Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Administrative Hearings
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Case Number: 1780746131-001

TO: Orono Commons
c/o Jan Talcove, R.N.
[redacted]

DECISION AFTER HEARING

On 11/17/2022, Hearing Officer Thomas Diebold, Esq., held a *de novo* administrative hearing by telephone in the case of Orono Commons. The Commissioner of Health and Human Services conferred jurisdiction to the Hearing Officer by special appointment. The record closed on 12/14/2022.

FACTUAL BACKGROUND AND ISSUE:

On or abou[redacted]022, Christina Stadig, R.N., with the State of Maine Office of MaineCare Services ("OMS"), completed an MDS[1] 3.0 Care Mix Review of Orono Commons. Exhibit D-4. On or about [redacted]2022, the audit report reviewed medical and billing records for 11 patients (from a population of 80), and found payment errors in 4 of the files, for a 36% error rate (4 / 11 = 36%). Id. The audit also found documentation errors in two patient files. Id. Pursuant to *MaineCare Benefits Manual*, Chapter III, § 67.2.3.4, a 2% sanction was imposed based on the 36% error rate. Id.

On or about [redacted]2022, Jan Talcove, R.N., Clinical Reimbursement Coordinator with Orono Commons, requested an informal review. Exhibit D-3.[2] Orono Commons agreed with the payment errors identified for patients #1, #9 and #11, but disputed the payment error found for patient #8. Id. Orono Commons also agreed there had been error in coding of patient #8, but asserted the error was a documentation error and not a payment error. Id. Specifically, Orono Commons argued that "the case-mix RUG[3] did not change". Id. On that basis, Orono Commons claimed the case mix review error rate was below 36% and therefore could not support the 2% sanction applied as a result of the Case Mix review findings. Id. Corrected documentation was submitted on [redacted]2022. Exhibit D-1.

On or about [redacted]2022, Suzanna Pinette, Case Mix Manager and State Resident Assessment Instrument ("RAI") Coordinator, the Office of MaineCare Services, the Department of Health

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[1] Minimum Data Set
[2] The Department did not include Orono Common's exhibits with its request for informal review in Exhibit 3. Instead, both parties agreed that the documents referenced in Exhibit 3 are attached to Exhibit 1.
[3] Resource Utilization Group

and Human Services (the "Department"), issued a Final Informal Review Decision ("FIRD)". Exhibit D-2. The FIRD notified Orono Commons that "the findings of the case mix nurse reviewer" were upheld. The FIRD found that patient #8 was coded with M0300F1 on the MDS reflecting an unstageable ulcer. The FIRD also found that there was no clinical support for an unstageable ulcer. Therefore, the FIRD concluded that "the unsupported coding of an unstageable ulcer (M0300F) caused the resident to receive a rate of reimbursement that was higher that (sic) he/she should have received". Id. The FIRD acknowledged there was clinical documentation that supported coding M0300C1 for a Stage 3 ulcer. The FIRD noted that "[t]he existence of a condition that could have been coded, but was not, does not change the analysis. Case Mix reviews must necessarily review the facility's coding and records as they exist on the date of the review." Id.

On or abou[redacted]2022, Orono Commons appealed. Exhibit D-1. The appeal was referred to the Division of Administrative Hearing on 9/14/2022. Exhibit HO-2. On 9/16/2022, the Division of Administrative Hearings sent Orono Commons a notice of hearing for 11/9/2022. Exhibit HO-1. By letter dated 9/29/2022, the hearing was rescheduled to 11/17/2022. Exhibit HO-3. By letter dated 11/4/2022, a case management conference was scheduled for 11/7/2022. The hearing was completed on 11/17/2022 and the record was left open until 12/2/2022 for submission of closing arguments by the parties. By letter dated 12/6/2022, additional supplemental argument was requested. The parties both submitted supplemental argument by 12/14/2022.

The issue for the hearing was whether the Department was correct when it determined there was a payment error for patient #8 in the [redacted]022 Case Mix review which, combined with stipulated payment errors for 3 other patients out of a sample of 11 patients, resulted in a case mix error rate of 36% and a corresponding 2% sanction.

APPEARING ON BEHALF OF APPELLANT:

Jan Talcove, R.N., Clinical Reimbursement Coordinator, Orono Commons
Tiffany McCann, R.N., Clinical Reimbursement Manager, Orono Commons

APPEARING ON BEHALF OF AGENCY:

Philip Burns, Esq., OMS
Suzanne Pinette, R.N., Case Mix Manager / RAI Coordinator, OMS

ITEMS INTRODUCED INTO EVIDENCE:

Hearing Officer Exhibits:

HO-1. Notice of Administrative Hearing dated 9/16/2022
HO-2. Fair Hearing Report Form dated 9/14/2022
HO-3. Scheduling notice dated 9/29/2022
HO-4. Case management conference scheduling notice dated 11/4/2022
HO-5. Letter to parties dated 12/6/2022

Department Exhibits:

D-1. Administrative Hearing Request
D-2. Final Informal Review Decision
D-3. Request for Informal Review
D-4. Exit Conference for MDS 3.0 Case Mix Review
D-5. Excerpts from MaineCare Benefits Manual, Chapters II and III, Section 67
D-6. Excerpts from Long-Term Care Facility RAI 3.0 User's Manual
D-7. Maine MDS RUG III Codes

Appellant Exhibits:

A-1. Screen shots from Orono Commons (4 pages)

Closing Arguments

12/1/2022 Closing argument from Orono Commons
12/2/2022 Closing argument from the Department
12/13/2022 Supplemental closing argument from Orono Commons
12/14/2022 Supplemental closing argument from the Department

STANDARD OF REVIEW

The hearing officer reviews the Department's claim for recoupment against an approved MaineCare services provider *de novo*. *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 *MaineCare Benefits Manual* states that "Nursing care facilities will be reimbursed for services provided to members based on a rate which the Department establishes on a prospective basis and determines is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated facility in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards." 10-144 C.M.R. Ch. 101, Chapter III, § 67.14.1.

Allowable costs under the prospective system of reimbursement are categorized based on the nature of the expense as either: 1) direct care costs (salaries, wages, and benefits for registered nurses, licensed practical nurses, nurse aides, patient activities personnel, and ward clerks), 2) routine costs, or 3) fixed costs. § 67.15. Direct care costs are relevant to case mix reviews, as "[t]he basis for reimbursement within the direct care cost component is a resident classification

system that groups residents into classes according to their assessed conditions and the resources required to care for them." § 67.15.

Accordingly, the rules provide for a "case mix reimbursement system." § 67.22.3.1. This rule states that "the direct care cost component utilizes a case mix reimbursement. Case mix reimbursement takes into account the fact that some residents are more costly to care for than others." Id. Therefore, the rules create a system that requires "(a) the assessment of residents on the Department's approved form – [Minimum Data Set] as specified in Principle 16.2; (b) the classification of residents into groups which are similar in resource utilization by use of the case mix resident classification groups as defined in Principle 22.3.2; [and] (c) a weighting system which quantifies the relative costliness of caring for different classes of residents by direct care staff to determine a facility's case mix index." Id.

Broadly, the Department determines the direct care cost component of a nursing facility's "prospective per diem rate" for a fiscal year based on the "case mix weight" for each of the facility's MaineCare residents. § 67.22.3. There are "a total of forty-five (45) case mix resident classification groups [alternatively, "resource utilization groups" or "RUG's"] including one (1) resident classification group used when residents cannot be classified into one (1) of the forty-four (44) clinical classification groups." § 67.22.3.2. The associated case mix weight values range from 0.749 for "unclassified" support to 2.484 for "extensive 3/ADL" support. Id.

The rule created the Resident Assessment Instrument (RAI) to "provide a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. It is comprised of the Minimum Data Set (MDS) currently specified for use by Centers for Medicare and Medicaid [Services] (CMS) . . ." § 67.16.2. The rule further states that the MDS "provides the basis for resident classification into one (1) of [the] forty-four (44) [clinical] case mix classification groups. An additional unclassified group is assigned when assessment data are determined to be incomplete or in error." Id.

CMS guidelines require that MDS assessments be submitted electronically for each resident within 14 days of admission and quarterly, annually, and "whenever the resident experiences a significant change in status, and whenever the facility identifies a significant error in a prior assessment" thereafter. §§ 67.16.2.1, 67.16.2.2, and 67.1.4.

The Department conducts MDS assessment reviews "to ensure that assessments accurately reflect the resident's clinical condition." Depending on a facility's "assessment review error rate," the latter being defined as, "the percentage of unverified Case Mix Group Record[s] in the drawn sample," the Department will impose a sanction equivalent to a specified percentage of MaineCare resident days billed by the facility for a three-month period following the review.

An "Unverified Case Mix Group Record" is in turn defined as being "one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident."

The Department is required to "hold an exit conference" and "share written findings for reviewed records" with facility representatives following the on-site portion of the review. The facility must correct any MDS assessment information determined to be inaccurate using the "MDS correction form" specified by CMS for that purpose. "Failure to complete MDS corrections by the nursing facility staff within fourteen (14) days of a written request by staff of the Office of MaineCare Services may result in the imposition of the deficiency per diem" rate, equivalent to 90% of the facility's per diem rate, "until the deficiencies have been corrected, as verified by representatives of the Department, following written notification by the provider that the deficiencies no longer exist." §§ 67.16.2.3 and 67.37.

Pursuant to *MaineCare Benefits Manual*, Chapter III, § 67.16.2.3.4, sanctions are calculated as follows:

1. A two percent (2%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of thirty-four percent (34%) or greater, but is less than thirty-seven percent (37%).
2. A five percent (5%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of thirty-seven percent (37%) or greater, but is less than forty-one percent (41%).
3. A seven percent (7%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of forty-one percent (41%) or greater, but is less than forty-five percent (45%).
4. A ten percent (10%) decrease in the total allowable inflated direct care rate per day after the application of the wage index and upper limit will be imposed when the NF assessment review results in an error rate of forty-five percent (45%) or greater.

FINDINGS OF FACT:

1. Notice of these proceedings was given in a timely and adequate manner. Orono Commons made a timely appeal.

2. On [redacted]2022, the Department completed an exit conference with Orono Commons following a case mix review of the records for 11 patients.

3. The Department identified payment errors in the records of 4 patients, #1, #8, #9, and #11. On this basis, the Department calculated a 36% error rate and imposed a 2% sanction.

4. Orono Commons stipulated there were payment errors in the records of patients #1, #9 and #11.

5. Orono Commons stipulated there was an error in the coding of patient #8, who was incorrectly coded with M0300F for an unstageable pressure ulcer.

6. The documentation for patient #8 supported coding M0300C for a stage 3 pressure ulcer.

7. The case mix weight for both M0300C and M0300F is SSA, or 1.511.

8. Orono Commons asserted that the Department incorrectly found there was increase in the case mix weight in its request for informal review.

9. The Department issued a Final Informal Review Decision on [redacted]2022 that found there was no documentation to support the billing code of M0300F, and therefore at the time of the ARD, the billing was an Unverified Case Mix Group Record.

10. There was no increase in the case mix weight for patient #8 as a result of the error by Orono Commons.

11. The billing documentation submitted by Orono Commons for patient #8 was an Unverified MDS Record.

DECISION:

The Department was incorrect in the [redacted]2022 Final Informal Review Decision. The error by Orono Commons in patient #8 was an Unverified MDS Record, and not an Unverified Group Case Mix Record.

REASON FOR DECISION:

The core facts in this case are not in dispute. On [redacted]2022, the Department completed an exit conference with Orono Commons following an MDS 3.0 case mix review. Exhibit D-4. The case mix review by the Department audited 11 files and identified payment errors in 4 of the samples – patients #1, #8, #9 and #11. Id. Because there was a 36% error rate (4/11), the Department applied a 2% sanction. *MaineCare Benefits Manual*, Chapter III, § 67.16.2.3.4.

The Department asserted that Orono Commons made a payment error in its documentation of patient #8 as follows:

> Medical record does not support the coding of **M0300F1 Unstageable Pressure Ulcer**. No RN or MD descriptive documentation during the 7 day look back. Medical record does not support coding of **M1200G Nonsurgical dressing**.[4] No delivery of a dressing not related to Pressure Ulcers during the look back. Medical record does not support the coding of M1200H Ointment / Medications to treat skin condition other than to feet. No delivery during the look back week. CORRECTION REQUIRED. (emphasis in original)

[4] Neither party has ever raised any issues with respect to this portion of the finding for #8, and therefore it is not a factor in this case.

In its [redacted]2022 request for Informal Review, Orono Commons agreed with the findings for patients #1, #9, and #11. Exhibit D-3. Therefore, there is no dispute with respect to those findings.

Orono Commons further agreed there was an error with respect to patient #8, but that the error was a documentation error and not a payment error. Id. Orono Commons asserted that patient #8 should have been coded as a stage 3 ulcer, rather than an unstageable ulcer. The parties stipulated at an 11/7/2022 case management conference that the documents attached to Orono Commons' request for informal review in Exhibit D-3 when originally submitted are attached to Exhibit D-1, the subsequent administrative appeal. Statements of Phil Burns, Esq., and Jan Talcove. These documents show that on the Section M Skin Condition form originally classed patient #8 with a M0300F1 unstageable ulcer with a Case Mix group of SSA, version code of 1.0044, billing code of HC160 and billing version of 1.0466. Exhibit D-1. The corrected Section M Skin Condition requested by the Department correctly classed patient #8 with a M0300C1 stage 3 ulcer, with a Case Mix group of SSA, version code of 1.0044, billing code of HC160 and billing version of 1.0466. Id. In other words, there was no change in the Assessment Administration between the form with the claimed payment error and the corrected form for patient #8.

The lack of change in the Assessment Administration coding submitted with the request for informal review is consistent with the applicable regulations. Pursuant to the Maine MDS RUG[5] III codes used by the Department in this case mix review, the RUG III Code of SSA has a Maine weight of 1.511, and both M0300C and M0300F fall within this RUG code. Exhibit D-7.

Because there was no change in the billing, Orono Commons argued in its request for Informal Review that "You will see that the state case-mix RUG did not change. It remained the SSA which is why we are asking that resident #8's errors be documentation errors and not be considered payment errors." Exhibit D-3.

The Department denied Orono Commons's appeal in a Final Informal Review Decision issued on [redacted]2022. Exhibit D-2. The Department noted that any issues not raised in the written request are waived in subsequent appeal proceedings and the request for informal review may not be amended to add further issues. The Department asserted in its decision that "[t]he unsupported coding of an unstageable ulcer (M0300F) caused the resident to receive a rate of reimbursement that was higher that (sic) he/she should have received. In addition to this error, the case mix nurse also found the error in which the facility could have coded a pressure ulcer but did not." Id.

In the Department's view, because Orono Commons incorrectly billed for an unstageable ulcer when there was no supporting documentation for an unstageable ulcer, the billing was therefore an "Unverified Case Mix Group Record" under *MaineCare Benefits Manual*, Chapter III, Section 67, 16.2.3.1(6). The Department provided the definition in full as follows:

[5] Resource Utilization Group, a reference to the categorization scheme in MDS 3.0 case mix reviews. See Exhibit D-7.

> **"Unverified Case Mix Group Record"** is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident. Records so identified will require facilities to submit the appropriate MDS correction form and follow CMS clinical guidelines for MDS completion. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.

The Department addressed the core argument raised by Orono Commons, that the corrected submission did not change the case mix weight, by asserting that "... the facility's records did not accurately represent the resident's condition and resulted in an increased case mix weight assigned to the Resident. The existence of a condition that could have been coded, but was not, does not change the analysis. Case mix reviews must necessarily review the facility's coding and records as they exist on the date of the review." Exhibit D-2. The Final Informal Review Decision therefore upheld the prior decision that found 4 payment errors for a 36% error rate and a 2% sanction and extended administrative appeal rights to Orono Commons.

Orono Commons exercised its right to an administrative appeal on 8/16/2022. Exhibit D-1. Orono Commons again stipulated that it made an error coding patient #8 at M0300F, and it further stipulated "that there was no documentation to support the coding of M0300F." Id. Orono Commons again argued that there was documentation to support coding patient #8 with a stage 3 ulcer at M0300C, and that the billing weight between the two classifications was the same. Id. Specifically, Orono Commons again asserted that, "...modifying the erroneous item coding of M0300F and correctly coding M0300C resulted in the same case mix group of SSA." Id.

Orono Commons also argued in its appeal that the Department was wrong to view the submitted documentation as an Unverified Case Mix Group Record because the case mix weight did not change. Instead, Orono Commons asserted that the item coding was an Unverified MDS Record under *MaineCare Benefits Manual*, Chapter III, Section 67, 16.2.3.1(7). In full, the definition is:

> **"Unverified MDS Record"** is one, which, for clinical purposes, does not accurately reflect the resident's condition. Records so identified will require facilities to submit the appropriate MDS correction form and follow the CMS clinical guidelines for MDS completion.

Following the submission of Orono Commons's appeal to the Division of Administrative Hearings, this matter was assigned to the undersigned. At a case management conference on 11/7/2022, the parties agreed the MDS review was on [redacted]2022, and the lookback period going from [redacted]2022 to [redacted]2022. The corrected form was submitted on [redacted]2022. Exhibit A-1. Based on this, since the error for patient #8 was not corrected until after the day of review, any error for patient #8 is appropriately included within the calculation of the assessment review error rate. This rate is based on errors identified on the day of review. *MaineCare Benefits Manual*, Chapter III, Section 67, 16.2.3.1(4) defines it as:

> "**Assessment review error rate**" is the percentage of unverified Case Mix Group Record in the drawn sample. Samples shall be drawn from Case Mix Group Record completed for residents who have MaineCare reimbursement. MDS Correction Forms received in the central repository or included in the clinical record will be the basis for review when completed before the day of the review and included as part of the resident's clinical record.

Accordingly, the issue for hearing was whether the Department was correct, and the error was a payment error because the case mix weight was impacted, or whether Orono Commons was correct that the error was a documentation error because the case mix weight was not impacted.

At hearing on 11/17/2022, the Department presented Suzanne Pinette, R.N., as its sole witness. Ms. Pinette testified that she is an employee of the Office of MaineCare Services and that she oversees the Case Mix Unit for the Department. Ms. Pinette is also the Resident Assessment coordinator for CMS. Ms. Pinette wrote the Final Informal Review Decision on [redacted]2022. Consistent with the Final Informal Review Decision, Ms. Pinette testified that because there was no documentation of an unstageable pressure ulcer, there was no support for the billing of M0300F submitted by Orono Commons for patient #8, so payment was unsupported – and therefore it was a payment error because the rate was higher than they "should have received" based on the documentation.

Ms. Pinette then testified that the documentation provided by Orono Commons did support a stage 3 ulcer coding but that it was not coded by Orono Commons. Ms. Pinette testified that the only relevant information is what is coded at the time of the review. Ms. Pinette testified that the case mix weight is based on the MDS record at the time of the review, and since the coding was for an unstageable pressure ulcer for which there was no supporting documentation, the result is a different case mix group. Ms. Pinette affirmed that since the existing documentation for a stage 3 ulcer was not coded, it could not be assessed. At 26:55 into the hearing record, this exchange occurred:

> Hearings Examiner: Well, ok so, do you agree that if it had been coded as a stage 3 ulcer based on the documentation that your nurse identified in her audit, the case mix weight would have been the same?
>
> Ms. Pinette: I agree.

Ms. Pinette then addressed the components of an unverified MDS record. As far as the Department was concerned, an MDS condition for unstageable pressure ulcer did not exist. Ms. Pinette testified that the timing of a correction has no impact on the coding of an error. Ms. Pinette testified that Case Mix teams do not have to identify items that could have been coded but were not; they may do so as a matter of teaching. In this case, Ms. Pinette testified that there was no loss of income to the facility because the coding could be resubmitted, but that did not alter the Department's determination that at the time of the review the billing coded was not supported by the documentation. That again led to this exchange at 38:35:

Hearings Examiner: Had it been accurately classified there would be no change in the case weight, right?

Ms. Pinette: That is correct.

When asked whether the Department's interpretation of "Unverified Case Mix Group Record" turns every error into a payment error because there could be no support for an error, Ms. Pinette denied that was true. Ms. Pinette asserted if Orono Commons had coded both M0300C and MO300F, that would be a documentation error in her view.

Ms. Pinette's attention was drawn to p. 115 in Exhibit D-7, which reflects that ulcers coded as either M0300C or M0330F are classed the same. Ms. Pinette again asserted that since there was no documentation for an unstageable ulcer that Orono Commons coded, there was a payment error.

Jan Talcove, R.N., is the Clinical Reimbursement Coordinator for Orono Commons. Ms. Talcove testified that the treatment of and documentation for patient #8 was for a stage 3 ulcer, which is M0300C. Ms. Talcove testified that it simply a documentation error to code #8 as a M0300F but there was no change in the case weight and there was no impact in the billing. Ms. Talcove acknowledged that Orono Commons had made an error, but the error was a documentation error.

Following the hearing, the parties submitted written closing arguments. The arguments submitted were consistent with the positions raised throughout – whether the error in this case was a payment error or a documentation error.

After review of these arguments, the undersigned Hearings Examiner wrote to the parties on 12/6/2022 to request they supplement the closing arguments to address whether the language of the *MaineCare Benefits Manual*, Chapter III, §67.16.2 regarding the Unclassified case weight was applicable. Exhibit HO-5. Orono Commons argued in response on 12/13/2022 that this category was not applicable because it was only used "when residents do not meet the criteria for another of the other above groups. Residents would fall into this group for instance if an MDS was not completed or was not completed timely. This category does not apply to Resident #8." *Orono Commons Supplemental Closing Argument* dated 12/13/2022. The Department first argued in its supplemental closing statement that new arguments could not now be raised since this question was not raised in the request for the informal review. The Department then asserted that if the argument were to be considered, the unclassified classification "was not relevant in this case because the facility was not, in fact, assigned an unclassified case mix index. The unclassified case mix index is also known as the default rate, which is equal to the lowest possible case mix index, the same as PA1." *Department Supplemental Closing Argument* dated 12/14/2022. The Department also attached a page which has not been entered into the administrative record as an exhibit. This page was therefore not considered by the Hearings Examiner as only argument can be submitted in closing, not additional proposed evidence that was not provided to the opposing party prior to hearing. The Department is generally correct that arguments not raised in the request for the informal review cannot be raised now. But it is clear Orono Commons has disputed the Department's determination that the case mix weight

was impacted by its error at all appropriate junctions in this case, including in the request for informal review.

However, given the agreement of the parties of that the unclassified classification is not a factor in this case, then the issue for the Hearings Examiner is simply which error definition is applicable to this case: Unverified Case Mix Group Record or Unverified MDS Record?

To recap, the relevant definitions are:

> **"Unverified Case Mix Group Record"** is one which, for reimbursement purposes, the Department has determined does not accurately represent the resident's condition, and therefore results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident. Records so identified will require facilities to submit the appropriate MDS correction form and follow CMS clinical guidelines for MDS completion. Correction forms received prior to calculating the rate setting quarterly index will be used in the calculation of that index.
>
> **"Unverified MDS Record"** is one, which, for clinical purposes, does not accurately reflect the resident's condition. Records so identified will require facilities to submit the appropriate MDS correction form and follow the CMS clinical guidelines for MDS completion.

This Hearings Examiner finds that Orono Commons's error was an Unverified MDS Record, and therefore a documentation error. As noted on p. 115 of Exhibit D-7, there is no increase in the case mix weight assigned to the resident because of the error.

There simply is no basis not to apply Unverified MDS Record to the facts in this case. The Department's argument that there was no documentation for an unstageable pressure ulcer is a true but incomplete application of the definition of Unverified Case Mix Group Record. The definition of Unverified Case Mix Group Record states that the error must be an error that "results in the resident's inaccurate classification into a case mix group that increases the case mix weight assigned to the resident." The resident was not inaccurately classified into a case mix group that increased the case mix weight because the case mix group was the same for both M0300C and M0300F – the case mix group for both was SSA, which has a weight value of 1.511.

Contrary to the Department's view, the Department's application of Unverified Case Mix Group Record turns virtually every error into a payment error. The circularity is clear because by definition there is no support for an error (or it would not be an error), and errors cannot support the billing, and therefore the billing must be wrong, so all errors are payment errors.

The Department's analysis in the Final Informal Review Decision, and in through Ms. Pinette's testimony, repeatedly make clear the Department's view that documentation "must be accurate as of the ARD". *Department's Closing Statement* dated 12/3/2022 and Exhibit D-2. It is undeniably true an error as of the ARD is an error, but the issue is whether essentially all errors as of the ARD are payment errors. The Department's unstated but implicit interpretation that

effectively all errors are therefore payment errors ignores the fact there is no dispute an error occurred, and it ignores the requirements in the definition of Unverified Group Case Mix Record that the error must reclassify the resident into a higher case mix weight.

The Department's interpretation essentially reads Unverified MDS Record out of the regulations. This argument is simply not persuasive against the reality of the facts in this case. The undisputed evidence at hearing is that the error left the patient in exactly the same case mix group, and therefore did not move #8 into a higher case mix group. This is the essence of a documentation error. Since all components of the definition of Unverified MDS Record are met, and since not all components of the definition of Unverified Case Mix Group Record are met, the applicable definition is Unverified MDS Record.

Because this error is not a payment error, there are 3 payments error out of a sample of 11 based on the prior stipulation from Orono Commons. This is an error rate of 27.27%, which is below the sanction threshold of the 34%. Therefore, the Department's imposition of a 2% sanction in the [redacted]2022 Final Informal Review Decision was in error.

MANUAL CITATIONS:

- *Administrative Hearing Regulations*, 10-144 C.M.R. Ch. 1, § VII
- *MaineCare Benefits Manual*, 10-144 C.M.R. Ch. 101, sub. Ch. I, § 1
- *MaineCare Benefits Manual*, 10-144 C.M.R. Ch. 101, sub. Ch. III, § 67

RIGHT TO JUDICIAL REVIEW:

ANY PERSON WHO IS DISSATISFIED THIS DECISION HAS THE RIGHT TO JUDICIAL REVIEW UNDER 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.

THE INFORMATION CONTAINED IN THIS DECISION IS CONFIDENTIAL. ***See, e.g.,*** **42 U.S.C. section 1396a(a)(7), 22 M.R.S.A. section 42(2) and section 1828(1)(A), 42 C.F.R. section 431.304, MaineCare Benefits Manual, Ch.1, sec. 1.03-5. ANY UNAUTHORIZED DISCLOSURE OR DISTRIBUTION IS PROHIBITED.**

DATED: 1/11/2023 **SIGNED:** ***/s/ Thomas Diebold, Esq.***
Thomas Diebold, Esq.
Administrative Hearing Officer
Division of Administrative Hearings

cc: Philip Burns, Esq., OMS
Jan Talcove, R.N., Orono Commons