and maintains a recoupment claims against Charles Palian, DMD, d/b/a Central Maine Oral and Maxillofacial Surgery Associates, PA in the amount of $116,852.05.

DATED: July 3, 2018 SIGNED: Ricker Hamilton
RICKER HAMILTON, COMMISSIONER
DEPARTMENT OF HEALTH & HUMAN SERVICES

YOU HAVE THE RIGHT TO JUDICIAL REVIEW UNDER THE MAINE RULES OF CIVIL PROCEDURE, RULE 80C. TO TAKE ADVANTAGE OF THIS RIGHT, A PETITION FOR REVIEW MUST BE FILED WITH THE APPROPRIATE SUPERIOR COURT WITHIN 30 DAYS OF THE RECEIPT OF THIS DECISION.

WITH SOME EXCEPTIONS, THE PARTY FILING AN APPEAL (80B OR 80C) OF A DECISION SHALL BE REQUIRED TO PAY THE COSTS TO THE DIVISION OF ADMINISTRATIVE HEARINGS FOR PROVIDING THE COURT WITH A CERTIFIED HEARING RECORD. THIS INCLUDES COSTS RELATED TO THE PROVISION OF A TRANSCRIPT OF THE HEARING RECORDING.

cc: Joshua D. Hadiaris, Esq., Norman Hanson & DeTroy
Thomas Bradley, AAG, Office of the Attorney General
Valerie Hooper, DHHS/Program Integrity

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor Ricker Hamilton, Commissioner

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JUN - 5 2018

Date Mailed: _____

Ricker Hamilton, Commissioner
Department of Health and Human Services
11 State House Station • 221 State Street
Augusta, ME 04333

In the Matter of: Charles Palian, DMD
d/b/a Central Maine Oral and
Maxillofacial Surgery Associates

NPI ID No. 1477516284

ADMINISTRATIVE HEARING RECOMMENDED DECISION

An administrative hearing was initially convened in the above-captioned matter on July 17, 2017, and reconvened on January 9, 2018, before Hearing Officer Richard W. Thackeray, Jr., at South Portland, Maine. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner of the Maine Department of Health and Human Services. The hearing record was left open through April 13, 2018, to allow submission of written closing arguments.

Pursuant to an Order of Reference dated August 9, 2016, the issue presented *de novo* for hearing was whether the Maine Department of Health and Human Services ["Department"] was "correct when it determined that for the review period of 9/1/2010 through 12/31/2013, Charles Palian, DMD owes the department $147,329.89 in recoupment for violations of Chapter I, Section 1.03-3, 1.03-3(J), 1.03-3(M), 1.03-3(R), 1.06-3(D), 1.07-3(B), 1.07-7(A), 1.08-1(D), 1.12-2, 1.18, 1.19-1, 1.19-2; Chapter III, Section 25, Chapter II, Sections 25.03-1(A)2, 25.03-1(B)1, 25.03-2(G), 25.03-7, 25.03-7(D), 25.04-2, 25.06-1(A)1, 25.06-1(A) 2?" Ex. D-1.

APPEARING ON BEHALF OF THE APPELLANT

- Joshua D. Hadiaris, Esq.
- Charles Palian, DMD
- Kate Stanley (by telephone, July 17, 2017 only)

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Valerie Hooper

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Reschedule Notice," dated April 19, 2017
HO-2 "Reschedule Notice," dated November 16, 2016

HO-3 "Notice of Hearing," dated October 19, 2016
HO-4 "Pre-Hearing Correspondence," dated March 21, 2017 to June 30, 2017
HO-5 "Department's Witness List and Exhibits List," dated July 13, 2017
HO-6 "Appellant's Witness List and Exhibits List," dated August 30, 2017
HO-7 "Reschedule Notice," dated July 26, 2017
HO-8 "Reschedule Notice," dated August 11, 2017
HO-9 "Reschedule Notice," dated November 3, 2017

Department Exhibits

D-1 "Order of Reference," dated August 9, 2016
D-2 "Fair Hearing Report Form," dated September 9, 2016
D-3 "Notice of Violation," dated October 2, 2015
D-4 "Informal Review Request," dated December 15, 2015
D-5 "Final Informal Review Decision," dated August 9, 2016
D-6 "Hearing Request," effective date August 31, 2016
D-7 "Final Rule – Gen. Admin. Policies and Proc.," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1 (eff. Jan. 11, 2010)
D-8 Final Rule, "Dental Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 25 (eff. Aug. 9, 2010)
D-9 Final Rule, "Allowances for Dental Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. III, § 25 (eff. Aug. 9, 2010)
D-10 "MaineCare/Medicaid Provider Agreement," dated September 11, 2009
D-11 "Treatment Records," Member
D-12 "Treatment Records," Member
D-13a "Treatment Records," Member
D-13b "Invoice," Henry Schein, Inc., dated June 17, 2010
D-13c "Memorandum of Evidence: 'Calculation used to determine acquisition cost"
D-13d Excerpt, "Current Dental Terminology," 2009-10 edition
D-14 "Treatment Records," Member
D-15 Excerpt, "Current Dental Terminology," 2009-10 edition
D-16a "Treatment Records," Member
D-16b "Billing Records," Member
D-17 "Treatment Records," Member
D-18a "Treatment Records," Member
D-18b "Treatment Records," Member
D-19a "Billing Records," Member
D-19b "Treatment Records," Member
D-20a "Treatment Records," Member
D-20b "Billing Records," Member
D-20c "Billing Ledger," Member
D-20d "Treatment Records," Member
D-21 "Treatment Records," Member

D-22 "Revised Recoupment Demand and Supporting Spreadsheet," dated January 18, 2018
D-23 "Post-Hearing Brief / Closing Argument," dated April 13, 2018

Appellant Exhibits

A-A "Records Request," dated March 5 2015
A-B "Records Request Correspondence," dated May 22, 2015
A-C "Records Request Response," dated June 15, 2015
A-D "Notice of Violation," dated October 2, 2015, with spreadsheet (NOT ADMITTED / Duplicative of Ex. D-3)
A-E "Records Request – Repeat," dated October 7, 2015
A-F "Extension of Time – 14 days," dated November 23, 2015
A-G "Informal Review Request," dated December 15, 2015, with attachments (#1 – #40)
A-H "Final Informal Review Decision," dated August 9, 2015 (NOT ADMITTED / Duplicative of Ex. D-5)
A-I "Hearing Request," effective date August 31, 2016
A-J Excerpt, "Current Dental Terminology," 2011-12 edition
A-K "Medicaid Management Information Systems / Maine Integrated Health Management Solution - CMS 1500 Billing Instructions Guide," Me. Dep't of Health & Hum. Servs., dated Aug. 11, 2015
A-L Excerpt, "Dental Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 25 (eff. July 1, 2014)
A-M "Remittance Advice Report" (UNREDACTED)
A-N "Member Records (#1 – #75)," (UNREDACTED)
A-O "Paper Remittance Advice," [redacted], 2010 to [redacted] 2010
A-P "Program Integrity Information Review Process Policy"
A-Q "Informal Review Form Letter"
A-R "Records," Member (UNREDACTED)
A-S "Records," Member .. (UNREDACTED)
A-T "Records," Member (UNREDACTED)
A-U "Records," Member . (UNREDACTED)
A-V "Invoices"
A-W "Post-Hearing Brief," dated April 13, 2018

STANDARD OF REVIEW

The hearing officer reviews the Department's claim for recoupment against an approved MaineCare services provider *de novo*. DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (C)(1); Provider Appeals, MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (A). The Department bears the burden to persuade the Hearing Officer that, based on a preponderance of the evidence, it was correct in establishing a claim for repayment or recoupment against an approved provider of MaineCare services. 10-144 C.M.R. Ch. 1, § VII (B)(1), (2).

LEGAL FRAMEWORK

The Department administers the MaineCare program, which is designed to provide "medical or remedial care and services for medically indigent persons," pursuant to federal Medicaid law. 22 M.R.S. § 3173. *See also* 42 U.S.C. §§ 1396a, *et seq.* To effectuate this, the Department is authorized to "enter into contracts with health care servicing entities for the provision, financing, management and oversight of the delivery of health care services in order to carry out these programs." *Id.* Enrolled providers are authorized to bill the Department for MaineCare-covered services pursuant to the terms of its Provider Agreement, Departmental regulations, and federal Medicaid law. "Provider Participation," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03. *See also* 42 C.F.R. § 431.107 (b) (state Medicaid payments only allowable pursuant to a provider agreement reflecting certain documentation requirements); 42 U.S.C. § 1396a (a)(27). Enrolled providers "must … [c]omply with requirements of applicable federal and state law, and with the provisions of this Manual." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-8 (S). Enrolled providers must also maintain records sufficient to "fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-8 (M). "The Division of Audit or duly Authorized Agents appointed by the Department have the authority to monitor payments to any MaineCare provider by an audit or post-payment review." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.16. Pursuant to federal law, the Department is also authorized to "safeguard against excessive payments, unnecessary or inappropriate utilization of care and services, and assess the quality of services available under MaineCare." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.17. *See also* 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.18; 22 M.R.S. § 42 (7); 42 U.S.C. § 1396a (a)(27); 42 C.F.R. § 431.960. This includes the imposition of "sanctions and/or recoup(ment of) identified overpayments against a provider, individual, or entity," for any of 25 specific reasons including:

- Failing to retain or disclose or make available to the Department or its Authorized Agent contemporaneous records of services provided to MaineCare members and related records of payments;
- Breaching the terms of the MaineCare Provider Agreement, and/or the Requirements of Section 1.03-8 for provider participation;
- Over utilizing MaineCare by inducing, furnishing, or otherwise causing a member to receive service(s) or merchandise not otherwise required or requested by the member;
- Failure to meet standards required by State and Federal law for participation (e.g. licensure or certification requirements). …

MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-1.

The Department bears the initial burden to prove "by a preponderance of evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (H). Once that threshold proof has been made, the Department is afforded discretion to recoup a penalty. The scope of that penalty, however, is limited by the degree to which the provider is able to demonstrate that the billed services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare

members. *Id.* The regulations provide that, "[w]hen the Department proves by a preponderance of the evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services, the Department in its discretion may impose the following penalties:

1. A penalty equal to one hundred percent (100%) recoupment of MaineCare payments for services or goods, if the provider has failed to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members.
2. A penalty not to exceed twenty-percent (20%), if the provider is able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. The penalty will be applied against each MaineCare payment associated with the missing mandated records.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (H).

To investigate and establish a Section 1.19 sanction, the Department may employ "surveillance and referral activities that may include, but are not limited to:

A. a continuous sampling review of the utilization of care and services for which payment is claimed;

B. an on-going sample evaluation of the necessity, quality, quantity and timeliness of the services provided to members;

C. an extrapolation from a random sampling of claims submitted by a provider and paid by MaineCare;

D. a post-payment review that may consist of member utilization profiles, provider services profiles, claims, all pertinent professional and financial records, and information received from other sources;

E. the implementation of the Restriction Plans (described in Chapter IV of this Manual);

F. referral to appropriate licensing boards or registries as necessary; and

G. referral to the Maine Attorney General's Office, Healthcare Crimes Unit, for those cases where fraudulent activity is suspected.

H. a determination whether to suspend payments to a provider based upon a credible allegation of fraud.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.18.

RECOMMENDED FINDINGS OF FACT

1. In accordance with agency rules, Charles Palian, DMD ["Dr. Palian"] was properly notified of the time, date, and location of the immediate proceeding.

2. Dr. Palian is a retired dental services provider whose practice, Central Maine Oral and Maxillofacial Surgery Associates, P.A., was based in throughout the period from September 1, 2010 to December 31, 2013.

3. Effective October 2, 2009, Dr. Palian entered into a "Medicaid/Maine Health Program Provider/Supplier Agreement" with the Department, pursuant to which Dr. Palian was able to receive reimbursement from the Department for provision of covered dental and related services to enrolled members of the MaineCare program. Ex. D-10.

4. On or about December 31, 2013, the Department initiated a post-payment review of billing claims submitted by Dr. Palian's dental surgery practice, using random selection of 100 dates of service within an identified review period of September 1, 2010 to December 31, 2013.

5. A Departmental post-payment review identified that during the September 1, 2010 to December 31, 2013 period, MaineCare reimbursed Dr. Palian for a total of $1,274,480.03 for claims billed to the Department. The 100 reviewed claims from the same period corresponded to MaineCare reimbursement of $87,930.40 to Dr. Palian.

6. Of the 100 sets of reviewed claims paid between September 1, 2010 and December 31, 2013, the Department initially identified an error rate of 14.89 percent where it found that $13,089.18 of the $87,930.40 paid by the Department toward those claims should not have been paid due to missing records, or otherwise being non-reimbursable or unacceptable as billed.

7. On October 2, 2015, the Department issued a "Notice of Violation" against Dr. Palian, in which it alleged a total overpayment claim in the amount of $189,770.08, derived from applying the 14.89 percent error rate against the amount in total claims it paid Dr. Palian from September 1, 2010 to December 31, 2013 ($1,274,480.03 x 14.89% = $189,770.08). Ex. D-3.

8. On December 15, 2015, Dr. Palian timely requested an informal review of the Department's "Notice of Violation," and more specifically alleged the following in response:

- Cases were mistakenly identified as missing documentation where records of the targeted procedures were provided from the operating room where such procedures were performed;
- Patient circumstances required certain procedures to be performed in the hospital and correlated to claims correctly billed using Procedure Code D9410;
- Claims for anesthesia were correctly coded and billed;
- Allegedly missing radiographs were properly documented and provided to the Department;
- The removal and alveoplasty of one patient's teeth, identified by the Department as incorrectly billed, was appropriately coded and billed;
- Several case-specific alleged overpayments were mistakenly identified by the Department and were, in fact, correctly billed by Dr. Palian;
- Sedative drug claims, identified as overpayments by the Department, were correctly billed;

Ex. D-4.

9. On August 9, 2016, the Department issued a "Final Informal Review Decision" against Dr. Palian, reflecting changes responsive to the arguments raised by Dr. Palian in his "Request for Informal Review," dated December 15, 2015. The Department revised its findings with respect to several identified claims, and found that total overpayments were lower than the amount specified in the December 15, 2015 Notice of Violation. Without expressly identifying a revised error rate, the Department identified a recalculated recoupment claim amount of $147,329.89. Ex. D-5.

10. On August 31, 2016, Dr. Palian timely requested an administrative hearing. Ex. D-6.

11. After the parties presented their cases-in-chief at hearing, the Department reviewed its recoupment claim in light of new evidence and/or explanation received from Dr. Palian. On January 18, 2018, the Department reduced its final recoupment demand to $116,852.05. In support of this figure, the Department identified the following:

- The total dollar value of claims universe was $1,274,480.00.
- The Department identified a sample of 960 claims within the claims universe.
- All claims within the universe had a total value of $86,667.40.
- The amount identified as "NOT allowed" within the claims sample was $9,375.39.
- The Universe-to-Sample (in dollars) ratio was 14.7054 to one.
- The pre-adjusted error rate derived (disallowed claims to total claims sample) was 0.108177.
- "Standard Error of the Proportion" was 0.01002.
- Claims Universe total dollar value x pre-adjusted error rate was $137,868.99.
- "Error rate at lower bound" (1.645 x Standard Error of the Prop.) was 0.09169.
- Amount of Reduction was $21,016.94 ("Point Estimate" x "Lower bound error rate").

Ex. D-22.

12. Valerie Hooper performed the post-payment review of Dr. Palian's practice and issued the Notice of Violation, dated October 2, 2015. Ex. D-3.

13. Herbert F. Downs, Director of the Division of Audit, performed the Final Informal Review of Ms. Hooper's audit of Dr. Palian's practice. Ms. Hooper reviewed and prepared responses to Dr. Palian's December 15, 2015 Request for Informal Review, consulted with Mr. Downs, and provided a draft letter of decision for Mr. Downs to use in finalizing the Final Informal Review Decision, dated August 9, 2016. Ex. D-5.

14. Mr. Downs did not participate in or otherwise assist Ms. Hooper in her preparation of the Notice of Violation issued on October 2, 2015. Test. of Valerie Hooper.

RECOMMENDED DECISION

For the review period of September 1, 2010 to December 31, 2013, the Department has correctly established and maintains a recoupment claim against Charles Palian, DMD, d/b/a Central Maine Oral and Maxillofacial Surgery Associates, P.A., in the amount of **$116,852.05**.

REASONS FOR RECOMMENDATION

As noted above, the Department bore the burden at hearing to demonstrate by a preponderance of evidence that it correctly established the amount of its recoupment claim against Dr. Palian, identified in its August 9, 2016 Final Informal Review Decision in the amount of $147,329.89, for reasons supported by the MaineCare statutes and regulations. At hearing, the Department described the process by which it employed random sampling of Dr. Palian's billing claims to investigate and establish that Dr. Palian was incorrectly reimbursed for certain dental services provided to his patients. Test. of Valerie Hooper.

Thereafter, Dr. Palian responded with additional evidence to support his arguments that documentation was proper and correctly generated in support of delivered, medically-necessary, covered MaineCare services. Test. of Charles Palian, DMD. Post-hearing, the Department revised its recoupment claim to reflect new findings that several, initially-identified claims were either appropriately recoverable at 20 percent or not at all. Ex. D-22. Thus, the issue presented requires review of the Department's final recoupment claim figure identified in its closing argument, i.e. $116,852.05, in light of the arguments and evidence presented by Dr. Palian at hearing. That issue-by-issue analysis follows below.

Post-hearing, the Department withdrew its demand for any recoupment related to "deficiencies in x-ray documentation." This withdrawal correlates to Dr. Palian's arguments that the Department mistakenly assessed an overpayment for claims that allegedly did not produce documentation supporting claims for certain radiographs. For this reason, this issue is deemed to no longer be in dispute.

The issues raised on appeal that remain for resolution can be generally grouped into three categories: whether the Department should be equitably estopped from seeking recoupment for each identified, billed claim that it allowed in the first instance, which Dr. Palian submitted in the manner consistent with his usual and customary billing practice; whether the Department correctly assessed sanctions against Dr. Palian for several case-specific and service-specific categories of alleged violations; and whether the Department's Final Informal Review Decision should be voided where the individual who conducted the audit and issued the Notice of Violation also substantially contributed to the drafting of the Final Informal Review Decision. These three sets of arguments are addressed below in reverse order.

Permissibility of a Notice of Violation issuer participating in the Final Informal Review

There was no factual disagreement between the parties as to who performed which functions for the Department during the post-payment review, preparation of the Notice of Violation, and Final Informal Review stages of this proceeding. Valerie Hooper testified that she performed the post-payment review of Dr. Palian's practice, issued the Notice of Violation on October 2, 2015, consulted Division of Audit Director Herbert F. Downs during the Final Informal Review, and wrote the draft Final Informal Review Decision that was substantially adopted by Mr. Downs as the version he finally and officially issued on August 9, 2016. Test of Valerie Hooper. The issue is whether this course of events was legally permissible. The regulations in effect throughout the period covered by the post-payment review provided that:

> Any provider or provider applicant who is aggrieved by a Departmental action made pursuant to this Manual (excluding emergency terminations as referenced in Section 1.19-3-D) has sixty (60) calendar days from the date of receipt of that decision, to request an informal review. The request for an informal review must be in writing, to the Director of the Office of MaineCare Services or other specified Departmental official. This review will be conducted by the Director of the Office of MaineCare Services, or other designated Department representative who was not involved in the decision under review. The informal review will consist solely of a review of documents in the Department's possession including submitted materials/documentation and, if deemed necessary by the Department, it may include a personal meeting with the provider to obtain clarification of the materials. Issues that are not raised by the provider, individual, or entity through the written request for an informal review or the submission of additional materials for consideration prior to the informal review are waived in subsequent appeal proceedings. The request for informal review may not be amended to add further issues. Requests for informal reviews shall be submitted to the Office of MaineCare Services or other designated Department representative unless otherwise directed by the governing sections of Chapter II or Chapter III of this Manual. A written report of the decision resulting from that review will be issued to the provider.

"Provider Appeals," MaineCare Benefits Man., 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (eff. Jan. 11, 2010).

Dr. Palian argues that Ms. Hooper's participation in the consultation and decision-drafting processes leading to Mr. Downs' Final Informal Review Decision deprived him of the guarantee that the Final Informal Review be "conducted by [a] designated Department representative who was not involved in the decision under review." *Id.* Dr. Palian's argument relies upon the proposition that Ms. Hooper, by performing the research and initial drafting of the Final Informal Review Decision, by extension became the individual who "conducted" the Final Informal Review. Yet, the undisputed evidence reflects that Mr. Downs applied Ms. Hooper's consultative work as a part of the Final Informal Review he conducted – that he, as the Director of the office in which she worked, independently gauged the correctness of her review and conclusions, and adopted those that his judgment determined were correctly reached. Nothing about this process violates the plain language of the regulation.

Dr. Palian did not allege that Mr. Downs participated in the preparation of the underlying Notice of Decision – either in review or writing. If the evidence reflected to a higher-than-not likelihood that

Mr. Downs was "involved" in Ms. Hooper's post-payment review, resulting in her Notice of Violation, such circumstance would have violated the plain language of the regulation. No such evidence was admitted into the record. Accordingly, it should be concluded that the Department did not violate Dr. Palian's procedural rights by virtue of Ms. Hooper assisting Mr. Downs during the Final Informal Review.

Correctness of Individual Violations Identified in the Department's Revised Final Claim

Dr. Palian's second set of arguments against the Department's recoupment claim broadly encompassed individual claims that the Department identified as having been improperly documented, medically unnecessary, not MaineCare-covered services, or otherwise improperly billed. Having distilled the issues initially identified in the October 2, 2015 Notice of Violation through those finally maintained by the Department, as listed in its April 13, 2018 Post-Hearing Briefs of both parties, the outstanding issues within this category are grouped as follows:

- Proper billing procedure for services performed in hospital operating rooms
- Proper billing procedure for anesthesia-related services
- Proper billing procedure / cost determination for non-sedative drugs
- Proper documentation of interpreter services
- Proper documentation of smoking cessation services
- Other member-specific billing and procedural violations

The generally applicable regulations in effect at the time of the review period required all MaineCare providers to "[m]aintain and retain contemporaneous financial, provider, and professional records sufficient to fully and accurately document the nature, scope and details of the health care and/or related services or products provided to each individual MaineCare member," and that:

> Records must be consistent with the unit of service specified in the applicable policy covering that service. Records must include, but are not limited to all required signatures, treatment plans, progress notes, discharge summaries, date and nature of services, duration of services, titles of persons providing the services, all service/product orders, verification of delivery of service/product quantity, and applicable acquisition cost invoices. Providers must make a notation in the record for each service billed. For example, if a service is billed on a per diem basis the provider must make a notation for each day billed. If a service is billed on a fifteen (15) minute unit basis, a notation for each visit is sufficient.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (M), (N) (eff. Jan. 11, 2010).

As noted above, the Department was thereafter authorized to apply a tiered penalty schedule – 100 percent vs. 20 percent – based on its determination about the underlying MaineCare services as to whether the provider had demonstrated 1). medical necessity of the underlying service, 2) that the service was a covered service, and 3) that the service had been actually provided to an eligible MaineCare member. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (G) (eff. Jan. 11, 2010). With this background, we look to the individually-disputed claims.

Proper billing procedure for services performed in hospital operating rooms

In its August 9, 2016 Final Informal Review Decision, the Department upheld a series of identified violations relating to services billed using billing code D9410, specifically stating that:

> The Department did seek guidance about whether a hospital is considered an extended care facility, and a Certified Professional Coder advised that a hospital is not an extended care facility and that the use of code D9410 for this purpose is "inappropriate billing." Per the MBM Chapter III, Section 25, the use of code D9410 (Hospital Call) is limited to emergency room trauma care, which was not the case for Dr. Palian's patients.

Ex. D-5.

Dr. Palian's position with respect to these claims was that they were limited to a special set of patients for whom non-emergency, outpatient surgery performed in his office was not feasible based on the patients' individualized anesthesia-related needs. Ex. A-W. All of these claims involved patients on whom Dr. Palian performed surgery at the St. Mary's Medical Center Operating Room. Ex. A-G. By Dr. Palian's reasoning, he was entitled to bill the Department for both the underlying dental service performed using the applicable procedure code and a second code for a house call or extended care facility call, under code D9410.

MaineCare includes as "covered services" under Section 25 all dental services provided to adult members, which are generally identified as "oral surgery" and meet the limitations identified in the regulations, "as indicated in Chapters II and III of this Section that are available under the adult dental care guidelines described in Chapter II, Subsection 25.04." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 25.03-7 (eff. Aug. 9, 2010). The Chapter III "Allowances for Dental Services" list all billable codes and identify applicable limits on providers' use of such codes. 10-144 C.M.R. Ch. 101, sub-Ch. III, § 25 (eff. Aug. 9, 2010). An excerpt of the promulgated MaineCare reimbursement principles for dental services in effect throughout the review period is re-created below:

Proc. Code	Description	Covered Service Age/ICF-MR		Prior Authorization Required		Additional Limits	Max Allow
		under age 21 & all ICF-MR residents*	age 21 & over when allowed under 25.04	under age 21 & all ICF-MR residents	age 21 & over when allowed under 25.04		
D9410	House/Extended Care Facility Call	YES	YES	NO	NO	Limited to dentist/denturist, only if medically necessary and providing a covered service under this policy	$60.00
D9420	Hospital or Ambulatory Surgical Call Center	YES	YES	NO	NO	Use for emergency room trauma care	$100.00

10-144 C.M.R. Ch. 101, sub-Ch. III, § 25, p. 41 (eff. Aug. 9, 2010)

It also merits noting that the Department relied upon the code descriptions published in the Current Dental Terminology ["CDT"] volume, 2009-10, for guidance on claims processed during the review period. Test. of Valerie Hooper. Code D9410, "house/extended care facility call," was defined by that volume to "[i]nclude[ ] visits to nursing homes, long-term care facilities, hospice sites, institutions, etc.," and included the instruction to "[r]eport in addition to reporting appropriate code numbers for actual services performed." Ex. D-15. Code D9420, "hospital call," was defined as being permissibly available to "be reported when providing treatment in hospital or ambulatory surgical center, in addition to reporting appropriate code numbers for actual services performed." Ex. D-15.

The Hearing Officer's "decision must be based on the agency regulations and the evidence which is a matter of hearing record." Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (B)(3). Only "where the agency's regulations are ambiguous or silent on the point critical to a determination" is "reference to other sources of law for guidance in interpreting the agency's regulations ... appropriate." *Voter v. Voter*, 2015 ME 11, ¶8, 109 A.3d 626, 630. As with statutory interpretation, the language of an administrative regulation "should be construed to avoid absurd, illogical, or inconsistent results," and in light of the whole regulatory scheme "for which the section at issue forms a part so that a harmonious result ... may be achieved." *See Dep't of Human Servs. ex rel. Hampson v. Hager*, 2000 ME 140, ¶21, 756 A.2d 489, 493.

Here, the Departmental regulations are clear: Code D9410 is given the description, "House / Extended Care Facility Call." The accompanying code, D9420, is described as "Hospital Call," with the express limitation of "use for emergency room trauma care." 10-144 C.M.R. Ch. 101, sub-Ch. III, § 25 p. 41 (eff. Aug. 9, 2010). Neither code is applicable, based on plain language, to non-emergency, outpatient surgeries performed in hospital operating rooms.

To the extent that some ambiguity is read into the absence of express limitations for D9410, it is appropriate to resort to the CDT instructions, which expressly identify its appropriateness for used for "visits to nursing homes, long-term care facilities, hospice sites, institutions, etc." Ex. D-15. Dr. Palian is correct to note that a hospital is generally included within the definition of "institution" – as notably acknowledged by a Departmental employee in an internal email discussion. Ex. A-G(3). However, applying the general definition of "institution" as including "hospital" would lead to the illogical result that hospital visits would be included in two code definitions – D9410 and D9420. Of course, the Department has limited the availability of D9420 to a specific sub-set of hospital visits, namely those for "emergency room trauma care." 10-144 C.M.R. Ch. 101, sub-Ch. III, § 25, p. 41 (eff. Aug. 9, 2010). It is, however, absurd to presume that the Department, by this limitation, intended to squeeze non-emergency hospital visits out of the CDT definition for D9420 and into the broad world of visits to "institutions," as identified within the CDT definition for D9410. To the extent that there is any ambiguity, the most reasonable interpretation is the one advanced by the Department – that the proper billing procedure for dental surgeries performed on a non-emergency, outpatient basis in hospital

operating rooms is to employ only the code for the underlying dental surgery service performed. This was the limit of what Dr. Palian was entitled to claim for non-emergency outpatient surgeries performed at the St. Mary's operating room. As such, the Department was correct when it identified violations for recoupment at the 100-percent sanction rate for non-emergency, outpatient surgeries performed in hospital operating rooms for which a claim using code D9410 was billed.

Proper billing procedure for anesthesia-related services

In its August 9, 2016 Final Informal Review Decision, the Department upheld a series of identified violations relating to the manner in which Dr. Palian calculated the time he spent with patients after administration of anesthesia, and the relationship between that calculation and reimbursement amounts claimed. Ex. D-5. However, after hearing, the Department withdrew several violations in this category and reduced the sanction percentage in several others, as reflected on the "Revised Recoupment Demand and Supporting Spreadsheet," dated January 18, 2018. Ex. D-22. With regard to the remaining recoupment claims in this category, the Department reduced all violations previously sanctioned at 100-percent recoupment down to a 20-percent recoupment. Ex. D-22. In support of its position that the 20-percent sanction should be upheld for such claims, the Department argued in closing:

> The 20 percent sanction is warranted. The documentation of the additional time is entirely absent, and the deficiencies in billing were numerous. In addition, Dr. Palian did not argue at the informal review stage that 20 percent sanctions were not warranted, so the issue of a sanction reduced below 20 percent was not preserved.

Ex. D-22.

While technically correct – Dr. Palian did not specifically raise the issue of the inappropriateness of the 20-percent sanction for anesthesia-related violations – the Department neglects the fact that most of the 20-percent sanctions now listed for such services on the Revised Recoupment Demand were not in effect at the time Dr. Palian presented his Final Informal Review Request. As such, Dr. Palian is not foreclosed from advancing this argument in his appeal due to waiver.

The Chapter III "Allowances for Dental Services" provide that code D9220 is available for "Deep Sedation / General Anesthesia – First 30 Minutes," and that code D9221 is available for "Deep Sedation / General Anesthesia – First additional 15 minutes." 10-144 C.M.R. Ch. 101, sub-Ch. III, § 25, p. 40. The 2010 edition of the CDT provides, with respect to D9221, that the time calculation begins with anesthesia administration by the doctor, continues while the doctor "remains in continuous attendance of the patient," and is "considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room to attend to other patients or duties." Ex. A-J.

. The Department accepted Dr. Palian's testimony as proof that the time billed actually correlated to the services provided and reduced from 100 to 20-percent each of the remaining claims in this category. However, the Department maintained that the failings of Dr. Palian's documentation still warranted a sanction at the 20-percent level, consistent with authorization in 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.19-2 (H), and demonstrated that the relevant patient records did not satisfy the documentation standard where they did not clearly indicate the amount of time actually spent with the patients after anesthesia was administered. Only through testimony presented at hearing was this fact made clear. As such, the Department sustained its burden to demonstrate, by a preponderance of the evidence, that it correctly maintained such violations at the 20-percent sanction rate.

Proper billing procedure / cost determination for non-sedative drugs

In its August 9, 2016 Final Informal Review Decision, the Department upheld a series of identified violations relating to billing claims submitted for non-sedative drugs using a calculation formula that it alleged did not reflect the drugs' acquisition cost. Ex. D-5. The Department more specifically stated that it "can only consider the cost of acquiring the drugs, not the costs of maintaining and administering them ...." Ex. D-5.

Chapter II of the MaineCare regulations provides that "[t]he amount of payment for services rendered shall be the lowest of the following:

A. the amount listed in Chapter III, Section 25, "Allowances for Dental Services;"
B. the lowest amount allowed by Medicare; or
C. the provider's usual and customary charge.

10-144 C.M.R. Ch. 101, sub-Ch. II, § 25.07-2 (eff. Aug. 9, 2010); *see also* 10-144 C.M.R. Ch. 101, sub-Ch. III,§ 25, intro (noting functionally equivalent terms to Chapter II). Chapter III instructs that "[p]roviders are requested to bill their usual and customary charge for all dental services." 10-144 C.M.R. Ch. 101, sub-Ch. III,§ 2, p. ii. However, the billing code specifically provided in Chapter III for "Therapeutic Parenteral Drug, Single Administration" – i.e. D9610 – is expressly limited to "acquisition cost only," with a maximum allowance defined "by report." 10-144 C.M.R. Ch. 101, sub-Ch. III,§ 25, p. 41. Further, the CDT instructs that code D9610 is designed for "single administration of antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications," but "not to report administration of sedative, anesthetic or reversal drugs." Ex. D-13(D).

Dr. Palian argues that the provisions authorizing providers to "bill their usual and customary charge" entitles him to be sheltered from the Department's effort to recoup the difference between amounts paid pursuant to his billed "usual and customary charge" and the allowable reimbursement cost, as determined by the Department. Ex. A-W. Further, he highlights a statement of the American Dental Association, part of which provides that "[i]t is always appropriate to report the full fee for each service reported to a third party payer." Ex. A-J; Ex. A-W.

To the extent that Dr. Palian's argues that the Department should be barred from recouping mistakenly paid MaineCare claims, implicitly raising the theory of equitable estoppel, the discussion of those arguments is addressed later in this recommended decision. *See infra.* However, Dr. Palian's argument that the Department too narrowly construes the meaning of "acquisition cost" will be addressed here.

At hearing, Departmental auditor Valerie Hooper testified that documentation produced by Dr. Palian's office and subsequent correspondence did not include any statements from Dr. Palian alleging any specific acquisition cost relating to several drugs at issue in the targeted billing claims. Test. of Valerie Hooper. Ms. Hooper then testified that she calculated drug acquisition cost based on her review of Dr. Palian's invoices from the applicable drug distributors. Test. of Valerie Hooper. The corticosteroid Decadron (a/k/a Dexamethasone), for example, was identified as having a "unit price" of $13.99 for 30 ml, but would be administered in 1 ml doses. Ex. D-13(b); Ex. D-13(c); Test. of Valerie Hooper. Using these factors, Ms. Hooper testified that she extrapolated a per-dose acquisition-based cost of $0.47 for Decadron. Test. of Valerie Hooper. Where Dr. Palian commonly billed $81.00 per dose of Decadron during the review period, Ms. Hooper testified that she assessed a recoupment claim for all but the 47-cents per-dose acquisition cost, or $80.53 per claim. Ex. D-22; Test. of Valerie Hooper.

It is undisputed that Dr. Palian submitted claims and received reimbursement from the Department for several therapeutic drugs, and that the per-claim amount for each was upwards of $80.00 per administration. However, Dr. Palian misapprehends the assignment of responsibilities between the Department and providers with respect to claim amounts. The introduction section of the Chapter III "Allowances for Dental Services" makes plain that providers are expected to "bill their usual and customary change for all dental services," but also that the reimbursement rate for each code will be the lowest of three identifiable amounts: the fee published in Chapter III for that code, the lowest amount paid by Medicare, or the provider's usual and customary charge. 10-144 C.M.R. Ch. 101, sub-Ch. III,§ 25, p. ii.

Dr. Palian's ultimate position with respect to the Department's drug cost-related sanction amounts was one of fairness – that it is not worth a provider's time or effort to submit a drug administration claim to MaineCare where the reimbursable rate is less than a dollar per dose, and completely neglects actual costs beyond what the distributor charges. The Department essentially concedes the unfairness of the reimbursement rates and scheme, acknowledging that "many dentists evidently do not even bill MaineCare for the acquisition costs of some drugs given the amount involved." Ex. D-22. However, this concession does not mean that the Department is not entitled to recoupment of the amount overpaid to Dr. Palian in the first instance, as established by the regulations. Dr. Palian had notice of the billing scheme contained within the MaineCare regulations and acknowledged through his Provider Agreement that he accepted its terms for participation. That the rate provided for drug reimbursement does not dovetail with a provider's usual and customary charge does not afford that provider with a right to a windfall. Here, the Department sustained its burden to

demonstrate that it rationally ascertained "acquisition cost" amounts for each of the three drugs, and that it correctly subtracted these amounts from the overpaid drug claims in calculating the related recoupment claims against Dr. Palian.

Proper documentation of interpreter services

In its August 9, 2016 Final Informal Review Decision, the Department upheld two overpayment claims for improperly documented interpreter services, which it sanctioned at 100 percent. Ex. D-5. The MaineCare regulations provide:

> When providers request reimbursement for any interpreter services, the services must be included in the member record. Documentation must include a statement verifying the interpreter qualifications, date, time and duration of service, language used, the name of the interpreter, and the cost of performing the service.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.06-3 (D) (eff. Jan. 11, 2010)

Dr. Palian conceded that the only documentation provided to support the two $20.00 reimbursement requests for interpreter services did not include all of the information required by the regulation. Ex. A-W. The only relevant documentation presented by either party consisted of a document marked "Evaluation," which stated that the member "is here with her interpreter stating that she is having pain associated with tooth #30," and that "she would like this removed." Ex. D-22; Ex. A-G (26). The interpreter, presumably paid by Dr. Palian, was not identified by name or agency, never mind her qualifications, such as might justify Departmental payment for interpreter services. The Department sustained its burden to show that Dr. Palian had failed to demonstrate by a preponderance of the evidence that the interpreter services were medically necessary, covered services under MaineCare, and actually provided to the member. Accordingly, the Department correctly determined that the two $20.00 interpreter claims were properly subject to the 100-percent sanction.

Proper documentation of smoking cessation services

In its August 9, 2016 Final Informal Review Decision, the Department upheld one overpayment claim for improperly documented smoking cessation services, which it sanctioned at 100 percent. Ex. D-5. The FIRD more specifically identified that a "statement that the member's medical history revealed a history of tobacco use does not indicate that there was a discussion about the risks of smoking, the benefits of quitting and an assessment of the member's willingness and readiness to quit, as required in the MBM Chapter II, Section 25.03-2 (G)." Ex. D-5.

The MaineCare regulations provide that "Smoking Cessation Counseling is a covered service only when performed by the dentist, for all members regardless of age in accordance with the following requirements:

> MaineCare covers counseling and treatment for smoking dependence to educate and assist members with smoking cessation. Services may be provided in the form of brief individualized behavioral therapy, which must be documented in the member's record. Providers must educate members about the risks of smoking, the benefits of quitting and assess the member's willingness and readiness to quit. Providers should identify barriers to cessation, provide support, and use techniques to enhance motivation for each member. Providers may also use pharmacotherapy for those member's for whom it is clinically appropriate and who are assessed as willing and ready to quit, or in the process of quitting.
>
> Reimbursement is not available for this service when provided through the Maine Center for Disease Control and Prevention's, Oral Health Program.

10-144 C.M.R. Ch. 25.03-2 (G).

Departmental auditor Ms. Hooper testified at hearing that she found no documentation that Dr. Palian provided any meaningful behavioral therapy to the member, discussed quitting or cessation strategies, or otherwise undertook the kinds of discussion with the member that is contemplated by the regulations. Test. of Valerie Hooper. In defending his billing for smoking cessation, Dr. Palian testified that for "every patient that smoked, you know, we're advised by ... our professional society to advise everybody that smokes to stop smoking," and that "I believe that they were asked about it (to stop smoking), and why they smoked, and 'Do you want to quit?'" Test. of Charles Palian, DMD.

The only documentation provided in support of this claim was a document titled, "Evaluation," the only smoking cessation-related reference contained therein noted "Discussion regarding [member]'s other past medical history revealed history of tobacco use 1 pack per day for 1 year." Ex. A-G(25). This notation, combined with Dr. Palian's vague recollection about his smoking-related discussions with his former patients, is insufficient to counter-weigh the Department's threshold showing that it correctly assessed a 100-percent sanction for this claim. The Department's claim on this score should be upheld.

Other member-specific billing and procedural violations

With respect to member " ," Dr. Palian challenged the Department's claim to recoup $35.00 of a $55.00 claim paid for a comprehensive oral evaluation. On July 24, 2012, Dr. Palian filed a reimbursement claim through the Department's online provider claims portal for a "Comprehensive Oral Evaluation," using code D0150. Ex. D-5; Ex. D-22; Test. of Valerie Hooper. On July 25, 2012, Dr. Palian's recorded on a ADA "Dental Claim Form" that the same procedure was a "Limited Oral Evaluation," and listed code D0140. Ex. A-G(31); Ex. D-19(A). The Department processed the claim as a "Comprehensive Oral Evaluation," code D0150, which was paid at the $55.00 rate allowed under the Chapter III Allowances for Dental Services. Ex. D-5; Ex. D-19(B); Ex. D-22; Test. of Valerie Hooper.

MaineCare regulations provide that a Limited Oral Evaluation, code D0140, is reimbursable at $20.00, whereas a Comprehensive Oral Evaluation, code D0150, is reimbursable at $55.00. 10-144

C.M.R. Ch. 101, sub-Ch. III, § 25, p. 1. There is no dispute between the parties that the service provided in relation to this claim was a Limited Oral Evaluation, or that the correct code for the procedure was D0140. Ex. D-23; Ex. A-W. As such, it should be concluded that the Department correctly determined that $35.00 of this claim was recoupable.

With respect to member " " Dr. Palian challenged the Department's determination that four of eight claims for "alveoplasty with extraction, per quadrant," dated May 31, 2012, were duplicate claims. Ms. Hooper testified that the four billable claims were submitted once by direct online entry on the Departmental provider portal, and a second time by a paper Dental Claim Form, but that both sets of claims represented the same set of procedures. Test. of Valerie Hooper. Ms. Hooper also referenced Departmental payment records, which showed Dr. Palian was paid for eight discreet "alveoplasty with extraction, per quadrant" claims, via code D7310, all of which reflected a service date of [redacted], 2012. Ex. D-5; Ex. D-22. In response, Dr. Palian did not deny that he was paid in duplicate, but rather, that "Palian Exhibit G(31) shows that only four procedures were billed for reimbursement." Ex. A-W. Thus, the Department sustained its burden to demonstrate that it correctly identified and calculated the recoupable billing claim, and Dr. Palian provided no evidence showing that he had not improperly received such reimbursement. Accordingly, the Department's claim in this regard should be upheld.

Similarly, Dr. Palian challenged the Department's maintenance of a 100-percent recoupment claim for an allegedly duplicate claim processed for member " ," on June 12, 2012. Ex. A-W. In its August 9, 2016 Final Informal Review Decision, the Department noted that "two separate evaluations [were] performed on [redacted]12 and [redacted]12"; that the employed code, D0140, is "reimbursable once per episode per provider"; and that the same episode "was billed twice, once via paper claim and once via direct data entry on the web portal." Ex. D-5. Documentation reviewed by the Department included an record dated [redacted], 2012, reflecting that member " " received a "Limited Oral Evaluation" related to a lesion in her mouth on that date, and that a "Progress Note," dated [redacted] 2012, reflected that member " " received an "[i]ntraoral examination" that day that "reveals improvement" related to the same lesion. Ex. D-18(A); Ex. D-18(B).

The MaineCare regulations provide that "[r]eimbursement for periodic oral examinations will not be made more than once every six months," and that "[r]eimbursement for limited oral or problem focused (emergency) exams is available once per emergency episode per provider." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 25.03-1 (A)(1), (2) (eff. Aug. 9, 2010). Here, the Department demonstrated that it based its [redacted] 2012 overpayment claim related to code D0140 for member " ." on the reasonable finding that it was the second such claim filed within seven days for the same episode, based on Dr. Palian's documentation. Ex. D-18(A); Ex. D-18(B); Test. of Valerie Hooper. Dr. Palian supplied no evidence to counterweigh the Department's threshold showing, relying instead on the argument that Dr. Palian deemed it medically necessary for a one-week follow-up visit as a conservative step to mitigate cancer risks. Ex. A-W. While Dr. Palian may have followed the medically appropriate course of treatment by having member " " return after a week for a second limited oral evaluation, this fact does not automatically trigger a right to reimbursement under MaineCare. The governing

regulation plainly limits providers to once such claim per episode. A preponderance of the evidence reflects that both the [redacted] and [redacted] 2012 visits were for the same episode. On this basis, it should be concluded that the Department correctly identified this claim as an overpayment.

Dr. Palian also challenged the Department's assessment of a 20-percent sanction with regard to four claims for code D9930 involving member ' ," between [redacted], 2011 and [redacted] 2011. The claims were initially identified for 100-percent recoupment and upheld as such in the Final Informal Review Decision, dated August 9, 2016. Ex. D-5. At hearing, Dr. Palian represented that the claims were documented on his practice's ledger sheets, and credibly testified as to the medical necessity and description of the services provided that gave rise to the claims. Test. of Charles Palian, DMD. In response, the Department reduced the sanction amount to 20 percent, noting that the ledger sheets were insufficient to fully satisfy the Department's documentation requirements. Ex. D-22; Ex. D-23. The Department sustained its burden in this regard, and the four related overpayment claims should be upheld.

Finally, Dr. Palian argued in his post-hearing brief that the recoupment claim included a total overpayment of "$72.80 for treatment on [redacted], 2010 provided to patient ." and that the "Department, however, has not withdrawn these overpayment claims." Ex. A-W. The Department's "Revised Recoupment Demand and Supporting Spreadsheet," dated January 18, 2018, lists 10 original claims reviewed for member ' " that showed a [redacted] 2010 date of service. Ex. D-22. No sanction or overpayment amount was identified in relation to any of the [redacted] 2010 claims associated with member ' ." and the only maintained overpayment claims related to member " ." during the same general period was a single claim for Decadron billed in excess of acquisition cost, the propriety of which was already addressed in an earlier section of this recommended decision. *See supra*. Accordingly, no addition discussion is needed with regard to this argument.

Availability of Equitable Estoppel as a Defense to the Department's Recoupment Claim

As noted above, Dr. Palian finally argued that the Department should be equitably estopped from maintaining its entire recoupment claim against him because he failed to correct Dr. Palian's claims billing practices as they were received.

In accordance with the Department's administrative hearings regulations, the Hearing Officer has limited authority to address arguments raising the issue of equitable estoppel. 10-144 C.M.R. Ch. 1, § VII (B)(6). The "doctrine of equitable estoppel may prevent a government entity from discharging governmental functions or asserting rights against a party who detrimentally relies on statements or conduct of a government agency or official." *State v. Brown*, 2014 ME 79, ¶14, 95 A.3d 82, 87. However, equitable estoppel "should be carefully and sparingly applied, especially where application would have an adverse impact on the public fisc." *Mrs. T. v. Comm'r of Dep't of Health and Human Servs.*, 2012 ME 13, ¶10, 36 A.3d 888, 891 (*citation omitted*). "To prove equitable estoppel against a governmental entity, the party asserting it must demonstrate that (1) the statements or conduct of the

governmental official or agency induced the party to act; (2) the reliance was detrimental; and (3) the reliance was reasonable." *Dep't of Health and Human Servs. v. Pelletier*, 2009 ME 11, ¶17, 964 A.2d 630, 635. *See also Mrs. T.*, 2012 ME 13, ¶10, 36 A.3d at 891 (party asserting equitable estoppel defense has the burden of proof). "Equitable estoppel requires misrepresentations, including misleading statements, conduct, or silence, that induce detrimental reliance." *Dep't of Human Servs. v. Bell*, 1998 ME 123, ¶8, 711 A.2d 1292, 1295. The "totality of the circumstances, including the nature of the government official or agency whose actions provide the basis for the claim and the governmental function being discharged by that official or agency" must be considered in determining whether governmental action should be equitably estopped. *Pelletier*, 2009 ME 11, ¶17, 964 A.2d at 636.

"Equitable estoppel based on a party's silence will only be applied when it is shown by clear and satisfactory proof that the party was silent when he had a duty to speak." *Bell*, 1998 ME 123, ¶8, 711 A.2d at 1295 (*citation omitted*). "Clear and satisfactory proof means clear and convincing proof." *Littlefield v. Adler*, 676 A.2d 940, 942 (Me. 1996). The requirement of "clear and convincing evidence" is "an intermediate standard of proof lying between the preponderance and the reasonable doubt standards," where "[t]he factfinder must be persuaded, on the basis of all the evidence, that the moving party has proved his factual allegations to be true to a high probability." *Taylor v. Comm'r of Mental Health and Mental Retardation*, 481 A.2d 139, 154 (Me. 1984).

The essence of Dr. Palian's equitable estoppel defense is that his practice "did as instructed" by the Department, where the Department received and reviewed each submitted claim, reduced the billable amounts to what was allowed under the regulations, and re-affirmed the allowability of those claims by routinely providing "Remittance Advice" forms to Dr. Palian's practice and maintaining an ongoing correspondence with the practice without demanding corrections. All of this, Dr. Palian argues, produced a reasonable impression that such claims had been correctly allowed. Further, Dr. Palian alleges that he relied upon the Department's silence about the correctness of the manner his practice billed for MaineCare services, and that he did so to his detriment. That is, the Department's failed to initially identify any problems with Dr. Palian's billing practices, and followed with "silence for years while Central Maine continued to bill in reliance on DHHS accepting the propriety of its requests for reimbursement ...." Ex. A-W. Finally, Dr. Palian points to Departmental instructions to providers that they bill MaineCare based on their usual and customary rates, which he demonstrated he did throughout the review period, as support for the proposition that his reliance upon Departmental silence was reasonable.[1]

[1] Weaved into his equitable estoppel argument, but not explicitly raised by Dr. Palian, are references to the Department's "tardy" effort to establish and enforce a recoupment claim against a retired dental surgeon's practice years after he closed his practice. Where the equitable estoppel theory contains no time element, such references are read as an effort to raise a laches defense despite no express pleading of the same. Where laches was not expressly raised by Dr. Palian, it is unnecessary to dispose of the issue. However, it merits noting that laches is "negligence or omission seasonably to assert a right," and will be enforced against an entity "when the omission to assert the right has continued for an unreasonable and unexplained lapse of time, and under circumstances where the delay has been prejudicial to an adverse party, and where it would be inequitable to enforce the right." *Dep't of Human Servs. v. Bell*, 1998 ME 123, ¶7 , 711 A.2d 1292, 1295. *See also Fisco v. Dep't of Human Servs.*, 659 A.2d 274, 275 (Me.1995). Here, there is no evidence that the amount of time between the reviewed period and the Department's issuance of its Notice of Violation was in any way "unreasonable" or "unexplained." *Id.* On the

The Department did not dispute that its claims division did not correct Dr. Palian's mistakenly billed claims as they were submitted, nor did it deny that "Remittance Advice" forms and ongoing instructions were provided to Dr. Palian's practice that essentially accepted Dr. Palian's claims as they were received. To do so would ignore its own evidence that many claims were mistakenly reimbursed in the first instance, all of which gave rise to the recoupment claim that it alleged was properly established against Dr. Palian. Nor did the Department present any argument or evidence that cast doubt on Dr. Palian's position that Departmental silence induced him to continue billing claims in the manner that he had adopted as a practice. Finally, the Department did not dispute the detriment alleged by Dr. Palian, i.e. that he would suffer if the Department's recoupment claim is wholly or partially upheld.

The question is whether Dr. Palian's detrimental reliance was reasonable, especially when viewed in the totality of the circumstances. Intertwined within this question is whether it is highly probable that the Department had any duty, as an ongoing matter, to correct Dr. Palian's improper billing practices any earlier than it did through its post-payment review.

All MaineCare provider billing flows from the statutory authorization to the Department to "enter into contracts with health care servicing entities for the provision, financing, management and oversight of the delivery of health care services in order to carry out" medical services programs for the medically indigent. 22 M.R.S. § 3173. Providers are expressly obligated to bill MaineCare for services in a manner that is consistent with the terms of its Provider Agreement, Departmental regulations, and federal Medicaid law. 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03 (eff. Jan 11, 2010). This requires providers to "[c]harge and bill MaineCare for the provision of services and supplies to members in an amount not to exceed the provider's usual and customary charges to the general public or, the contractual agreement for a member with a liable third party." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (H) (eff. Jan 11, 2010). However, "[t]he Provider is expressly responsible for understanding and applying applicable regulations and requirements for proper billing." Ex. D-10, p. 7.

Further, the requirements that inhere upon enrolled providers also include the obligation to "make available, during regular business hours … all records concerning the provision of health care services to MaineCare members, and all financial records of MaineCare members, to any duly authorized representative of DHHS," and "[m]aintain accurate, auditable and sufficiently detailed financial and statistical records to substantiate cost reports, negotiated rates, by report items, or any other fee for service rate for a period of at least five (5) years following the date of final settlement or established rate with the Department." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (N), (X) (eff. Jan 11, 2010). Dr. Palian's October 2, 2009 Provider Agreement also expressly bound him to "retain all

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contrary, the Department demonstrated at hearing that it undertook its post-payment review of Dr. Palian's practice well-within the time period authorized by regulation. The Notice of Violation was issued less than two years after the end-date of the reviewed period, December 31, 2013 – a date that also represented Dr. Palian's retirement from practice. The amount of time taken by the Department to perform its audit cannot be deemed to become "unreasonable" or "unexplained" solely by virtue of the fact that the audited provider availed himself of the option to retire. As such, Dr. Palian's arguments – express and implicit – about the Department's election to perform a post-payment review after a provider has retired are afforded no weight.

medical, financial, administrative or other records and documents required by the MBM relating to the Member's medical history, care received and verification of services and products furnished, for at least five (5) years from the date of service," and "must be retained until the completion of [a timely-commenced audit] and resolution of all issue which arise from it ...." Ex. D-10, p. 6. These requirements also include the acknowledgement that "[a]n overpayment from MaineCare may indicate that a provider has submitted bills and/or received payment to which he or she is not properly entitled." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.12-2 (eff. Jan 11, 2010).

The Department's provider billing reimbursement scheme pre-supposes the Departmental right to audit provider records for the purposes of determining whether incorrectly billed claims were reimbursed by the Department – by no fault of either the provider or the Department. Providers are directed to retain their records for no less than five years after date of service in anticipation of any post-payment audits that the Department might undertake, and must expressly accede to the Department's right to undertake such audits. And providers expressly assume responsibility for all billed claims – including those for which the Department provides reimbursement – that might not have been submitted in accordance with the methods and procedures described in the MaineCare regulations.

Dr. Palian bore the burden to demonstrate – to a high probability – that his practice acted reasonably in relying upon the Department's silence about all lack of accord between his billing practices and the methods and procedures expressly described in the MaineCare benefits manual and Departmentally-issued billing instructions. More critically, Dr. Palian bore the burden to demonstrate – to a high probability – that the Department had a duty to identify and notify him about problems with his billing practices earlier than it did through the post-payment review process. The totality of the circumstances reflects that the Department expressly binds providers to be independently aware of the correctness of their billing practices in the first instance and to expressly accept the possibility that the Department might audit those practices, years after each date of service, to assure that they have been undertaken in a manner consistent with the published methods and procedures. To rely on such Departmental silence in the face of the clear assignment of roles and responsibilities expressed in the MaineCare regulations is not reasonable. In plainest terms, Dr. Palian had the duty to be aware of and correct the mistakes that he erroneously seeks to impute to the Department. The Department had no such duty. For this reason, the Department should not be equitably estopped from maintaining a recoupment claim against Dr. Palian in the manner urged by the appellant.

Departmental discretion to assess percentage-based sanctions

At hearing and through his post-hearing brief, Dr. Palian initially raised the argument that the Department exceeded the scope of its discretion by imposing the maximum penalty for improperly documented claims, for which the Department determined that the underlying services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members – i.e. 20 percent. Dr. Palian specifically argued that the Department had a duty to consider "[e]very single one of

the potentially mitigating factors identified in the MaineCare Benefits Manual" as a component of its discretionary establishment of sanction percentages.

As noted, Dr. Palian did not raise this issue as a part of his request for Final Informal Review. "Issues that are not raised by the provider, provider applicant, individual, or entity through the written request for an informal review or the submission of additional materials for consideration prior to the informal review are waived in subsequent appeal proceedings." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.23-1. "The request for informal review may not be amended to add further issues." *Id.* While the Hearing Officer's authority in this matter is to conduct a de novo review of the matters in issue, the issues that are subject to that de novo review cannot be expanded beyond what was pleaded through the Final Informal Review Request. Accordingly, it should be concluded that Dr. Palian has waived this issue for appeal purposes.

Even if Dr. Palian had not waived this issue for failing to raise it in his Final Informal Review Request, it should still be concluded that the Department acted within its discretion to impose the full 20 percent allowed for the described claims, and had no duty to account for any mitigating factors by reducing that percentage below 20 percent. Dr. Palian compares the Department's discretion to what the Maine Rules of Criminal Procedure authorizes trial judges to apply when weighing sanctions against prosecutors who violate discovery rules. Ex. A-W. Such comparison is misplaced. Judicial discretion of the kind referenced is, as Dr. Palian noted, only relevant in light of the "law applicable to the particular circumstances of the case." *State v. Mason*, 408 A.2d 1269, 1272 (Me. 1979). It should not be concluded that the law governing Department discretion to impose specific percentage sanctions directly correlates to the discretion by which a judge is bound when weighing discovery violation sanctions in a trial court proceeding, merely because some measure of "discretion" is afforded in both instances.

The "abuse of discretion" standard[2] imposed upon trial judges has no application to the law that controls the Department's discretion to impose specific percentage sanctions based on improper documentation of medically necessary and covered services that have been actually provided to MaineCare members. MaineCare regulations provide that a "sanction may be applied to a provider, individual, or entity, or to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (B)(1) (*emphasis added*). "The following factors may be considered in determining the sanction(s) to be imposed:

a. Seriousness of the offense(s);
b. Extent of violation(s);

[2] The Law Court has declared that "a trial court has exceeded the bounds of its discretion when, in discretionary decision-making, the court: (1) considers a factor prohibited by law; (2) declines to consider a legally proper factor under a mistaken belief that the factor cannot be considered; (3) acts or declines to act based on a mistaken view of the law; or (4) expressly or implicitly finds facts not supported by the record according to the clear error standard of review." *Smith v. Rideout*, 2010 ME 69, ¶ 13, 1 A.3d 441, 444.

c. History of prior violation(s);
d. Prior imposition of sanction(s);
e. Prior provision of provider education;
f. Provider willingness to obey MaineCare rules;
g. Whether a lesser sanction will be sufficient to remedy the problem; and
h. Actions taken or recommended by peer review groups, other payers, or licensing boards.

10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-3 (A)(1) (*emphasis added*)

"When the Department proves by a preponderance of the evidence that a provider has violated MaineCare requirements because it lacks mandated records for MaineCare covered goods or services, the Department in its discretion may impose … [a] penalty not to exceed twenty-percent (20%), if the provider is able to demonstrate by a preponderance of the evidence that the disputed goods or services were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.20-2 (H)(2) (*emphasis added*).

The Department concedes that it routinely assesses 20-percent sanctions for qualifying documentation-related violations, and does not contemplate any lesser-percentage sanctions without a specific request by the provider to consider the factors listed in Section 1.20-3 (A)(1). Under the plain language of the regulation, the Department is within its discretion to follow such a course. Each of the provisions authorizing the Department to consider applying such discretion is a "may," or permissive clause. There is no cross reference to any express mandate or duty to consider ancillary factors related to any of the determinations to exercise discretion. This is in stark contrast to the rules and applicable caselaw governing judicial discretion to impose discovery-related sanctions. Were the appellant inclined to challenge the propriety of the Department's regulatory authority to assess the discussed provider sanctions, that challenge would more likely need to take the form of a facial challenge rather than an as-applied challenge. No such argument was raised in the present case, and thus, no more discussion is warranted.

For these reasons, it should be concluded that the Department was within its discretion to assess 20-percent sanctions for each improper documentation-related violation it identified, where it conceded that the underlying services were MaineCare-covered, medically necessary, and actually provided to a MaineCare member.

Based on the foregoing, the Hearing Officer respectfully recommends that it be concluded that, for the review period of September 1, 2010 to December 31, 2013, the Department has correctly established and maintains a recoupment claim against Charles Palian, DMD, d/b/a Central Maine Oral and Maxillofacial Surgery Associates, P.A., in the amount of **$116,852.05**.

MANUAL CITATIONS

- DHHS Administrative Hearing Regulations, 10-144 C.M.R. Ch. 1, § VII (eff. Jan. 23, 2006)
- MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101 (eff. Jan. 11, 2010, *et seq.*).

RIGHT TO FILE RESPONSES AND EXCEPTIONS

THE PARTIES MAY FILE WRITTEN RESPONSES AND EXCEPTIONS TO THE ABOVE RECOMMENDATIONS. ANY WRITTEN RESPONSES AND EXCEPTIONS MUST BE RECEIVED BY THE DIVISION OF ADMINISTRATIVE HEARINGS WITHIN FIFTEEN (15) CALENDAR DAYS OF THE DATE OF MAILING OF THIS RECOMMENDED DECISION.

A REASONABLE EXTENSION OF TIME TO FILE EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER FOR GOOD CAUSE SHOWN OR IF ALL PARTIES ARE IN AGREEMENT. RESPONSES AND EXCEPTIONS SHOULD BE FILED WITH THE DIVISION OF ADMINISTRATIVE HEARINGS, 11 STATE HOUSE STATION, AUGUSTA, ME 04333-0011. COPIES OF WRITTEN RESPONSES AND EXCEPTIONS MUST BE PROVIDED TO ALL PARTIES. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER.

CONFIDENTIALITY

THE INFORMATION CONTAINED IN THIS DECISION IS CONFIDENTIAL. *See* 42 U.S.C. § 1396a (a)(7); 22 M.R.S. § 42 (2); 22 M.R.S. § 1828 (1)(A); 42 C.F.R. § 431.304; 10-144 C.M.R. Ch. 101 (I), § 1.03-5. ANY UNAUTHORIZED DISCLOSURE OR DISTRIBUTION IS PROHIBITED.

Dated: 6/04/2018

Richard W. Thackeray, Jr.
Administrative Hearing Officer

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