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

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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O.K. w/redactions, JB 8-10-16

DATE OF MAILING: MAY 31 2016

Mary C. Mayhew, Commissioner
Department of Health and Human Services
11 SHS, 221 State Street
Augusta, ME 04333

RE: Bridges of Maine, LLC – Final Informal Review Decision, Recoupment Action

ADMINISTRATIVE HEARING RECOMMENDATION

An administrative hearing in the above-referenced matter was held on December 5, 2015, at Portland, Maine, before Hearing Officer Jeffrey P. Strickland. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner, Maine Department of Health and Human Services. The hearing record was initially left open through December 11, 2015, for closing arguments and subsequently reopened through April 1, 2016, for stipulations and amended closing arguments.

CASE BACKGROUND AND ISSUE:

Bridges of Maine, LLC (Claimant) appeals a June 1, 2015, Final Informal Review Decision of the Department of Health and Human Services (Respondent) which determined, based on an audit of randomly-selected claims within the period September 1, 2010, through October 31, 2014,[1] and materials submitted by Claimant in connection with Respondent's informal review, that Claimant was subject to recoupment of $929,229.12 due to overbilled services and recordkeeping deficiencies.

The Commissioner's Order of Reference, dated August 6, 2015, identifies the issue for the immediate proceeding as follows: *"Was the Department correct when for the review period of 9/1/2010 through 10/31/2014, it found that Bridges of Maine, LLC failed to maintain contemporaneous documentation and over billed for services, as detailed in the Informal Review Decision dated 6/1/2015, which resulted in a recoupment amount of $929,229.12 owed to the Department?"*

Based on documentation submitted following the June 1, 2015, Final Informal Review Decision, Respondent prior to the December 5, 2015, hearing in this matter reduced the assessed recoupment amount from $929,229.12 to $693,212.12. Subsequent to hearing, the parties stipulated to a further reduction of the latter amount by $113,030.00,[2] leaving a total of $580,182.12 in dispute.

[1] As related in Respondent's March 12, 2015, Notice of Violation, which assessed a recoupment amount of $3,492,029.38.

[2] The estimated total value of underpayments not accounted for in the assessed recoupment amount. Exhibit HO-2.

The latter being the actual amount in dispute at this point, the Hearing Officer recommends that the issue for this proceeding be changed to the following: *"Was the Department correct when it determined that Bridges of Maine, LLC, was subject to recoupment in the amount of $580,182.12 based on recordkeeping deficiencies and billing errors identified in a random sample of records associated with MaineCare claims within the period September 1, 2010, through October 31, 2014?"*

APPEARING ON BEHALF OF CLAIMANT:

Jay McCloskey, Esq.
Gregg Alexis, President, Bridges of Maine, LLC
Michael Austin (former Quality Improvement Specialist)
Clariss Dunn (former Quality Improvement Specialist)
Robert Barton (former Quality Improvement Supervisor)

APPEARING ON BEHALF OF RESPONDENT:

Thomas Bradley, Assistant Attorney General
James Wade, Auditor
Denise Osgood, Program Manager

ITEMS INTRODUCED INTO EVIDENCE:

Hearing Officer exhibit(s):

HO-1: The following items, collectively:
- Reschedule letter dated September 2, 2015.
- Reschedule checklist dated August 25, 2015.
- Scheduling letter dated August 13, 2015.
- Order of Reference dated August 6, 2015.
- Fair Hearing Report form dated August 3, 2015.
- Letter (Jay McCloskey / Mary Mayhew) dated July 28, 2015.
- Final Informal Review Decision dated June 1, 2015.
- Letter (Gregg Alexis / James Wade) dated April 23, 2015.
- Notice of Violation dated March 12, 2015.
- Letter (James Bivins / Jay McCloskey) dated October 14, 2015.
- Subpoena dated October 14, 2015.
- Letter (Jay McCloskey / DAH) dated October 13, 2015.
- Subpoena request form (1).
- Letter (James Bivins / Jay McCloskey) dated October 7, 2015.
- Letter (Jay McCloskey / DAH) dated October 3, 2015.
- Subpoena request forms (14).
- Letter (James Bivins / Jay McCloskey) dated October 7, 2015.
- Subpoenas (11) dated October 14, 2015
- Subpoena request forms (11).

HO-2: The following items, collectively:

- Reopen letter dated February 22, 2016.
- Letter (Thomas Bradley / Jeffrey Strickland) dated March 8, 2016.
- E-mail (Jeffrey Strickland / Deborah Davidson) dated March 8, 2016.
- Letter (Thomas Bradley / Jeffrey Strickland) dated March 29, 2016.

Claimant exhibit(s):

A-1: Comprehensive Assessment Signature Page ([redacted]) dated May 25, 2010.

A-2: Comprehensive Assessment Signature Page ([redacted]) dated November 9, 2012.

A-3: Comprehensive Assessment Signature Page ([redacted]) dated November 18, 2011.

A-4: Comprehensive Assessment Signature Page ([redacted]) dated October 3, 2013.

A-5: Comprehensive Assessment Signature Page ([redacted]) dated December 21, 2010.

A-6: Comprehensive Assessment Signature Page ([redacted]) dated December 10, 2012.

A-7: Comprehensive Assessment Signature Page ([redacted]) dated September 9, 2013.

A-8: Comprehensive Assessment Signature Page ([redacted]) dated October 6, 2013.

A-9: Comprehensive Assessment Signature Page ([redacted]) dated May 19, 2014.

A-10: Comprehensive Assessment Signature Page ([redacted]) dated November 21, 2013.

A-11: Comprehensive Assessment Signature Page ([redacted]) dated August 10, 2012.

A-12: Comprehensive Assessment Signature Page ([redacted]) dated December 9, 2010.

A-13: Comprehensive Assessment Signature Page ([redacted]) dated October 28, 2013.

A-14: Comprehensive Assessment Signature Page ([redacted]) dated June 18, 2012.

A-15: Comprehensive Assessment Signature Page ([redacted]) dated July 9, 2012.

A-16: Comprehensive Assessment Signature Page ([redacted]) dated May 9, 2011.

A-17: Comprehensive Assessment Signature Page ([redacted]) dated April 25, 2013.

A-18: Comprehensive Assessment Signature Page, [redacted] dated August 2, 2012.

A-19: Comprehensive Assessment Signature Page ([redacted]) dated June 6, 2012.

A-20: Comprehensive Assessment Signature Page ([redacted]) dated May 4, 2010.

A-21: Comprehensive Assessment Signature Page ([redacted]) dated May 4, 2011.

A-22: Comprehensive Assessment Signature Page ([redacted]) dated July 12, 2012.

A-23: Comprehensive Assessment Signature Page ([redacted]) dated September 23, 2013.

A-24: Comprehensive Assessment Signature Page ([redacted]) dated May 19, 2014.

A-25: Comprehensive Assessment Signature Page ([redacted]) dated September 19, 2013.

A-26: Comprehensive Assessment Signature Page ([redacted]) dated July 22, 2014.

A-27: Comprehensive Assessment Signature Page ([redacted]) dated May 21, 2012.

A-28: Comprehensive Assessment Signature Page ([redacted]) dated November 17, 2011.

A-29: Comprehensive Assessment Signature Page ([redacted]) dated July 19, 2011.

A-30: Comprehensive Assessment Signature Page ([redacted]) dated February 15, 2011.

A-31: Comprehensive Assessment Signature Page ([redacted]) dated August 30, 2011.

A-32: Comprehensive Assessment Signature Page ([redacted]) dated June 22, 2010.

A-33: Comprehensive Assessment Signature Page ([redacted]) dated July 25, 2011.

A-34: Comprehensive Assessment Signature Page ([redacted]) dated May 31, 2013.

A-35: Comprehensive Assessment Signature Page ([redacted]) dated January 23, 2012.

B-1: Fax cover sheet dated May 28, 2010.

B-2: Grandfathered Supervisor Form ([redacted]) dated May 28, 2010.

B-3: Grandfathered Supervisor Form ([redacted]) dated May 28, 2010.

B-4: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-5: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-6: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-7: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-8: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-9: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-10: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

B-11: Grandfathered Supervisor Form [redacted] dated May 28, 2010.

C-1: E-mail (Clarice Dunn / Diana Alexis / Robert Barton) dated March 9, 2011.

C-2: E-mail [redacted] Clarice Dunn / Diana Alexis) dated March 31, 2010.

C-3: E-mail [redacted] / Clarice Dunn / Robert Barton / Diana Alexis) dated May 11, 2011.

C-4: E-mail [redacted] / Clarice Dunn / Robert Barton / Diana Alexis) dated May 11, 2011.

C-5: E-mail ([redacted] / Michael Austin / Diana Alexis) dated June 3, 2011.

C-6: E-mail [redacted] / Clarice Dunn / [redacted]) dated June 2, 2011, and June 7, 2011.

C-6.1: E-mail [redacted] / Clarice Dunn) dated June 1, 2011.

C-7: E-mail [redacted] / Clarice Dunn / Diana Alexis) dated June 16, 2011.

C-8: E-mail [redacted] / Clarice Dunn) dated January 19, 2011, and January 24, 2011.

C-9: E-mail [redacted] / Michael Austin) dated Febuary 24, 2011.

R-1: Comprehensive Assessment Signature Page [redacted] dated April 16, 2010.

R-2: Comprehensive Assessment Signature Page [redacted] dated June 20, 2011.

E-1: Individual Treatment Plan [redacted] dated May 16, 2011.

E-2: Individual Treatment Plan [redacted] dated September 2, 2011.

E-3: Fax cover sheet dated May 19, 2011.

E-3.1: Continuing Stay Request [redacted] dated May 4, 2011.

E-3.2: Comprehensive Assessment Signature Page [redacted] dated May 4, 2011.

E-3.3: Consent to Services [redacted] dated May 18, 2011.

E-3.4: Individual Treatment Plan Meeting Record [redacted] dated May 4, 2011.

E-4: Fax cover sheet dated June 16, 2011.

E-4.1: Consent to Services [redacted] dated June 30, 2011.

E-4.2: Consent to Services [redacted] dated June 14, 2011.

E-5: Fax cover sheet dated July 7, 2011.

E-5.1: Continuing Stay Request [redacted] dated May 12, 2011.

E-6: Individual Treatment Plan [redacted] dated June 3, 2011.

E-7: Approval(s) of Requested Services [redacted] dated September 14, 2011, July 26, 2011, June 19, 2011, June 14, 2011, and December 22, 2010.

F-1: Comprehensive Assessment [redacted] dated July 31, 2013.

Respondent exhibit(s):

R-1: Order of Reference dated August 6, 2015.

R-2: Fair Hearing Report form dated August 3, 2015.

R-3: Notice of Violation dated March 12, 2015.

R-4: Letter (Gregg Alexis / James Wade) dated April 23, 2015.

R-5: Final Informal Review Decision dated June 1, 2015.

R-6: Letter (Jay McCloskey / Mary Mayhew) dated July 28, 2015.

R-7: 10-144 C.M.R. Ch. 101, Chapter I, Section 1, version effective January 11, 2010.

R-8: 10-144 C.M.R. Ch. 101, Chapter I, Section 1, version effective February 7, 2011.

R-9: 10-144 C.M.R. Ch. 101, Chapter I, Section 1, version effective March 26, 2013.

R-10: 10-144 C.M.R. Ch. 101, Chapter I, Section 1, version effective June 24, 2013.

R-11: 10-144 C.M.R. Ch. 101, Chapter I, Section 1, version effective January 1, 2014.

R-12: 10-144 C.M.R. Ch. 101, Chapter II, Section 28, version effective April 10, 2010.

R-13: 10-144 C.M.R. Ch. 101, Chapter II, Section 28, version effective September 28, 2010.

R-14: 10-144 C.M.R. Ch. 101, Chapter III, Section 28, version effective April 1, 2010.

R-15: 10-144 C.M.R. Ch. 101, Chapter III, Section 28, version effective September 28, 2010.

R-16: 10-144 C.M.R. Ch. 101, Chapter III, Section 28, version effective June 11, 2011.

R-17: Comprehensive Assessment [redacted]) dated July 12, 2012.

R-18: Comprehensive Assessment [redacted]) dated November 18, 2011.

R-19: Declaration of [redacted] dated April 10, 2015.

R-20: Individual Treatment Plan [redacted], dated November 29, 2011.

R-21: Individual Treatment Plan [redacted] dated December 30, 2010.

R-22: Quarterly Review [redacted] dated August 3, 2010.

R-23: Daily Progress Note [redacted]) dated April 12, 2011.

R-24: Daily Progress Note [redacted]) dated August 6, 2014.

R-25: Medicaid/Maine Health Program Provider/Supplier Agreement dated January 26, 2010.

R-26: Post-Final Informal Review Decision spreadsheet.

FINDING(S) OF FACT:

1. Claimant is a provider of MaineCare services under 10-144 C.M.R. Ch. 101, Chapter II, § 28 (Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations). Exhibit R-25.

2. Claimant received MaineCare payments totaling $6,696,471.00 in satisfaction of 41,397 claims for reimbursement of Section 28 services provided within the period September 1, 2010, through October 31, 2014. Exhibits R-3, R-5, and R-26.

3. Respondent in connection with an audit of claims for Section 28 services provided during the period September 1, 2010, through October 31, 2014, assessed a recoupment amount of $693,212.12 based on recordkeeping deficiencies and billing errors identified among a random sample of 105 claims for that period. Exhibit R-26.

4. The total value of the 105 claims randomly sampled from the period September 1, 2010, through October 31, 2014, was $21,000.06, of which amount 100 "typical" claims accounted for $16,458.54 and five "outlier" claims accounted for $4,541.52. Exhibit R-26.

5. Claimant was overpaid $277.14 as a result of billing errors in the 100 "typical" claims totaling $16,458.54 in value. Exhibit R-26.

6. Claimant was overpaid $268.08 as a result of billing errors in the five "outlier" claims totaling $4,541.52 in value. Exhibit R-26.

7. Respondent provided Claimant with forms for completing Comprehensive Assessments and Individual Treatment Plans in connection with Section 28 services. Testimony of Gregg Alexis.

8. Respondent instructed Claimant to refrain from altering the Comprehensive Assessment and Individual Treatment Plan forms provided in any way. Testimony of Robert Barton.

9. Individual Treatment Plan forms provided by Respondent to Claimant do not contain spaces for parent signatures in connection with 90-day reviews. Exhibits E-1, E-2, E-6, R-20 and R-21.

10. Respondent did not provide Claimant with separate forms for documenting 90-day reviews of Individual Treatment Plans. Testimony of Denise Osgood.

11. Claimant documented 90-day reviews of Individual Treatment Plans during the period September 1, 2010, through October 31, 2014, by means of single-page, typewritten, dated summaries reflecting treatment objectives and success rates relative to same. Exhibit R-22.

12. Claimant's single-page, typewritten, dated summaries of 90-day Individual Treatment Plan reviews do not contain parent signatures. Exhibit R-22.

13. Respondent instructed Claimant to leave that section of the Comprehensive Assessment form signature page entitled "Provider Use Only" blank. Testimony of Gregg Alexis.

14. Comprehensive Assessment form signature pages provided by Respondent do not contain spaces for provider staff signatures. Exhibits A-1 through A-35, R-1, R-2, E-3.2, R-17, and R-18.

15. Comprehensive Assessment forms completed by Claimant in connection with services during the audit period lack provider staff signatures. Exhibits A-1 through A-35, R-1, R-2, E-3.2, and R-18.

16. Respondent in connection with reviews of prior authorization and continuing stay requests submitted by Claimant during the period September 1, 2010, through October 31, 2014, at no point informed Claimant that documentation reviewed was deficient in terms of Section 28 recordkeeping requirements. Testimony of Michael Austin, Clariss Dunn, and Gregg Alexis.

17. Respondent in connection with site reviews during the period September 1, 2010, through October 31, 2014, at no point informed Claimant that documentation reviewed was deficient in terms of applicable recordkeeping requirements. Testimony of Gregg Alexis.

18. Respondent's June 1, 2015, Final Informal Review Decision expresses that penalties remaining following Respondent's review of additional documentation relate only to overbilling and unsigned Comprehensive Assessments and ITP 90 day reviews. Exhibit R-5.

19. Claimant was underpaid $304.32 as a result of billing errors among sampled claims. Stipulated.

<u>CONCLUSION(S) OF LAW:</u>

1. The entire amount of that portion of the total proposed recoupment still in dispute represents 20% penalties related to unsigned Comprehensive Assessments and ITP 90 day reviews.

2. Claimant's documentation of 90-day Individual Treatment Plan reviews completed during the audit period complies with applicable documentation and recordkeeping requirements.

3. Comprehensive Assessments completed by Claimant during the audit period do not comply with applicable documentation and recordkeeping requirements.

4. Claimant in documenting Comprehensive Assessments during the audit period acted in reliance on Respondent's statements, conduct, and silence.

5. Claimant's reliance on Respondent's statements, conduct, and silence in documenting Comprehensive Assessments during the audit period was detrimental.

6. Claimant's reliance on Respondent's statements, conduct, and silence in documenting Comprehensive Assessments during the audit period was reasonable.

RECOMMENDED DECISION:

The Hearing Officer recommends that the Commissioner REVERSE the proposed recoupment of $580,182.12 in this case for the period September 1, 2010, through October 31, 2014.

REASON FOR RECOMMENDATION:

Claimant is a provider of services under 10-144 C.M.R. Ch. 101, Chapter II, § 28 (Rehabilitative and Community Support Services for Children with Cognitive Impairments and Functional Limitations). Per the latter rule, these are treatment services designed to retain or improve functional abilities and measurably improve socially significant behaviors and developmentally appropriate skills. Services include problem-solving activities and development of skills and behaviors necessary to interact and live with others and independently, build and maintain relationships, improve environmental and self awareness, and support social appropriateness and integration. §§ 28.04-1 and 28.04-2.

Respondent's proposed action in this case is the partial recoupment of MaineCare payments made to Claimant for Section 28 services provided during the 50-month period September 1, 2010, through October 31, 2014, based on an audit of claims for that period. Per the applicable rule, Respondent is authorized to conduct post-payment audits of MaineCare provider claims and to assess recoupment amounts by extrapolating audit results from randomly-selected samples to all claims for services within a given period. Chapter I, § 1.16 et seq.

Grounds for recoupment include, among others, "Breaching the terms of the MaineCare Provider/Supplier Agreement and/or the Requirements of Section 1.03-3." § 1.19-1(G). Based on the evidence presented, applicable terms of the MaineCare/Medicaid Provider Agreement to which Claimant is a party include compliance with "provisions of the MaineCare Benefits Manual ('MBM'), 10-144 C.M.R. Ch. 101." Exhibit D-25. Similarly, Section 1.03-3 requires that MaineCare providers "[c]omply . . . with the provisions of this Manual." § 1.03-3(R).

Recordkeeping requirements specific to Section 28 services are enumerated in § 28.05 of Chapter II, and in pertinent part concern "Comprehensive Assessments" and "Individual Treatment Plans." The former of these serves to "identify strengths and needs of the member and family and develop an Individual Treatment Plan" while the latter "is the plan of care developed by the treatment team" based on the Comprehensive Assessment. §§ 28.01-4 and 28.01-9. Both documents are to be completed within 30 days of service initiation and maintained in the member's records. §§ 28.05-1(B), 28.05-1(C), 28.05-2(A), and 28.05-3(A). Additionally, the Comprehensive Assessment must be "updated as needed, annually at a minimum," while the Individual Treatment Plan must be "reviewed every ninety (90) days by the treatment team." §§ 28.05-2(A) and 28.05-3(B).

In the case of sanctions related to documentation or recordkeeping violations, the rule provides that the Department "may" impose penalties "not to exceed" 20% of MaineCare payments for services that were actually provided and medically necessary and 100% of MaineCare payments otherwise.

Chapter I, § 1.19-2. Factors pertinent to whether and to what extent sanctions are imposed include: seriousness of the offense(s); extent of violation(s); history of prior violation(s); prior imposition of sanction(s); prior provision of provider education; provider willingness to obey MaineCare rule; whether imposition of a lesser sanction will be sufficient to remedy the problem; and other actions taken or recommended by peer review groups, other payors, or licensing boards. § 1.19-3.

The evidence shows that Claimant received $6,696,471.00 in MaineCare payments as reimbursement for Section 28 services provided during the period September 1, 2010, through October 31, 2014 (hereinafter "audit period"). The recoupment amount of $580,182.12 is based on Respondent's review of provider documentation associated with 105 claims selected at random ("sampled") from the 41,397 total claims submitted by Claimant for the audit period. Of those 105 claims, 100 account for $16,458.54 of payments for services within the audit period, while the remaining five "outlier" (atypically high value) claims account for $4,541.52. Exhibits R-3, R-5, and R-26.

In calculating the recoupment amount, an "error rate" representing the ratio of the total value of improper payments identified among the 100 "typical" claims to the total value of all payments associated with those claims was extrapolated to the total value of all payments for all claims within the audit period, both values being first adjusted based on a 95% confidence level.[3] The five "outlier" claims were excluded from this calculation on the basis that the atypically high values associated with those claims would unjustifiably increase the error rate, and thus the recoupment amount, calculated on the basis thereof. Instead, improper payments identified among those five claims were simply added to the amount determined by extrapolating the value of improper payments from the 100 "typical" claims in determining the total recoupment amount. Exhibits R-3, R-5, and R-26.

Respondent's initial review identified improper MaineCare payments related to overbilling and inadequate documentation, the latter being based on documentation requirements per § 28.05-2 (Comprehensive Assessments) and § 28.05-3 (Individual Treatment Plans). Altogether, Respondent's March 12, 2015, Notice of Violation identified improper MaineCare payments totaling $9,505.01 among the 100 "typical" claims and $2,029.38 among the five "outlier" claims comprising the sample. Improper payments identified per the latter document related to overbilled services (100% penalty), services not provided pursuant to timely Comprehensive Assessments or Individual Treatment Plans (100% penalty), and services not provided pursuant to Comprehensive Assessments documented with clinician signatures and credentials (20% penalty). Of the total value of improper payments identified among the typical claims, $277.14 related to overbilling, $8,135.40 related to untimely Comprehensive Assessments and Individual Treatment Plans, and $1,092.47 related to Comprehensive Assessments lacking clinician signatures and credentials. Of the total value of improper payments identified among the outlier claims, $286.08 related to overbilling and $1,743.30 related to untimely Comprehensive Assessments and Individual Treatment Plans. Exhibit R-3.

[3] Based on the evidence presented, it is not clear whether or not Respondent's calculations relative to sample size, adjusted error rate, etc. are consistent with accepted statistical methodology for purposes of determining the recoupment amount by extrapolation. The methodology employed is not in dispute, however, and is in any event ultimately immaterial to the recommended decision.

Respondent on the basis of the above calculated an adjusted error rate of 54.86%, i.e., 95% of 57.75%, representing the ratio of the total value of improper payments among typical claims ($9,505.01) to the total value of typical claims in the sample ($16,458.54). Extrapolating the adjusted error rate (54.86%) to the adjusted total value of claims within the audit period[4] (95% of $6,696,471.00, or $6,361,647.45), and adding to that product ($3,490,000.00) the total value of improper payments identified among the outlier claims ($2,029.38), Respondent initially assessed a total recoupment amount of $3,492,029.38, as communicated to Claimant in Respondent's March 12, 2015, Notice of Violation. Exhibit R-3.

In response to the above, Claimant on April 23, 2015, requested an informal review of Respondent's March 12, 2015, Notice of Violation. Based on additional documentation submitted by Claimant, which included documentation pertaining to 90 day reviews of Individual Treatment Plans, Respondent reduced the total value of improper payments among the typical and outlier claims, respectively, to $2,542.55 and $429.12. Exhibits R-4 and R-5.

Per the Final Informal Review Decision, penalties remaining following Respondent's review of the documentation submitted by Claimant related to overbilling, unsigned Comprehensive Assessments, and "unsigned ITP or 90-day review[s]." The decision does not relate violations to penalty values; per the attached spreadsheet, however, of the $2,542.55 in improper payments among typical claims, $455.94 represented 100% penalties, of which $277.14 related to overbilling and $178.80 related to untimely Individual Treatment Plans, while $2,086.61 represented 20% penalties related to unsigned Comprehensive Assessments and "unsigned ITP review[s] dated [dd/mm/yy]." Of the $429.12 in improper payments among outlier claims, $286.08 represented 100% penalties related to overbilling, while $143.04 represented 20% penalties related to unsigned Comprehensive Assessments and "unsigned ITP review[s] dated [dd/mm/yy]." Respondent based on the above reduced the recoupment amount to $929,229.12. Exhibits R-3 and R-5.

Based on additional documentation submitted in connection with Claimant's appeal of Respondent's June 1, 2015, Final Informal Review Decision, Respondent pending hearing further reduced total improper payments among typical claims to $1,886.36. Of that amount, $277.14 represented 100% penalties related to overbilling while $1,609.22 represented 20% penalties related to unsigned Comprehensive Assessments and "ITP review[s] covering dos signed by parent not provided." Respondent based on the above further reduced the recoupment amount to $693,212.12. Exhibit R-26.

At hearing, Respondent presented testimony and other evidence regarding the methodology used in calculating the recoupment amount, as outlined above, and the bases of penalties related to unsigned Comprehensive Assessments and ITP reviews. In sum, the evidence presented shows that Comprehensive Assessments were not signed by provider staff members in the "Provider Use Only"

[4] Although improper payments identified among the five outlier claims were excluded from Respondent's calculation of the error rate, this is not fully reflected in extrapolating sample results of the 100 typical claims to the universe of claims in that the total value of all claims reimbursed for the audit period ($6,696,471.00) was not first reduced by the total value of the five outlier claims ($4,541.52) in the total sample. Again, however, the methodology employed by Respondent is not in dispute and is in any event ultimately immaterial to the recommended decision.

section and that Individual Treatment Plan 90 day review forms did not contain parent signatures. Exhibits R-5, R-17 through R-22, and R-26, testimony of James Wade and Denise Osgood.

Claimant in turn presented evidence showing that prior authorization and continuing stay requests were routinely approved on the basis of Comprehensive Assessments lacking provider signatures, that site reviews conducted during the audit period disclosed no deficiencies in Claimant's records relative to Section 28 recordkeeping requirements, that Claimant was instructed to refrain from modifying forms provided by Respondent, that the Comprehensive Assessment signature page section entitled "Provider Use Only" did not apparently call for the signature of the staff member completing the assessment, and that Respondent instructed Claimant to leave the latter section blank. Exhibits C-1 – C-9, testimony of Michael Austin, Clariss Dunn, Robert Barton, and Gregg Alexis.

Respondent in closing cites Section 28 requirements concerning Comprehensive Assessments and Individual Treatment Plans and Claimant's obligation to follow same pursuant to the terms of the Medicaid/Maine Health Program Provider/Supplier Agreement dated January 26, 2010. Respondent argues that Respondent's acceptance of documentation in connection with prior authorization, continuing stay, and site reviews is irrelevant with respect to audit findings and recoupment amount, as is Claimant's understanding of the "Provider Use Only" section of the signature page.

Claimant in closing argues that Respondent's Final Informal Review Decision taken together with other evidence including testimony presented at hearing provides insufficient notice of the basis of Respondent's action with respect to audit findings concerning recordkeeping violations. Claimant further argues that the latter are not supported by the evidence or the MaineCare Benefits Manual sections cited by Respondent. Claimant further argues that "signed" is not defined under the rule, and that the printed name of the staff member completing the assessment is therefore sufficient. Finally, Claimant argues that Respondent, having expressed no concerns regarding Claimant's recordkeeping practices previously, has waived its right to sanction Claimant on the basis of recordkeeping violations identified in connection with the disputed action.

Relative to the issue of notice, specific findings for each of the 105 sampled claims are reflected in spreadsheets included with Respondent's Notice of Violation and Final Informal Review Decision, and in connection with revised audit findings subsequent to the latter. The spreadsheets are divided into vertical columns for data including, among other things, comments and recoupment amounts, the latter being classified as either 20% or 100% recoupments. Exhibits R-3, R-5, and R-26.

As noted previously, Respondent's March 12, 2015, Notice of Violation expresses that 100% penalties relate to overbilling and untimely Comprehensive Assessments and Individual Treatment Plans, while 20% penalties relate to unsigned Comprehensive Assessments. And, as discussed previously, Respondent's June 1, 2015, Final Informal Review Decision states that penalties remaining following Respondent's review of additional documentation submitted by Claimant relate to overbilling, unsigned Comprehensive Assessments, and "unsigned ITP 90 day review[s]," but does not correlate these violations with penalty values (i.e., 20% or 100% recoupments). Exhibits R-3 and R-5.

Evidence concerning Respondent's findings conflicts as between the Final Informal Review Decision, the attached and subsequently-revised spreadsheets, and the testimony presented at hearing. The Final Informal Review Decision references penalties related to unsigned Comprehensive Assessments and "unsigned ITP 90 day review[s]," but does not indicate that any penalties were assessed on the basis of timeliness issues relative to those documents. Evidence presented, however, shows the latter were identified in connection with Respondent's informal review and subsequent revisions. The latest spreadsheet, prepared immediately prior to hearing, indicates that recordkeeping violations associated with all penalties related to Individual Treatment Plans include both timeliness issues and "unsigned ITP 90 day review[s]." Exhibits R-5 and R-26, testimony of James Wade.

Under Maine law, defective notice constitutes grounds for reversal of agency action only to the extent an appellant is actually prejudiced as a result thereof. E.g., *Hopkins v. Department of Human Services*, 802 A.2d 999, 1002 – 1003 (Me. 2002). As argued by Claimant, inconsistencies in the evidence render it difficult or impossible in many cases to appreciate whether improper payments concerning Individual Treatment Plans relate to timeliness issues, to "unsigned ITP 90 day review[s]," or to both; this poses an obvious practical difficulty in terms of Claimant's ability to address the basis of Respondent's action in detail with respect to all claims in the sample.

As discussed previously, Respondent's Final Informal Review Decision makes no reference to timeliness issues with respect to Individual Treatment Plans or "ITP 90 day reviews." Respondent's most recent spreadsheet indicates that all 100% recoupment penalties remaining at this point relate to overbilling. Per Respondent's March 12, 2015, Notice of Violation, 100% recoupment penalties related to overbilling and untimely Comprehensive Assessments or Individual Treatment Plans, whereas 20% recoupment penalties related to unsigned Comprehensive Assessments. Exhibit R-3.

Given the above, Claimant's position regarding Respondent's notice is reasonable to the extent that the latter must be understood to express that all remaining improper payments relate either to overbilling or to unsigned Comprehensive Assessments and "ITP 90 day reviews," and that none relate to timeliness issues with respect to either of those documents. Accordingly, the immediate recommended decision addresses Respondent's action in terms of the former three findings only.

Relative to Claimant's position concerning Respondent's failure to account for underbilling errors, the parties following the reopening of the hearing record agreed that underbilling errors among the sampled claims total $304.32 and that the latter amount extrapolated to the total value of claims for the audit period compels a reduction of the recoupment amount by $113,030.00[5]. The latter amount exceeds by $10,958.00 that portion of the recoupment amount representing 100% penalties related to overbilling errors ($102,072.08). Exhibits HO-2 and R-26.

[5] The Hearing Officer is unable to duplicate this result ($113,030.00) from the agreed-upon underbilling error amount using the methodology employed by Respondent. Using Respondent's methodology, the Hearing Officer calculates a reduction of $111,746.10, the latter amount exceeding that portion of the total recoupment amount representing 100% penalties related to overbilling errors ($102,072.08) by $9,674.02. Except to the extent that the extrapolated value of underbilled claims exceeds the extrapolated value of overbilled claims, however, the former is ultimately immaterial to the recommended decision.

In light of the above-noted factors, the portion of the total recoupment amount remaining in dispute, or $580,182.12, is attributed to unsigned Comprehensive Assessments and "ITP 90 day reviews." Again, overpayments identified in either category incurred penalties representing 20% recoupment of the claim value. The evidence shows that a significant number of overpayments relate to both issues; the total penalty assessed in such cases, however, was nevertheless limited to 20% recoupment of the claim value. Exhibits R-3, R-5, and R-26, testimony of James Wade.

As noted previously, Respondent points out that Claimant in accordance with the terms of the Medicaid/Maine Health Program Provider/Supplier Agreement dated January 26, 2010, is required to comply with documentation and recordkeeping requirements per MaineCare regulations. As a condition of MaineCare participation, 10-144 C.M.R. Ch. 101, Chapter I, Section 1.03-1(A) further requires that Provider Agreements be executed between the Department and providers.

According to the Medicaid/Maine Health Program Provider/Supplier Agreement signed by Claimant on November 12, 2009, and by Respondent on January 26, 2010: (Exhibit R-25.)

> *The Provider will maintain in a systematic and orderly manner, medical and financial records that are necessary to document fully the extent, nature and cost of the services provided to Members receiving assistance under this Agreement, as required by the MBM and applicable professional standards. The records must be maintained in the form, if any, required by the Department. [. . . , and]*
>
> *The Provider acknowledges that failure to maintain all required documentation may result in sanctions set out in the MBM, including the disallowance and recovery by the Department of any amounts paid to the Provider for which the required documentation is not maintained and provided to the Department upon request.*

In the case of Section 28 providers, required documentation includes, per 10-144 C.M.R. Ch. 101, Chapter II, § 28.05-1, Comprehensive Assessments and Individual Treatment Plans for all members receiving services. Sections 28.01-4 and 28.01-9, respectively, define these documents as follows:

> ***Comprehensive Assessment** is used to identify strengths and needs of the member and family and develop an Individual Treatment Plan. The comprehensive assessment process determines the intensity and frequency of medically necessary services and includes utilization of instruments as may be approved or required by DHHS. [. . . , and]*
>
> ***Individual Treatment Plan (ITP)** is the plan of care developed by the treatment team and includes the member, if appropriate, the parent or guardian, the provider and natural supports, and is based on a comprehensive assessment and a diagnostic evaluation of the member. The Individual Treatment Plan shall include a Crisis/Safety Plan and a Discharge Plan, along with other elements of the plan of care. The Individual Treatment Plan describes the medically necessary treatment the member will receive."*

Recordkeeping violations identified with respect to the above relate to unsigned forms; significantly, identical forms were found to be lacking the same required signatures in every case. In the case of Comprehensive Assessments, all violations relate to provider staff signatures; in the case of Individual Treatment Plans, all violations relate to parent signatures on "ITP 90 day reviews." Exhibits R-5 and R-26.

Claimant presented evidence in the form of testimony from Bridges of Maine President Gregg Alexis as well as former Department employees regarding prior authorization and continuing stay reviews for Section 28 services. The evidence supports that the documents in question were reviewed in connection with prior authorization and continuing stay requests and with site visits by Respondent, and were found to be acceptable for purposes of MaineCare reimbursement on those occasions. Testimony of Michael Austin, Clariss Dunn, and Gregg Alexis.

The evidence further supports that Claimant was instructed by Respondent to refrain from altering or modifying the forms provided for Comprehensive Assessments and Individual Treatment Plans and that no forms were provided by Respondent for use in connection with 90 day reviews of the latter. Finally, the evidence supports that Respondent at some point instructed Claimant to leave the section of the Comprehensive Assessment form "signature page" entitled "Provider Use Only" blank. Testimony of Robert Barton and Gregg Alexis.

As to Comprehensive Assessments, § 28.05-2(C) describes recordkeeping applicable requirements in pertinent part as follows:

> *The assessment must be summarized, signed, credentialed with licensure or certification, if applicable, and dated by the staff conducting the assessment, the parent or guardian and the member, if appropriate, and include the source and date of the diagnosis.*

All penalties related to the above requirement were assessed based on Comprehensive Assessments forms lacking signatures by the provider staff members that completed the assessments. The evidence supports that, in each case, the name of the staff member completing the assessment was printed in a space at the top of the page. Exhibit R-18.

Respondent argues that a cursive signature is required in order to satisfy the requirement that the assessment be "signed" by the staff member completing the assessment; Claimant in turn argues that the term "signed" is not defined under the rule, and that the hand-printed name of the staff member completing the assessment is therefore legally sufficient for purposes of the latter.

Relative to the above, the form in question is 22 pages in length and includes a "Signature Page" appearing as follows:

MaineCare Section 28, Rehabilitative and Community Support Services for
Children with Cognitive Impairments and Functional Limitations
Comprehensive Assessment: A Guide to Conversation

Signature Page

Parent/Guardian/Caregiver:

I talked with _____ from
Agency Person

_____ to help the agency learn about my child,
Agency

_____ We talked about his/her strengths, needs, likes, dislikes, history, and other important information. This information will help the agency better serve my child. I think this comprehensive assessment is a fair representation of what I said. I understand I can add information at any time.

_____ _____
Parent/Guardian/Caregiver Date

_____ _____
Child/Youth Date

Provider Use Only:

Date Provider Accepted Referral: _____

Comprehensive Assessment:

Guide to Conversation completed by: _____

Title: _____ Date: _____

Respondent with respect to the above argues that the provider staff member's signature should be recorded in the box captioned, "Provider Use Only," in order to satisfy documentation requirements per § 28.05-2(C). Again, the latter rule Section describes recordkeeping requirements specific to Comprehensive Assessments in pertinent part as follows: *The assessment must be summarized, signed, credentialed with licensure or certification, if applicable, and dated by the staff conducting the assessment, the parent or guardian and the member, if appropriate, and include the source and date of the diagnosis.*

As discussed previously, the evidence supports that the forms were found to be acceptable in connection with prior authorization and continuing stay requests as well as site visits by Respondent, that Respondent instructed Claimant to refrain from altering or modifying the forms in any way, and that Respondent at some point instructed Claimant to leave the section of the "signature page" entitled "Provider Use Only" blank.

Claimant asserts the doctrine of waiver relative to the above issue. "Waiver is the voluntary and knowing relinquishment of a right and may be shown by a course of conduct signifying a purpose not to stand on a right, and leading, by a reasonable inference, to the conclusion that the right in question will not be insisted upon." *Department of Human Services v. Bell,* 711 A.2d 1292, 1294 – 1295 (Me. 1998) (citing *Department of Human Services v. Brennick,* 597 A.2d 933, 935 (Me. 1991)).

Closely related to waiver is the doctrine of equitable estoppel. While identical in terms of their effect, the doctrines are distinct as concerns the significance of the parties' intentions as opposed to actions. "It will be seen from these rules that waiver is a voluntary relinquishment of a known right; yet, if a party without such intention by his conduct or silence misleads the other party, he then is estopped." *Holt v. New England Telephone & Telegraph Co.,* 85 A. 159, 160 (Me. 1912).

"Equitable estoppel requires a misrepresentation." *Department of Health and Human Services v. Pelletier, 964 A.2d 630, 636* (Me. 2009) (citing *Bell,* 711 A.2d 1292, 1295 (Me. 1998)). "A misrepresentation need not consist solely of an affirmative statement; it may arise through a combination of misleading statements, conduct, or silence." Id. Whereas waiver involves the "voluntary and knowing" relinquishment by a party of a known right, "Estoppel bars the assertion of the truth by one whose misleading conduct has induced another to act to his detriment in reliance on what is untrue." *Anderson v. Commissioner of Department of Human Services,* 489 A.2d 1094, 1099 (Me. 1985) (citing *Roberts v. Maine Bonding & Casualty Co.,* 404 A.2d 238, 241 (Me. 1979)).

Despite the connotation of deceit, "It is not necessary that the conduct creating the estoppel should involve an actual intention to mislead and deceive. If [a party] remains silent when it is his duty to speak, as where inquiries are made of him, or if, instead of merely remaining silent, he does some positive affirmative act, even if it be mere encouragement, he subjects himself to the application of the doctrine of equitable estoppel, if such silence or active conduct would naturally have the effect of misleading or deceiving and did so . . ." *Milliken v. Buswell,* 313 A.2d 111, 119 (Me. 1973).

As concerns its applicability in this case, "The activities of a governmental entity may be equitably estopped if the party asserting the doctrine . . . can prove 'that (1) the statements or conduct of the governmental official or agency induced the party to act; (2) the reliance was detrimental; and (3) the reliance was reasonable.'" *Mrs. T. v. Commissioner of Department of Health and Human Services*, 36 A.3d 888, 891 (Me. 2012) (quoting *Pelletier* at 635). And, 'An equitable estoppel defense that is based on reliance on the governmental agency's silence must be proved by "clear and satisfactory" evidence.' *Pelletier* at 635 (quoting *Bell* at 1295).

Based on the above, the application of collateral estoppel is supported in this case with respect to violations related to Comprehensive Assessments lacking provider staff signatures. To begin with, the form cannot reasonably be understood as reflecting the requirements of § 28.05-2(C). Specifically, the section in question appears to call for the identity and job title of the person completing the "Guide to Conversation" (i.e., Comprehensive Assessment), and not that individual's signature or professional credentials ("licensure or certification" per § 28.05-2(C)). In contrast, lines intended for "Parent/Guardian/Caregiver" and "Child/Youth" signatures are identified as such immediately below the line; notably, the area outside the "Provider Use Only" box provides sufficient room for a provider staff signature below the other two signatures, but instead contains only blank space.

As discussed previously, the evidence shows that Respondent in connection with prior authorization and continuing stay reviews and site visits appeared to have no particular issues with respect to Comprehensive Assessments lacking provider staff signatures. The significance of this evidence with respect either to waiver or to collateral estoppel is perhaps debatable, as asserted by Respondent; there is, however, no evidence that Respondent at any point provided any directive or other guidance to Claimant or other providers relative to completing the form, other than testimony that Respondent instructed Claimant to refrain from altering or modifying the form and to leave the section entitled "Provider Use Only" blank. Given the latter's insufficiency relative to documentation requirements, the application of collateral estoppel to recoupment on the basis of Comprehensive Assessments lacking provider signatures is supported on the basis of Respondent's conduct and silence.

As to Individual Treatment Plans, meaning ITP 90 day reviews specifically, it is Respondent's position that these should be documented on a provider-generated form to include parent/guardian signatures on the basis of the following language from § 28.05-3(B): *The provider will provide the member with a copy of the initial and reviewed ITP within ten (10) days of signing.*

All penalties relating to the latter requirement were assessed on the basis of "ITP 90 day reviews" lacking parent or guardian signatures. The evidence supports that agency-produced single-page "forms" were submitted by Claimant to satisfy the requirement of an "ITP 90 day review" for purposes of Respondent's audit. The documents in question are captioned with the member's name, "Quarterly Review," and date, followed by double-spaced, typewritten notes reflecting the member's progress toward goals; the documents contain neither signatures nor spaces for signatures. Claimant argues that, per the applicable rule, parent signatures are not required for quarterly reviews of Individual Treatment Plans unless a revised plan is generated based on the results of the review.

Again, the evidence shows that the Individual Treatment Plan form provided by Respondent makes no provision for signatures or other documentation pertaining to ITP 90 day reviews, that Respondent instructed Claimant to refrain from altering or modifying Individual Treatment Plan forms, and that Respondent does not provide separate forms for this purpose. There is no evidence that Respondent at any point instructed Claimant or other providers to create forms for the purpose of documenting ITP 90 day reviews. Section 28.05-3 appears as follows:

> *28.05-3 Individual Treatment Plan (ITP)*
>
> *A. Within thirty (30) days of initiation of services, the treatment team must develop an ITP. The ITP is based on the comprehensive assessment and is appropriate to the developmental level of the member.*
>
> *B. The ITP must contain the following:*
>
> *1. The member's diagnosis and reason for receiving the service.*
>
> *2. Specific medically necessary treatment services to be provided with methods, frequency and duration of services and designation of who will provide the service.*
>
> *3. Objectives with target dates that allow for measurement of progress toward meeting identified developmentally appropriate goals.*
>
> *4. Special accommodations needed to address barriers to provide the service.*
>
> *5. The parent or guardian and the member, if applicable, must sign and date the ITP.*
>
> *6. Be reviewed every ninety (90) days by the treatment team.*
>
> *7. If indicated, the member's needs may be reassessed and the ITP revised.*
>
> *8. The provider will provide the member with a copy of the initial and reviewed ITP within ten (10) days of signing.*
>
> *9. Discharge Plan . . .*
>
> *10. Crisis/Safety Plan . . .*

As written, § 28.05-3(B) directly addresses documentation requirements (i.e., "The ITP must contain the following . . .") applicable to the Individual Treatment Plan that is the subject of § 28.05-3(A), meaning the ITP that is developed "[w]ithin thirty (30) days of initiation of services . . . ."

Section 28.05-3(B) additionally contains syntax errors with respect to paragraphs six through nine, e.g., "The ITP must contain the following: . . . 6. Be reviewed every 90 days by the treatment team." While the latter paragraph seemingly expresses a requirement that ITP's be reviewed every 90 days, its inclusion within the Section addressing documentation requirements obscures its meaning. Must the ITP form contain a statement that the ITP is to be reviewed by the treatment team every 90 days? Must ITP 90 day reviews be documented? Must the ITP form make provisions for such documention? "Yes" as to all three? "No" as to all three? One can only guess as to what, if anything, § 28.05-3(B) requires of providers in terms of documenting ITP 90 day reviews (for which purpose, again, Respondent per both parties inexplicably does not provide a form of any kind).

Paragraph five clearly requires that ITP's be signed by parent/guardian and member (if applicable), but cannot be understood to address documentation requirements for ITP 90 day reviews given that: 1) this is not stated; and 2) § 28.05-3(B) explicitly pertains to the ITP developed within 30 days of the initiation of services. Paragraph seven states that the ITP may be revised based on the results of the ITP 90 day review, which the parties agree implies a requirement that a new ITP complying with applicable documentation requirements be completed whenever substantial revisions are necessary. The parties furthermore agree that there is otherwise no requirement that a new ITP be completed in connection with an ITP 90 day review (i.e., where substantial revisions are <u>not</u> necessary).

Paragraph eight requires that members be provided with copies of "initial and reviewed" ITP's "within ten (10) days of signing." Respondent argues that this language amounts to a requirement for parent/guardian signatures on ITP 90 day reviews, for which Claimant is responsible to create its own form. Claimant in turn argues that "reviewed" ITP's per paragraph eight actually refers to "revised" ITP's per the immediately preceding paragraph (seven).

Relative to the above, the language in question directly addresses the provider's obligation to provide members with copies of ITP's, but reflects an assumption that "initial and reviewed" ITP's are signed. The predicating language concerning signatures does not in and of itself amount to a signature requirement with respect either to ITP's or to ITP 90 day reviews; signature requirements applicable to ITP's, and inferably to "revised" ITP's (given that the latter per both parties amount to a new ITP), are stated in paragraph five. Signature requirements applicable to ITP 90 day reviews, which, again, the parties agree entail completion of a new ITP only if substantial revisions to the ITP are needed, are not expressed in paragraph five or anywhere else in the rule.

In sum, even if § 28.05-3(B) were actually intended to express a requirement that ITP 90 day reviews be documented and signed as per Respondent's proposed construction, there is simply no way of appreciating such an intent based on the language of the rule. Lacking evidence of legislative intent, that proposed by Claimant is the only permissible construction of paragraph eight in terms of the plain meaning of the rule. Consequently, the documentation maintained by Claimant with respect to ITP 90 day reviews must be considered compliant with documentation requirements of § 28.05-3(B).

CONCLUSION:

Based on the evidence presented, recordkeeping violations related to Comprehensive Assessments lacking provider signatures and 90 day ITP reviews lacking parent signatures, which together comprise the remaining recoupment amount of $580,182.12, are attributable in the case of the former to poorly-designed forms, and in the case of the latter to no forms and a poorly-written rule.

Relative to Claimant's assertion of equitable estoppel with respect to Comprehensive Assessments, the evidence supports that Claimant was induced to act based on Respondent's conduct and silence, and that Claimant's reliance thereon was both detrimental and reasonable. As discussed previously, the Comprehensive Assessment signature page makes no provision for a provider staff signature, and Respondent expressly instructed Claimant not to alter the form in any way. The evidence further supports that Respondent at some point instructed Claimant to leave blank the section entitled "Provider Use Only." No evidence was offered either to show that Claimant was at any point instructed to use the "Provider Use Only" section for provider signatures or to otherwise contradict Claimant's evidence relative to this issue. Respondent as a matter of law is estopped from asserting a right to recoupment related to unsigned Comprehensive Assessments based on this evidence.

The applicable rule does not impose any particular requirements with respect to documentation of ITP 90 day reviews. Assuming arguendo that Respondent is correct in its assertions to the contrary, the evidence supports that the purported documentation requirements were never brought to Claimant's attention previously. Individual Treatment Plan forms provided by Respondent make no provision for documenting ITP 90 day reviews, nor does Respondent provide a separate form for this purpose. In either case, the evidence and applicable rule do not support the basis for recoupment asserted by Respondent relative to unsigned ITP 90 day reviews.

Simply put, there does not appear to be a single aspect of the issues raised by Respondent with respect to recordkeeping violations that is not more or less directly attributable to Respondent. The issue of whether Claimant should be subject to recoupment is ultimately one of fundamental fairness, and the applicable rules allow the Commissioner to exercise discretion in imposing penalties. Factors relevant to this issue, per Chapter I, § 1.19-3, include, among others, seriousness of the offense(s); extent of violation(s); history of prior violation(s); prior imposition of sanction(s); prior provision of provider education; provider willingness to obey MaineCare rule; whether imposition of a lesser sanction will be sufficient to remedy the problem; and, other actions taken or recommended by peer review groups, other payors, or licensing boards. Based on the evidence presented, reversal of Respondent's action is additionally warranted from the standpoint of those considerations.

Accordingly, the Hearing Officer recommends that the Commissioner resolve this matter in favor of CLAIMANT.

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 OFFICE OF ADMINISTRATIVE HEARINGS WITHIN TWENTY (20) 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 OFFICE OF ADMINISTRATIVE HEARINGS, 11 STATE HOUSE STATION, AUGUSTA, ME 04333-0011. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER. COPIES OF WRITTEN EXCEPTIONS AND RESPONSES MUST BE PROVIDED TO ALL PARTIES.

DATED: 5-27-16

SIGNED: _____
Jeffrey P. Strickland, Esq.
Hearing Officer

cc: Jay McCloskey, Esq.
Thomas Bradley, AAG
Gregg Alexis, Bridges of Maine, LLC
James Wade, Auditor II, OMS