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Date Mailed: JAN 22 2019

In the Matter of:
Employment Specialists of Maine

NPI ID Nos. [redacted]

ADMINISTRATIVE HEARING RECOMMENDED DECISION (corrected)

An administrative hearing was convened in the above-captioned matter on September 13, 2018, before Hearing Officer Richard W. Thackeray, Jr., at Augusta, 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 October 19, 2018, then re-opened through October 23, 2018, to allow submission of post-hearing briefs and a Departmental technical correction memorandum.

Pursuant to an Order of Reference dated January 12, 2018, the issue presented *de novo* for hearing was whether the Maine Department of Health and Human Services ["Department"] was "correct when for the review period of [redacted]15 through [redacted]/16, it determined that for NPI; [redacted] and [redacted], Employment Specialists of Maine owe a recoupment in the amount of $74,622.86 because progress notes did not depict the required duration of services to support the number of units billed to MaineCare and for exceeding a service units' cap, as stated in the Final Informal Review Decision dated January 12, 2018?" Ex. D-1.

APPEARING ON BEHALF OF THE APPELLANT, EMPLOYMENT SPECIALISTS OF MAINE

- Charles F. Dingman, Esq.
- Jean Gallant
- Heather Ulmer
- Eric Morin

APPEARING ON BEHALF OF THE DEPARTMENT

- Thomas C. Bradley, AAG
- Patrick Bouchard
- Beth Ketch

ITEMS INTRODUCED INTO EVIDENCE

Hearing Officer Exhibits

HO-1 "Reschedule Notice," dated May 24, 2018
HO-2 "Reschedule Request," dated May 8, 2018
HO-3 "Administrative Prehearing Order," dated April 25, 2018
HO-4 "Notice of an Administrative Hearing," dated April 11, 2018
HO-5 "Department's Witness List and Exhibit List," dated September 11, 2018
HO-6 "Appellant's Witness List and Exhibit List," dated September 11, 2018
HO-7 "Administrative Prehearing Order," dated September 11, 2018
HO-8 "Department's Post-Hearing Brief," dated October 19, 2018
HO-9 "Appellant's Post-Hearing Brief," dated October 19, 2018
HO-10 "Request for Technical Correction to Post-Hearing Brief," dated October 23, 2018

Department Exhibits

D-1 "Order of Reference," dated April 5, 2018
D-2 "Fair Hearing Report Form," dated March 28, 2018
D-3 "Notice of Violation," dated June 23, 2017
D-4 "Informal Review Request," dated August 25, 2017
D-5 "Final Informal Review Decision," dated January 12, 2018
D-6 "Hearing Request," effective date February 13, 2018
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. 1, 2014)
D-8 Final Rule, "Community Support Services," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17 (eff. Oct. 1, 2009)
D-9 Final Rule, "Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder," MaineCare Bens. Man., 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21 (eff. Sept. 1, 2014)
D-10 "MaineCare Provider Agreement," dated February 2, 2010
D-11 "Treatment Records," [redacted], dated [redacted] 2016
D-12 "Treatment Records," [redacted], dated [redacted], 2016
D-13 "Treatment Records," [redacted], dated [redacted] 2016
D-14 "Treatment Records," [redacted], dated [redacted], 2016
D-15 "Treatment Records," [redacted], dated [redacted] 2016
D-16 "Treatment Records," [redacted], dated [redacted] 2016
D-17 "Treatment Records," [redacted], dated [redacted], 2016
D-18 "Treatment Records," [redacted], dated [redacted], 2016
D-19 "Treatment Records," [redacted], dated [redacted] 2016
D-20 "Treatment Records," [redacted], dated [redacted], 2016
D-21 "Treatment Records," [redacted], dated [redacted], 2016
D-22 "Treatment Records," [redacted], dated [redacted], 2016
D-23 "Treatment Records," [redacted], dated [redacted], 2015
D-24 "Treatment Records," [redacted], dated [redacted], 2015
D-25 "Treatment Records," [redacted], dated [redacted] 2016

D-26 "Post Informal Review Spreadsheet"

Appellant Exhibits

A-1 "Service Note Sheet," dated [redacted] 2016

A-2 "Service Note Sheet," dated [redacted] 2016

LEGAL FRAMEWORK

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) (eff. Jan. 23, 2006); "Provider Appeals," MaineCare Benefits Manual, 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.21-1 (A) (eff. Jan. 1, 2014). 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).

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.* An enrolled provider is 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) (provider agreements must require providers "to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan," and "to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request."). Enrolled providers also "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, § 1.03-3 (Q). Enrolled providers are also required to 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, § 1.03-3 (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 assessing the quality of such 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; 42 C.F.R. § 455.1; 42 C.F.R. § 456.3 (a), (b). 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 but not limited to:

- 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 1.03-3 for provider participation;
- Violating the applicable provision of any law governing benefits governed by the MaineCare Benefits Manual, or any rule or regulation promulgated pursuant thereto;
- 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, § 1.19-1.

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 (G). 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 (G).

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, the Employment Specialists of Maine ["ESM"] was properly notified of the time, date, and location of the immediate proceeding. Ex. HO-1; Ex. HO-4.

2. ESM is a statewide Community Support Services and In-Home Support Services provider that was in operation during the period from [redacted] 2015 through [redacted], 2016.

3. Effective February 2, 2010, ESM entered into a "Medicaid/Maine Health Program Provider/Supplier Agreement" with the Department, through which ESM became able to receive reimbursement from the Department for provision of covered medical and related services to enrolled members of the MaineCare program. Ex. D-10.

4. On an unspecified date during early 2017, the Department initiated a post-payment review of billing claims submitted by ESM, specifically requesting from ESM all records related to two MaineCare members – [redacted] and [redacted] – entered during the period of [redacted], 2015 to [redacted], 2016. The post-payment review was trigged by a complaint received from Departmental prior authorization and utilization review agent, KEPRO. Test. of Patrick Bouchard.

5. The Departmental post-payment review identified that during the [redacted] 2015 to [redacted] 2016 period, MaineCare reimbursed ESM for a total of $366,965.74 for all claims billed to the Department for the two members under billing codes H2017 (for [redacted] – Section 17, Daily Living Support Services) and T2017 (for [redacted] – Section 21, In-Home Support, Quarter-Hour). This total included $251,390.86 for claims billed for [redacted] using code H2017 and $115,574.88 for claims billed for [redacted] using code T2017. Ex. D-3.

6. On June 23, 2017, Departmental comprehensive health planner Patrick Bouchard issued a "Notice of Violation" to ESM, establishing a claim for recoupment in the amount of $184,097.72, related to its post-payment review findings. Mr. Bouchard found the ESM either breached "the terms of its MaineCare Provider/Supplier Agreement, and/or the Requirements of Section 1.03-3 for provider participation," or failed "to repay or make arrangements to repay overpayments or payments made in

error." Mr. Bouchard determined that the one-half of the universe of claims submitted for [redacted] using billing code T2017 was subject to recoupment (in the amount of $58,402.29), and that one-half of the claims submitted for [redacted] using billing code H2017 was subject to recoupment (in the amount of $125,695.43). Mr. Bouchard also found:

- Comprehensive Assessments and Individual Service Plans recorded for [redacted] did not align with the number of Section 17 DLS services units billed to the Department;
- Billing claims for ongoing Section 17 DLS services for [redacted] were made without required, regular clinical review;
- Section 21 Home Support services claims submitted for [redacted] were incorrectly classified as "in-home" supports, rather than supports provided in an "agency home";
- Section 21 Home Support service claims submitted for [redacted] routinely exceeded the weekly cap of 336 quarter-hour units (84 hours) per week;
- Progress Notes recorded for both [redacted] and [redacted] failed to provide the necessary information to demonstrate that ESM workers were helping meet the goals and objectives identified on the members' plans of care;
- Progress Notes and other records reviewed by the Department reflected that "staffing hours are being shared" between the two members.

Ex. D-3.

7. On August 25, 2017, ESM timely requested an informal review of the Department's "Notice of Violation," and more specifically alleged all of the following in defense:

- The Department mistakenly characterized the premises at [redacted] in [redacted] as an "agency home," which was in fact an ordinary rental property at which the two residents received ESM support services in an independent living setting;
- The Department mistakenly characterized the two residents' circumstance as including "shared" staffing services, and mistakenly found that EMS "double-billed" the Department;
- Departmental officials were aware of ESM's service arrangement for the two members living at [redacted] and consented to that arrangement;
- ESM's electronic medical record software, Medisked, was misinterpreted by the Department as suggesting that double-billing was submitted to the Department, where the actual claims reflected that each member was generally billed for an average of 12 hours of services per day.

Ex. D-4.

8. On January 12, 2018, the Department issued a "Final Informal Review Decision" ["FIRD"] against ESM, in response to the "Request for Informal Review," dated August 25, 2017. The FIRD included a revised recoupment claim, reduced to $74,622.86, and noted the following bases for that reduction:

- Billed claims reflecting documentation errors attributable to ESM's medical record software remained subject to a 20-percent sanction;
- Section 21 Home Support services billed under code T2017 in excess of the 84-hour per week cap remained subject to 100-percent recoupment

Ex. D-5.

9. On February 13, 2018, ESM timely requested an administrative hearing. In so doing, ESM conceded that the Department correctly included in its revised recoupment claim all billing code T2017 claims in excess of the 84-hour per week unit service cap, in total amount of $1,229.69. However, ESM maintained that the Department should have rescinded all claims for recoupment under the 20-percent "inadequate documentation" rationale, urging that the documentation error in question did not rise to a level appropriate for a 20-percent sanction. Ex. D-6.

10. Immediately prior to hearing, the Department presented an newly-revised recoupment claim in the amount of $73,514.60, reflecting the removal of four total claims billed from [redacted], 2016 to [redacted] 2016, which the Department's FIRD identified as being subject to 20-percent sanction. The sum removed from the recoupment claim as a result of this revision was $1,108.26. Ex. D-5; Ex. D-26; Test. of Patrick Bouchard.

11. Throughout the post-payment review period from [redacted] 2015 to [redacted], 2016, the premises located at [redacted] in [redacted] owned by ESM, served as an independent living residence rented to two individuals, [redacted] and [redacted] Ex. HO-8; Ex. HO-9.

12. For the period of [redacted] 2015 to [redacted], 2016, ESM was overpaid an amount equal to $1,229.69 for all claims using billing code T2017 billed in excess of the 84-hour per week unit services cap. Ex. HO-8; Ex. HO-9.

13. Progress notes recorded by ESM for all billed claims identified in the Department's recoupment claim as being subject to a 20-percent sanction reflected a service duration of "24 hours" and did not otherwise clarify the duration of services provided in a manner that was consistent with units billed on the corresponding dates or periods. Ex. D-11; Ex. D-12; Ex. D-13; Ex. D-14; Ex. D-15; Ex. D-16; Ex. D-17; Ex. D-18; Ex. D-19; Ex. D-20; Ex. D-21; Ex. 22.

14. ESM's electronic medical record software was programmed to incorrectly annotate the amount and/or duration of services provided in members' progress notes in all billed claims identified in the Department's recoupment claim from [redacted], 2015 to [redacted] 2016. Test. of Jean Gallant; Ex. HO-9.

15. With regard to all claims identified by the Department in its revised recoupment claim as being sanctionable at 20-percent, the Department demonstrated by a preponderance of the evidence that the ESM did not correctly document the duration of services.

RECOMMENDED DECISION

For the review period of [redacted] 2015 to [redacted] 2016, it should be concluded that Employment Specialists of Maine owes the Department a sum of **$73,514.60**, related to insufficient documentation of duration of services and claims billed in excess of a service units cap.

REASONS FOR RECOMMENDATION

The question presented for adjudication was whether the Department correctly established a claim for recoupment against ESM, most recently identified in the amount of $73,514.60. The individual claims that comprise that final figure are substantively divided into two categories. The first category includes all claims for MaineCare Section 21 "Home Support" services units billed in excess of the regulatory service cap of 84 hours per week. The second category includes all claims for which the Department assessed sanctions equal to 20-percent of the billed amounts due to ESM maintaining insufficient or inadequate documentation to support those original, billed claims. ESM conceded at hearing that the Department correctly established and maintains a recoupment claim for $1,229.69 for all claims fitting into the first of these two categories. However, ESM argued that there was no sustainable basis for upholding the Department's recoupment claim at any percentage of billed amounts reflected in the second category. Thus, the sole matter in issue is whether the Department sustained its burden to demonstrate by preponderance of the evidence that ESM failed to maintain and produce documentation supporting the amounts and/or duration of MaineCare services for which it billed the Department.

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) (eff. Jan. 1, 2014).

As noted above, the Department is authorized to recoup "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, § 1.19-2 (G) (eff. Jan. 1, 2014). "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);
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, § 1.19-3 (A)(1) (eff. Jan. 1, 2014).

The allegedly flawed documentation at issue in the present case consists of "progress notes," as required by both Section 17 and 21 of the MaineCare Benefits Manual and presented by ESM in support of its assertion that it correctly billed MaineCare for amounts and/or a duration of services that were actually provided to the two members under the two programs.

The Section 17 regulations in effect during the review period specifically described the documentation process that had to be followed for services – including Daily Living Support ["DLS"] Services – to be reimbursable through MaineCare. *See* 10-144 C.M.R. Ch. II, § 17.08. In general terms, the Section 17 services provider must

1. perform a comprehensive psychosocial assessment ["CA"] of the member,
2. develop an Individual Support Plan ["ISP"] identifying treatment goals and services needed to achieve those goals, and
3. record progress notes documenting "each service provided, including the date of service, the type of service, the goal to which the service relates, the duration of the service, the progress the member has made towards goal attainment and the signature and credentials of the individual performing the service."

10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-3 (D) (eff. Oct. 1, 2009).

The applicable version of Section 21 provided that a member's record must contain written documentation of the "member's social and medical history, including any allergies, and diagnoses," the "member's Personal Plan," and "[w]ritten progress notes that identify actions related to the progress toward the achievement of the goals, activities and needs established by the member's Personal Plan signed by the staff performing the service." 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.09 (eff. Sept. 1, 2014). Section 21 also provides the following specific directive to providers:

> All providers must document each service provided, the date of each service, the type of service, the activity, need or goal to which the service relates, the length of time of the service, and the signature of the individual performing the service. If services are provided by two (2) or more staff working different shifts, then each shift must be documented separately.
>
> Example: a member receives twenty four hour (24) coverage from three (3) staff members working Monday through Friday in eight (8) hour shifts, and one (1) staff member that covers the week end. The provider must have documentation for each eight (8) hour shift per day.

Id.

The Department conceded that all of the initially challenged MaineCare-billed claims were for services that were medically necessary, MaineCare covered services, and actually provided to eligible MaineCare members. Departmental comprehensive health planner Patrick Bouchard testified at hearing, however, that the Department decided to impose a 20-percent penalty for every billed claim reviewed

for which there was insufficient documentation of the duration of the service provided. Test. of Patrick Bouchard.

For example, ESM billed the Department for 60.25 hours (i.e. 241 units at 15 minutes per unit) of Section 21 Home Support services for [redacted] using code T2017 for the five-day period from [redacted] 2016 to [redacted] 2016, and also billed the Department for 69.25 hours (277 units at 15 minutes per unit) of Section 17 DLS services for [redacted] using code H2017 for the five-day period from [redacted], 2016 to [redacted] 2016. Ex. D-11; Ex. D-12. Progress notes correlating to [redacted] Section 21 services over those five days included the notation – "Duration: 24 hours" – and no other indications of the amounts or periods in which the services were provided to the member. Ex. D-11; Ex. D-13; Ex. D-15; Test. of Patrick Bouchard. Progress notes correlating to [redacted] Section 17 services over those five days included the same notation – "Duration: 24 hours" – but provided no other indications of the amounts or periods in which the services were provided to the member. Ex. D-12; Ex. D-14; Ex. D-16; Test. of Patrick Bouchard. Mr. Bouchard determined, based on the billed amounts, that approximately 14 hours of [redacted] DLS services were billed over the five-day period and approximately 12 ½ hours of [redacted] Section 21 services were billed over the same five days. Ex. D-11; Ex. D-12; Ex. D-13; Ex. D-14; Ex. D-15; Ex. D-16; Test. of Patrick Bouchard. However, Mr. Bouchard testified that he could find no supporting information for those presumptions in the corresponding progress notes as to how much and when, within that five-day period, the services were actually provided to [redacted] and [redacted] Test. of Patrick Bouchard. This, Mr. Bouchard testified, was the Department's rationale for imposing 20-percent penalties for the two sets of billed claims for the five-day period from [redacted], 2016 to [redacted] 2016. Test. of Patrick Bouchard.

The Department sustained its threshold burden to demonstrate that the same lack of proof of duration of services was manifest with the Progress Notes for the two members during the periods from [redacted] 2016 to [redacted] 2016, and [redacted] 2016 to [redacted], 2016. Ex. D-17; Ex. D-18; Ex. D-19; Ex. D-20. Ex. D-21; Ex. D-22. The Department asserted that the evidence of inadequate documentation for the [redacted] 2016 and [redacted] 2016 periods was offered as representative of every penalty included in the recoupment claim. Test. of Patrick Bouchard. ESM did not dispute the plain assertion of the Department – that the form progress notes for each penalized billing claim reflected "24 hours" and did not otherwise precisely identify what services were provided relative to each 15-minute unit billed. Nor did ESM present any categorical dispute as to the Department's assertion that the identified claims for [redacted] 2016 and [redacted] 2016 were representative of every other billing claim (exclusive of those targeted for exceeding the 84-hour weekly cap) included on the final recoupment claim spreadsheet.

The crux of ESM's argument was essentially two-fold. First, ESM argued that the Department should not maintain the 20-percent penalty where the Department's post-payment review did not expressly conclude that it was actually overbilled by ESM under codes T2017 and H2017. Second, ESM argued that the Department should have, in its discretion, waived its authority to impose any sanction up to 20-percent, where the cause of missing documentation – linked to its electronic medical

record software programming – was self-corrected by ESM before the Department initiated its post-payment review.[1]

In the cases of both MaineCare programs (Section 17 DLS services and Section 21 In-Home services), the regulations authorize billing in 15-minute increments, or units. *See* 10-144 C.M.R. Ch. 101, sub-Ch. III, § 17.1; 10-144 C.M.R. Ch. 101, sub-Ch. III, § 21.8. Chapter 1, Section 1 provides that services a single "notation for each visit," i.e. in a progress note, "is sufficient," for services that are "billed on a fifteen (15) minute unit basis." 10-144 C.M.R. Ch. 101, sub-Ch. I, § 1.03-3 (M) (eff. Jan. 1, 2014). However, the present situation – where the reviewed progress notes consistently reflected that the duration of each service provided was 24 hours – does not appear to comport to the plain language of the rule. Sections 17 and 21 both expressly require time-specificity in their progress notes. *See* 10-144 C.M.R. Ch. 101, sub-Ch. II, § 17.07-3 (D) (progress notes must document "the duration of the service."); 10-144 C.M.R. Ch. 101, sub-Ch. II, § 21.09 (progress notes must document "the length of time of the service.").

The evidence plainly reflects that the reviewed documentation categorically did not accurately identify duration of service for the relevant billing claims. ESM did argue that the Department should have requested additional business records – namely, employee time sheets – that ESM representatives testified could have been made available to the Department to demonstrate what hours individual service providers worked with the two members. Ex. HO-9; Test. of Jean Gallant. ESM bore the obligation to come forward with any additional documentation it believed it would have supported its argument. No such records were proffered at hearing, and there is no evidence that they were produced to the Department for consideration before or after hearing. Even if they had been produced, it is insufficiently clear that such employee work schedule records would have been (or should be) construed as documentation of a MaineCare member's course of care. As such, it cannot be found that ESM satisfied the plain language of the requirement to correctly document the duration of services.

Nor has ESM demonstrated that it is entitled to relief due to its self-correction of the improperly programmed electronic medical record software or because there was no actual overpayment. MaineCare regulations provide no basis upon which the Department is required to forego enforcement of an otherwise colorable recoupment claim for either of these two circumstances. The sole basis upon which such considerations might aid ESM lies within the Department's discretion to assess a 20-percent sanction.

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[1] Throughout the course of this proceeding, ESM focused substantial energy and argument to the relationship between ESM and Departmental Director of Policy and Provider Services Beth Ketch, urging findings that Ms. Ketch approved of ESM's MaineCare services arrangement for the two [redacted] residents and obliquely suggesting that the Department should be equitably estopped from seeking recoupment of any billed claims identified as overpayments somehow linkable to Ms. Ketch's alleged verbal assent. This line of evidence and argument is no longer relevant to any of the matters left in issue, where the entirety of the Department's recoupment claim (exclusive of T2017 units billed in excess of the 84-hour weekly cap) consists of sanctions identified for lack of required documentation of services duration. ESM has not suggested that Ms. Ketch at any time relieved ESM of its responsibility to accurately document services duration in member progress notes. As such, none of the discussion about Ms. Ketch's interactions with ESM – beyond her testimony that ESM did not double-bill for [redacted] and [redacted] and was otherwise a reputable MaineCare provider – bears any relevance to the matters remaining in issue.

ESM essentially argues that the Department exceeded its discretionary authority by imposing any penalty – never mind the maximum penalty of 20 percent. ESM specifically argues that the Department failed to account for the purportedly low "seriousness of the offense" by applying the full 20 percent allowed for the described claims.

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.-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);
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 conceded that it routinely assesses 20-percent sanctions for qualifying documentation-related violations, and does not contemplate any lesser-percentage sanction 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 an unqualified, permissive "may" 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. 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, and more critically, would need to take place in a judicial rather than an administrative forum. No such argument was raised in the present case.[2] Here, there is no basis upon which the hearing officer

[2] ESM finally argues that "given the *de novo* nature of this appeal, it would be appropriate for the Commissioner to consider those criteria," i.e. those in Chapter 1, Section 1.20-3 (A)(1), "against the particular facts in this case." Ex. HO-9. Where this request for an exercise of discretion is directly posed to the Commissioner, the hearing officer takes no position. ESM may

finds that the Department abused its discretion when it assessed 20-percent sanctions against ESM for billed claims found to insufficiently document the duration that billed services were provided.

Based on the foregoing, the Hearing Officer respectfully recommends that it be concluded that the Department was correct when, for the review period of [redacted] 2015 to [redacted], 2016, it determined that Employment Specialists of Maine owes the Department a sum of **$73,514.60**.

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, sub-Chs. I, II, III; §§ 1, 17, 21 (2014-16)

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

CERTAIN 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 OF CONFIDENTIAL INFORMATION IS PROHIBITED.

Dated: 1/22/2019

Richard W. Thackeray, Jr.
Administrative Hearing Officer

cc: Charles F. Dingman, Esq., PRETI FLAHERTY BELIVEAU & PACHIOS, LLP, Augusta
Jean Gallant, LCSW, Employment Specialists of Maine
Thomas Bradley, AAG, OFFICE OF THE ATTORNEY GENERAL
Patrick Bouchard, Program Integrity/Division of Audit, DHHS Augusta

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renew this request through any Responses and Exceptions it might elect to file with the Office of the Commissioner upon receipt of this recommended decision.