Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel.: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

IN THE MATTER OF:

Merrimack River Medical Services)
C/o Rachel Wertheimer, Esq.)
Verrill Law) **FINAL DECISION**
One Portland Square)
Portland, ME 04112-0586)

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

The Recommended Decision of Hearing Officer Strickland mailed March 17, 2022, and the responses and exceptions submitted on behalf of Merrimack River Medical Services and the Department have been reviewed.

I hereby adopt Findings of Fact #1 through 17 and 19 through 30. I do not accept Finding of Fact #18. I find that Merrimack River Medical Services did not provide MaineCare covered services for claim lines 14, 28, 29, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, 73, 85, and 88. MaineCare Benefits Manual, Chapter II, Section 65.08-1 mandates that only services provided in the ITP will be reimbursed. In the absence of an ITP or an updated ITP, I find that any services provided are not "MaineCare covered services".

I accept the Recommendation of the Hearing Officer that the Department was correct when it issued a Final Informal Review Decision dated May 21, 2021, with a modified recoupment amount of $142,185.04.

DATED: 5-5-22 SIGNED: Jeanne M. Lambrew

JEANNE M. LAMBREW, Ph.D., 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: William Logan, Esq., OMS

Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

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Jeanne M. Lambrew, Ph.D., Commissioner
Department of Health and Human Services
11 SHS, 109 Capitol Street
Augusta, ME 04333

DATE OF MAILING: March 17, 2021

Re: Merrimack River Medical Services – Final Informal Review Decision

ADMINISTRATIVE HEARING RECOMMENDATION

An administrative hearing in the above-referenced matter was convened telephonically on December 7, 2021, before Hearing Officer Jeffrey P. Strickland. The record was left open through January 14, 2022, for closing arguments. The Hearing Officer's authority was conferred under 5 M.R.S. § 9062 by the Commissioner, Department of Health and Human Services.

CASE BACKGROUND AND ISSUE:

Merrimack River Medical Services appeals the Department of Health and Human Services' Final Informal Review Decision ("FIRD") dated May 21, 2021, which determined that Appellant was subject to recoupment of $249,664.89 in MaineCare payments for services during the period [redacted], 2017, through [redacted] 2019. The Chief Administrative Hearing Officer's July 29, 2021, Order of Reference states the issue for this proceeding as follows:

> *(1) Was the Department correct when for the review period of [redacted], 2017 through [redacted], 2019, it determined that Merrimack River Medical Services, Inc. owes the Department $249,664.89 in recoupment due to: 1) non-compliance with the MaineCare Benefits Manual; 2) breach of the MaineCare Provider/Supplier Agreement; and/or 3) failure to repay overpayments or payments made in error as found in a Final Informal Decision dated May 21, 2021 and Notice of Violation dated October 2, 2019?*

APPEARING ON BEHALF OF THE DEPARTMENT:

- William Logan, Esq., Director of Compliance
- Kenneth Jamison, Comprehensive Health Planner II

APPEARING ON BEHALF OF APPELLANT:

- Rachel Wertheimer, Esq.
- Dan Greer, Vice President of Operations
- Patrice Trisvan, Senior Vice President of Operations

ITEMS INTRODUCED INTO EVIDENCE:

Hearing Officer Exhibits:

H-1: The following items, collectively:
- Administrative hearing scheduling letter dated September 2, 2021.
- Status conference scheduling letter date July 30, 2021.
- Order of Reference dated July 29, 2021.
- Fair Hearing Report Form dated July 26, 2021.
- Request for administrative hearing dated July 9, 2021.
- Final Informal Review Decision dated May 21, 2021.
- Request for informal review dated December 2, 2019.
- Notice of Violation dated October 2, 2019.

Department Exhibits:

D-1: Order of Reference dated July 29, 2021.

D-2: Fair Hearing Report Form dated July 26, 2021.

D-3A: Record Request dated April 10, 2019.

D-3B: Expanded Record Request dated June 14, 2019.

D-4: Notice of Violation letter dated October 2, 2019, with redacted spreadsheet.

D-5: Request for Informal Review dated December 4, 2019.

D-6: Final Informal Review Decision (FIRD) letter dated May 21, 2021, with redacted spreadsheet.

D-7: Request for Administrative Hearing dated July 21, 2021.

D-8A: 10-144 CMR Ch. 101, Chapter I, § 1 (eff. 3/23/16).

D-8B: 10-144 CMR Ch. 101, Chapter I, § 1 (eff. 7/5/17).

D-8C: 10-144 CMR Ch. 101, Chapter I, § 1 (eff. 9/17/18).

D-9: 10-144 CMR Ch. 101, Chapter II, § 65 (eff. 11/23/16).

D-10: 10-144 CMR Ch. 101, Chapter III, § 65 (eff. 11/23/16).

D-11: MaineCare Provider Agreement signed by provider on September 15, 2011.

D-12A: Member 16 excerpt from FIRD spreadsheet.

D-12B: Member 16 documents submitted during FIRD request.

D-13A: Member 19 excerpt from FIRD spreadsheet.

D-13B: Member 19 documents submitted during FIRD request.

D-14: Member 15 excerpt from FIRD spreadsheet.

D-15A: Member 48 excerpt from FIRD spreadsheet.

D-15B: Member 48 documents submitted during record request.

D-16: Member 43 excerpt from FIRD spreadsheet.

D-17: Member 57 excerpt from FIRD spreadsheet.

D-18A: Member 11 excerpt from FIRD spreadsheet.

D-18B: Member 11 Comprehensive Assessment dated [redacted] 2017, provided during FIRD request.

D-19A: Member 24 excerpt from FIRD spreadsheet.

D-19B: Member 24 Comprehensive Assessment dated [redacted] 2018, provided during FIRD request.

D-20A: Member 9 excerpt from FIRD spreadsheet.

D-20B: Member 9 Individual Service Plan dated [redacted] 2017, provided during record request.

D-21A: Member 14 excerpt from FIRD spreadsheet.

D-21B: Member 14 Individual Service Plan dated [redacted] 2018, provided during record request.

D-22A: Member 5 excerpt from FIRD spreadsheet.

D-22B: Member 5 Individual Service Plan dated [redacted] 2018, provided during record request.

D-23A: Member 8 excerpt from FIRD spreadsheet.

D-23B: Member 8 Individual Service Plan dated [redacted] 2017, provided during FIRD request.

D-24: Licensing - Office of Adult Mental Health Chapter 6.

D-25: Revised Redacted Recoupment Spreadsheet.

Appellant Exhibits:

A-1: Record Request dated April 10, 2019.

A-2: Expanded Record Request dated June 14, 2019.

A-3: Notice of Violation dated October 2, 2019.

A-4: Request for Informal Review dated December 2, 2019.

A-5: Final Informal Review Decision dated May 21, 2021.

A-6: Member 5 Patient Records.

A-7: Member 8 Patient Records.

A-8: Member 9 Patient Records.

A-9: Member 11 Patient Records.

A-10: Member 11 Patient Records.

A-11: Member 14 Patient Records.

A-12: Member 15 Patient Records.

A-13: Member 16 Patient Records.

A-14: Member 16 Patient Records.

A-15: Member 19 Patient Records.

A-16: Member 22 Patient Records.

A-17: Member 22 Patient Records.

A-18: Member 24 Patient Records.

A-19: Member 24 Patient Records.

A-20: Member 25 Patient Records.

A-21: Member 26 Patient Records.

A-22: Member 30 Patient Records.

A-23: Member 32 Patient Records.

A-24: Member 38 Patient Records.

A-25: Member 39 Patient Records.

A-26: Member 40 Patient Records.

A-27: Member 41 Patient Records.

A-28: Member 43 Patient Records.

A-29: Member 46 Patient Records.

A-30: Member 47 Patient Records.

A-31: Member 48 Patient Records.

A-32: Member 52 Patient Records.

A-33: Member 54 Patient Records.

A-34: Member 57 Patient Records.

A-35: Member 58 Patient Records.

A-36: Member 61 Patient Records.

A-37: Member 62 Patient Records.

A-38: Member 63 Patient Records.

A-39: Member 67 Patient Records.

A-40: Member 70 Patient Records.

A-41: Member 71 Patient Records.

A-42: Member 73 Patient Records.

A-43: Member 74 Patient Records.

A-44: Member 76 Patient Records.

A-45: Member 80 Patient Records.

FINDINGS OF FACT:

1. Appellant is an enrolled provider of Medication-Assisted Treatment with Methadone (10-144 C.M.R. Ch. 101, Chapter II, § 65.06-11).

2. On April 10, 2019, the Department notified Appellant that it had been "selected by the Department of Health and Human Services, Program Integrity Unit, for a record review," and requested that Appellant provide records for 15 MaineCare members for dates of service within the review period [redacted], 2017, through [redacted] 2019.

3. On June 14, 2019, the Department requested that Appellant provide records for an additional 85 MaineCare members for dates of service within the review period [redacted], 2017, through [redacted] 2019.

4. On October 2, 2019, the Department issued a Notice of Violation ("NOV") notifying Appellant that, based on its review of 100 claims with a total value of $6,364.54, the Department was seeking recoupment of $1,000,600.56 from MaineCare payments made for the review period, which totaled $1,059,455.35. The recoupment amount was determined as the lower limit of the 90% confidence interval for an error rate of 97.17% based on total penalties of $6,184.54.

5. Appellant requested an informal review of the Department's NOV on December 2, 2019.

6. On May 21, 2021, the Department issued a Final Informal Review Decision ("FIRD") that revised the recoupment amount to $249,664.89 based on additional records submitted by Appellant. The reduced recoupment amount was determined as the lower limit of the 90% confidence interval for an error rate of 31.19% based on total penalties of $1,984.84.

7. Following the FIRD, the Department revised the recoupment amount to $178,525.39 based on additional records submitted by Appellant. The revised recoupment amount was determined as the lower limit of the 90% confidence interval for an error rate of 23.86% based on total penalties of $1,518.73.

8. Of the total penalties assessed, $1,127.30 (claim lines 14, 28, 29, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, 73, 85, and 88) represented 100% penalties for missing or expired individual service plans ("ISP's").

9. Of the total penalties assessed, $221.48 (claim lines 77, 90, and 93) represented 100% penalties for lack of documentation showing that required counseling occurred.

10. Of the total penalties assessed, $87.15 (claim lines 15, 21, 22, 32, 79, 80, and 95) represented 20% penalties for lack of documentation of a comprehensive assessment.

11. Of the total penalties assessed, $35.20 (claim lines 34, 51, and 52) represented 20% penalties for lack of documentation of a complete medical examination by a physician, physician assistant, or nurse practitioner.

12. Of the total penalties assessed, $24.00 (claim lines 11 and 19) represented 20% penalties for ISP's lacking the member's signature.

13. Of the total penalties assessed, $12.00 (claim line 5) represented a 20% penalty for a progress note lacking the provider's signature.

14. Of the total penalties assessed, $11.60 (claim line 10) represented a 20% penalty for a progress note lacking a description of the member's progress toward goals.

15. Appellant requested a hearing on the Department's FIRD on July 21, 2021.

16. Appellant's records do not include updated ISP's for claim lines 14, 28, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, and 73. Appellant received MaineCare payments totaling $1,016.44 for claim lines 14, 28, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, and 73.

17. Appellant's records include updated ISP's for portions of claim lines 29 (two of seven days), 85 (two of seven days), and 88 (four of seven days). Appellant received MaineCare payments of $60.00 for claim line 29, $58.00 for claim line 85, and $60.00 for claim line 88.

18. Appellant's records do not include other documentation of MAT services provided (i.e., counseling, dosing, or drug testing records) for claim lines 14, 28, 29, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, 73, 85, and 88.

19. Appellant must bill for MAT services under an all-inclusive "bundled" weekly rate (procedure code H0020) and therefore cannot bill separately for separate MAT services (i.e., counseling, dosing, and drug testing).

20. Appellant's records for claim line 77 show that the member was out of town ("Excused: Travel") between [redacted], 2018, and [redacted], 2018.

21. Appellant's records for claim line 90 show that the member was "host dosing" at MRMS and therefore was not receiving counseling services.

22. Appellant's records for claim line 93 show that the member failed to attend scheduled counseling appointments on [redacted] 2018, [redacted] 2018, and [redacted], 2018.

23. Appellant's records for claim line 93 do not include documentation of other MAT services (dosing, drug testing) provided to the member during the dates of service. Appellant received MaineCare payments totaling $79.74 for claim line 93.

24. Appellant's records for claim lines 21 and 22 include documentation of an assessment that addressed the educational, vocational rehabilitation, employment, medical, psychosocial, economic, legal, and other needs of the member.

25. Appellant's records for claim lines 15, 32, and 79 do not include documentation of an assessment that addressed the educational, vocational rehabilitation, employment, medical, psychosocial, economic, legal, and other support needs of the member. Appellant received MaineCare payments totaling $180.00 for claim lines 15, 32, and 79.

26. Appellant's records for claim lines 80 and 95 include documentation of an assessment that partially addressed the educational, vocational rehabilitation, employment, medical, psychosocial, economic, legal, and other needs of the member. Appellant received MaineCare payments totaling $137.74 for claim lines 80 and 95.

27. Appellant's records for claim lines 34, 51, and 52 do not include documentation of a complete medical examination by a physician, physician assistant, or nurse practitioner. Appellant received MaineCare payments totaling $176.00 for claim lines 34, 51, and 52.

28. Appellant's records for claim lines 11 and 19 include ISP's lacking members' signatures. Appellant received MaineCare payments totaling $120.00 for claim lines 11 and 19.

27. Appellant's records for claim line 5 include a progress note lacking provider's signature. Appellant received MaineCare payments totaling $60.00 for claim line 5.

28. Appellant's records for claim line 10 include a progress note lacking a description of member's progress toward goals. Appellant received MaineCare payments totaling $58.00 for claim line 10.

29. Appellant received MaineCare payments totaling $6,364.54 for all claims in the sample.

30. Appellant received MaineCare payments totaling $1,059,455.35 for all claims with dates of service within the review period [redacted] 2017, through [redacted] 2019.

CONCLUSIONS OF LAW:

1. Appellant is subject to 100% penalties for claim lines 14, 28, 31, 33, 38, 41, 49, 50, 54, 57, 58, 59, 63, 72, 73, and 93.

2. Appellant is subject to prorated 100% penalties for claim lines 29 (two of seven days), 85 (two of seven days), and 88 (four of seven days).

3. Appellant is subject to 20% penalties for claim lines 15, 32, 34, 51, 52, and 79.

4. Appellant is subject to 10% penalties for claim lines 5, 10, 11, 19, 80, and 95.

5. Appellant is not subject to penalties for claim lines 21, 22, 77, and 90.

6. Appellant is subject to recoupment of $142,178.90 from MaineCare payments made for Medication-Assisted Treatment with Methadone within the review period [redacted], 2017, through [redacted], 2019.

RECOMMENDED DECISION:

The Hearing Officer recommends that the Commissioner UPHOLD the Department's Final Informal Review Decision dated May 21, 2021, with a revised recoupment amount of $142,178.90.

RATIONALE:

MaineCare Benefits Manual Chapter I, Section 1, requires that participating providers "Bill only for covered services" and "Maintain 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." § 1.03-8. MaineCare claims are subject to "audit or post-payment review," and "[i]n the absence of proper and comprehensive records, no payment will be made, and/or payments previously made may be recouped." §§ 1.16 and 1.18.

In imposing penalties due to lack of adequate documentation, "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 . . . 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 . . . [or] 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." § 1.20-2.

Factors that "may be considered in determining the sanction(s) to be imposed" include: "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." § 1.20-3.

Prior to imposing sanctions, the Department must issue the provider a Notice of Violation that includes the nature and dollar value of discrepancies or violations, computation method, and appeal process. Allowable methods of computing the dollar value include, in pertinent part, "Extrapolation from a systematic random sampling of records." § 1.20-4. Relative to appeals, "A provider or provider applicant must properly request an informal review and obtain a [final informal review] decision prior to requesting an administrative hearing." § 1.23-1(A). And, "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." § 1.23-1.

Appellant is a provider of Behavioral Health Services under Chapter II, Section 65. The disputed action is a recoupment of MaineCare payments for claims billed under procedure code H0020 (Medication-Assisted Treatment) for dates of service ("DOS") within the review period 2017, through , 2019.

As defined, "Medication-Assisted Treatment (MAT) with Methadone is a form of treatment for substance use disorder that includes the use of medication with counseling and other support. Medication-Assisted Treatment services assist the stabilization of symptoms of addiction and co-occurring behavioral health conditions. Compliance with Federal and State laws and regulations that govern treatment, including DHHS, Office of Behavioral Health, the Center for Substance Abuse Treatment (Division of the Substance Abuse and Mental Health Services Administration), the US Drug Enforcement Agency, the US Food and Drug Administration, and the State Pharmacy Board is required in the provision of services." Chapter II, § 65.02-27. Medication-Assisted Treatment services are reimbursed at a "bundled" weekly rate.[1] Chapter III, § 65.

Relative to required records, "All individuals participating in Medication-Assisted Treatment facilities must undergo a complete medical exam by a physician, physician assistant, or nurse practitioner within fourteen (14) days following admission. [. . .] All individuals admitted to a Medication-Assisted Treatment facility shall be assessed initially and periodically by qualified personnel for treatment planning purposes. The initial assessment must address the following elements in the preparation and development of treatment planning goals: the educational, vocational rehabilitation, employment needs of the member, and the member's needs for medical, psychosocial, economic, legal, and other support services." In addition,

[1] The evidence shows that the "bundled" weekly rate for MAT services during the review period 2017, through 2019, ranged from $58.00 to $81.74 per week. Exh. D-25.

"Within seven (7) visits following admission, the initial ISP is completed and signed by a clinician, the member (or, when appropriate, the member's parent or guardian), and the medical director. At least every ninety (90) days, updates to the ISP must be completed and signed by the clinician and the member." Medication-Assisted Treatment services include individual or group counseling at least weekly for the first 45 days, biweekly during the "stabilization stage," and monthly during the "maintenance phase." Chapter II, § 65.06-11.

Per its record request letter dated April 10, 2019, and expanded record request letter dated June 14, 2019, the Department directed Appellant to "submit copies of your entire records" for a total of 100 MaineCare members selected from a sample of 275 claims. On October 2, 2019, the Department issued a Notice of Violation ("NOV") informing Appellant that it had been overpaid $1,000,600.56 based on a review of the documentation submitted. Specifically, the Department determined that, of the 100 claims reviewed, "items that failed the audit total[ed] $6,184.54" of the total sample value of $6,364.54, resulting in an "error rate" of 97.17%. Applying the error rate to the $1,059,455.35 "universe" of total payments for the review period and adjusting to the lower bound of the 90% confidence interval for the estimated overpayment, the Department calculated a $1,000,600.56 recoupment for the review period. The Department's NOV and attached spreadsheet reflect that 100% penalties were imposed in every case in determining the error rate. Exh. D-4.

Appellant requested an informal review of the Department's NOV on December 2, 2019. Based on records submitted in connection with the informal review request, the Department revised the error rate to 31.19%, reducing the recoupment amount to $249,664.89. Per the Department's May 21, 2021, Final Informal Review Decision ("FIRD") and attached spreadsheet, penalties imposed in determining the 31.19% error rate related to missing or deficient Individual Service Plans, Comprehensive Assessments, and Progress Notes, missing/untimely signatures, and other issues. Exh. D-6. Based on additional records submitted following the review, the Department revised the error rate to 23.86%, reducing the recoupment amount to $178,525.39. The "Revised Redacted Recoupment Spreadsheet" shows that the error rate is based on total penalties of $1,518.73.[2] Exh. D-25. Of the latter total penalty amount, $1,151.30 relates to issues with "individualized service plans," $122.35 relates to issues with "comprehensive assessments," and $245.08 relates to issues with "progress notes." Exh. D-25.

Appellant's evidence in this case includes testimony of Dan Greer, VP of Operations, and Patrice Trisvan, Senior VP of Operations, for MRMS parent company BayMark Health Services, as well as patient records for the 35 claim lines constituting the $1,518.73 total penalties for the 100-claim sample.

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[2] In all, penalties were imposed as to 35 claim lines (5, 8, 9, 14, 15, 19, 21, 22, 28, 29, 31, 32, 33, 34, 38, 41, 49, 50, 51, 52, 54, 57, 58, 59, 63, 72, 73, 77, 79, 80, 85, 88, 90, 93, and 95). Exh. D-25.

Mr. Greer testified generally concerning Appellant's patient population and services. According to Mr. Greer's testimony, patients served by Appellant commonly have comorbid mental health conditions and issues with employment and homelessness. Mr. Greer testified that patients are prescreened and, if deemed appropriate, undergo a clinical assessment that includes a "biopsychosocial assessment" and "formulation/interpretive summary" with a substance abuse counselor prior to admission. Of the latter, Mr. Greer testified that the biopsychosocial assessment is the equivalent of a "comprehensive assessment" for purposes of MaineCare requirements. Mr. Greer testified that the biopsychosocial assessment comprises a series of screenings related to drug use and mental health treatment history as well as lifestyle, employment, housing, family, legal, and other factors. Mr. Greer testified that the results of the biopsychosocial assessment are encompassed in the formulation/interpretive summary. Other assessment documents maintained by Appellant, per Mr. Greer's testimony, include an annual "aftercare/discharge plan" that aligns with the biopsychosocial assessment, clinical evaluations, and medical reviews. Mr. Greer testified that treatment plans are prepared within two weeks following admission and updated quarterly thereafter.

Mr. Greer testified that Appellant bills for MAT services at a weekly "bundled" rate that covers medication and all required services, regardless of the treatment phase and required frequency of counseling. Relative to tracking required services, Mr. Greer testified that Appellant's EHR software ("SMART" or "SAMMS") included features that notified counselors of upcoming service requirements when viewing a patient's chart and that allowed management to run reports for legal compliance purposes. Mr. Greer testified that Appellant would first attempt to contact a patient and reschedule in the event he or she failed to attend a required assessment or service, and would place a "medication hold" on the patient's next scheduled dose if necessary to enforce attendance. Relative to missing records, Mr. Greer testified that patient lifestyle instability, patient vacations, winter storms, and high staff turnover were factors relative to missed appointments and insufficiency of documentation. Mr. Greer testified that counselor staffing was a significant issue statewide, and that the Department had waived counselors' caseload limits from 50 to 75 patients as a result. Finally, Mr. Greer testified that Appellant had taken measures to ensure that errors identified by the Department's review would not occur in the future.

Ms. Trisvan testified regarding the Department's findings as to claim lines 80, 77, 28, 57, 52, and 63. Relative to claim line 80,[3] Ms. Trisvan testified that the patient's "aftercare/discharge plan" (Exh. A-38) addressed the patient's medical, psychosocial, educational, and employment needs, thereby satisfying the requirement of a "comprehensive assessment." Relative to claim line 77,[4]

[3] The spreadsheet shows that a 20% penalty was imposed for claim line 80 due to "[a]ssessment does not 'address the educational, vocational rehabilitation, employment needs of the member and the member's needs for medical, psychological, economic, legal and other support services.'" Exh. D-25.

[4] The spreadsheet shows that a 100% penalty was imposed for claim line 77 due to "[n]o documentation of counseling services delivered within the month." Exh. D-25.

Ms. Trisvan testified that the patient's "dosing history" (Exh. A-36) showed "that the patient was absent from treatment" between 2018, and 2018, thus accounting for the lack of documentation satisfying the requirement of a "comprehensive assessment." Relative to claim line 28,[5] Ms. Trisvan testified that the patient's EHR (Exh. A-36) showed that the patient was hospitalized, preventing timely completion of an updated ISP. Relative to claim line 57,[6] Ms. Trisvan testified that the patient's ISP (Exh. A-29) expired only six days prior to the end date for the DOS. Relative to claim line 52,[7] Ms. Trisvan testified that the biopsychosocial assessment, annual clinical evaluation, and "Methadone Treatment Quality Assurance System (MTQAS)" (Exh. A-27) addressed the patient's medical condition. Relative to claim line 63,[8] Ms. Trisvan testified that the patient's updated ISP (Exh. A-32) was completed one month after it was due.

Appellant argues in closing that the Department's imposition of 100% sanctions for the 21 claim lines at issue (18 related to missing or expired ISP's, three related to lack of documentation of required counseling services) is inappropriate in that the members concerned actually received medically necessary, MaineCare covered services during those dates of service, therefore limiting the maximum sanction to 20% as per Chapter I, § 1.20-2. Relative to the other 14 claim lines at issue, Appellant argues that the maximum 20% sanction imposed in each case is not justified from the standpoint of the factors under § 1.20-3.

Upon review, the Hearing Officer finds that 100% sanctions are warranted relative to the 18 claim lines for which an ISP or updated ISP was not provided. Again, the rule requires that ISP's be updated every 90 days. More importantly, the record does not include evidence (e.g., dosing or drug testing records) that services were actually provided during the DOS in question. Consequently, per Chapter I, § 1.20-2, the evidence supports that 100% sanctions are warranted as to those 18 claim lines in the total amount of $1,084.44. [9, 10]

Relative to the three claim lines for which 100% sanctions were imposed for lack of documentation supporting that required counseling occurred, 77, 90, and 93, the Hearing Officer

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[5] The spreadsheet shows that a 100% penalty was imposed for claim line 28 due to "ISP for dates of service not provided," and additionally notes that "[d]ocumentation provided does not satisfy requirements of "Comprehensive Assessment" as described in [§] 65.06-11." Exh. D-25.

[6] The spreadsheet shows that a 100% penalty was imposed for claim line 57 due to "ISP not provided for dates of service." Exh. D-25.

[7] The spreadsheet shows that a 20% penalty was imposed for claim line 52 due to "[d]ocumentation provided does not satisfy requirements of "Comprehensive Assessment" as described in [§] 65.06-11" and "[n]o documentation of complete medical exam, by physician, physician assistant, or nurse practitioner." Exh. D-25.

[8] The spreadsheet shows that a 100% penalty was imposed for claim line 63 due to "ISP not provided for dates of service." Exh. D-25.

[9] Two of the 18 claim lines representing 100% penalties (claim lines 85 and 88) were prorated due to the ISP expiring within the seven-day periods covered by those claims. Exh. D-25.

[10] Appellant's evidence includes an ISP for Member 22 dated 2018. The Hearing Officer therefore finds that the recoupment for claim line 29, for DOS 2018, through 2018, should be reduced from $60.00 to $17.14 (prorated) reducing the total recoupment for missing/expired ISP's from $1,067.48 to $1,024.62. Exh. A-17.

finds that sanctions are not warranted as to claim lines 77 and 90. In the case of claim line 77, the evidence shows that the member was out of town ("Excused: Travel") between [redacted] 2018, and [redacted] 2018. Exh. A-36. In the case of claim line 90, the evidence shows that the member was "host dosing" only at MRMS and therefore not receiving counseling services. Exh. A-41. Relative to claim line 93, the spreadsheet states, "No documentation showing dosing, testing, or counseling during dates of service." A 100% sanction is therefore warranted as to claim line 93. Exh. D-25. Consequently, the evidence supports that total sanctions based on lack of documentation for required counseling should be reduced from $221.48 to $79.74.

Of the 14 claim lines for which 20% penalties were imposed in connection with or following the Department's informal review, no penalty is warranted as to claim lines 21 and 22. The spreadsheet shows that penalties were assessed as to those claims due to "[d]ocumentation provided does not satisfy requirements of "Comprehensive Assessment" as described in [§] 65.06-11." Exh. D-25. Appellant's evidence, however, includes a "biopsychosocial assessment" for the member at issue that satisfies those requirements. Exh. A-13; Exh. A-14. Of the other 12, no documentation of biopsychosocial assessments was provided for claim lines 15, 32, and 79, and no documentation of a complete medical examination by a physician, physician assistant, or nurse practitioner was provided for claim lines 34, 51, and 52.

Factors that "may be considered in determining the sanction(s) to be imposed" per Chapter I, § 1.20-3, apply to the determination of sanctions under § 1.20-2. *See Palian v. Dept. of Health & Human Services*, 2020 ME 131, ¶ 23 – ¶ 25, 242 A.3d 164, 171 – 172. Relative to these, the Department argues that 20% sanctions are warranted as to all of the claim lines at issue based on the seriousness and extent of violations. Having considered the factors under § 1.20-3, the Hearing Officer finds that the 20% penalties imposed are warranted as to claim lines 15, 32, 34, 51, 52, and 79 based on the "seriousness of the offense(s)." Consequently, sanctions for those claims should be upheld in the total amount of $71.20. Of the other six,[11] the evidence supports that ISP's and progress notes lacking required signatures (claim lines 5, 11, and 19) and progress note not describing member's progress toward goals (claim line 10) are otherwise satisfactory, and that "aftercare/discharge plans" provided by Appellant (claim lines 80 and 95) partially address the "educational, vocational rehabilitation, employment needs of the member, and the member's needs for medical, psychosocial, economic, legal, and other support services." Having considered the factors under § 1.20-3, the Hearing Officer finds that 10% penalties are "sufficient to remedy the problem" as to these claims. Consequently, total sanctions for these claims should be reduced from $75.15 to $37.57, resulting in total sanctions of $108.77 for the 14 claims at issue.

[11] Penalties imposed for remaining claim lines relate to ISP's lacking signatures (claim lines 11 and 19), progress note not signed (claim line 5), progress note not describing member's progress toward goals (claim line 10), and "[d]ocumentation provided does not satisfy requirements of "Comprehensive Assessment" as described in [§] 65.06-11" (claim lines 80 and 90).

Given the above, the evidence supports total penalties of $1,272.95 for the claim sample. The recommended revised recoupment amount is calculated as follows:

1) Error rate: $\$1,272.95 \div \$6,364.54 = 20.00\%$;
2) SEProp: $\sqrt{((0.2000 \times (1 - 0.2000)) \div 100)} = 0.0400$;
3) Error rate at 90% CI lower bound: $0.2000 - 0.0400 \times 1.6449 = 13.42\%$;
4) 90% CI lower bound: $0.1342 \times \$1,059,455.35 = \$142,178.90$.

Accordingly, the Hearing Officer recommends that the Commissioner UPHOLD the Final Informal Review Decision in this case, with a revised recoupment amount of $142,178.90.

<u>RIGHT TO FILE EXCEPTIONS AND RESPONSES:</u>

THIS IS A RECOMMENDED DECISION OF THE DIVISION OF ADMINISTRATIVE HEARINGS; THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER. PARTIES TO THIS RECOMMENDED DECISION MAY SUBMIT WRITTEN EXCEPTIONS AND RESPONSES TO THE DIVISION OF ADMINISTRATIVE HEARINGS PRIOR TO THE FINAL DECISION. EXCEPTIONS AND RESPONSES SHALL INCLUDE A CLEAR STATEMENT OF THE PARTY'S POSITION AND THE REASONS FOR IT, ANY ERRORS OR OMISSIONS MADE BY THE HEARING OFFICER, AND ANY LEGAL ARGUMENT THE PARTY WISHES TO MAKE. FACTUAL INFORMATION NOT PRESENTED AT HEARING NEED NOT BE CONSIDERED BY THE FINAL DECISION MAKER. EXCEPTIONS AND RESPONSES MUST BE RECEIVED BY THE DIVISION OF ADMINISTRATIVE HEARINGS BY MAIL, FAX, OR EMAIL WITHIN TWENTY (20) CALENDAR DAYS FOLLOWING THE DATE OF MAILING INDICATED IN THE UPPER RIGHT CORNER OF THE FIRST PAGE OF THIS RECOMMENDED DECISION. ANY PARTY SUBMITTING EXCEPTIONS AND RESPONSES MUST PROVIDE COPIES TO ALL OTHER PARTIES. A REASONABLE EXTENSION OF THE TWENTY-CALENDAR-DAY TIME LIMIT FOR SUBMITTING EXCEPTIONS AND RESPONSES MAY BE GRANTED BY THE CHIEF ADMINISTRATIVE HEARING OFFICER IF THE PARTIES ARE IN AGREEMENT TO THE EXTENSION OR FOR GOOD CAUSE SHOWN. 10-144 C.M.R. CH. 1, § VII(B)(5).

DATED: <u>March 17, 2022</u>

SIGNED: */S/ <u>Jeffrey P. Strickland</u>*
Jeffrey P. Strickland, Esq.
Hearing Officer

cc: William Logan, Esq.
Rachel Wertheimer, Esq.