TO: JOHN R. NICHOLAS, COMMISSIONER
DEPARTMENT OF HEALTH and HUMAN SERVICES
STATE HOUSE STATION 11
221 STATE STREET
AUGUSTA, ME 04333

RE: Aroostook Home Health Services –
MaineCare reimbursement for
services rendered to [confidential].

ORDER OF REFERENCE HEARING RECOMMENDED DECISION

A de novo Order of Reference hearing was held in Caribou on September 30, 2004 in the case of Aroostook Home Health Services before Hugh B. Hooper, Hearing Officer. The Hearing Officer's jurisdiction was conferred by special appointment from the Commissioner, Department of Health and Human Services.

CASE BACKGROUND AND ISSUE:

Aroostook Home Health Services (hereinafter Aroostook) has been providing home care services to [confidential] since June 2002. A re-determination of [confidential] continued medical eligibility for services was due by June 23, 2003. That re-determination was completed by Aroostook staff on June 23, 2003 and Aroostook continued to provide services to [confidential]. Because [confidential] was potentially eligible for coverage under another medical insurance plan, Aroostook's monthly bills for their services were rejected by the Department. Once the issue of other insurance coverage was resolved, Aroostook re-submitted all of its unpaid bills for services to the Department for payment. In late April 2004 Aroostook was notified by the Department that the June 2003 Medical Eligibility Determination (MED) form was not in the Department's file and, that because of that, Aroostook's bills for services would not be paid. On May 11, 2004 Aroostook faxed the June 2003 MED form to the Department, and was subsequently notified that the Department would not pay for services rendered to [confidential] between June 24, 2003 and May 10, 2004 because the

MED form had not been submitted to the Department within 72 hours of completion.

On May 12, 2004 Aroostook requested an informal review of the Department's denial action. The Department's action was upheld by a June 7, 2004 Informal Review Decision. On June 16, 2004 Aroostook appealed the Informal Review Decision.

An Order of Reference was signed on July 6, 2004 instructing the Office of Administrative Hearings to conduct an administrative hearing and submit to the Commissioner written findings of fact and recommendations on the following issue:

> Was the Department correct when it denied reimbursement payment to Aroostook Home Health Services for services rendered to [confidential] from 6/23/03 through 5/10/04?

The hearing in this matter was scheduled to convene at the Caribou DHHS office at 9:00 a.m. on September 30, 2004. As reported on the Fair Hearing Report Form,[1] the Department planned to have two people – Carole Kus and Audrey Savoie – testify by telephone. Two witnesses, and counsel, for the appellant were present prior to 9:00 a.m. on September 30, 2004. This Hearing Officer placed a telephone call to the number provided by the Department at exactly 9:00 a.m. and was told by the person answering the phone that neither of the two Departmental witness were in the office that day. After seeking guidance from the Chief Administrative Hearing Officer, this Hearing Officer then, at 9:35 a.m., tried to contact James Lewis of BMS (Mr. Lewis received a copy of the Notice of Hearing) in an attempt to locate someone to represent the Department at the hearing, but was unable to reach him. Jude Walsh, Carole Kus' supervisor was then contacted by telephone at 9:40 a.m.. She advised that Ms. Kus was working out of the office that day and that she (Ms. Walsh) would contact her to arrange for her testify from her present location. Ms. Kus did contact the Hearing Officer by telephone and the hearing was convened at 9:55 a.m..

The record of this hearing was kept open until October 15, 2004 to allow Attorney Solman to submit written closing arguments. The Department declined the opportunity to submit written closing arguments. Attorney Solman's arguments have been received, made part of the record and considered**.**

APPEARING ON BEHALF OF APPELLANT:

Tanya Sleeper – Executive Director. Aroostook Home Health
Anthony Lahey – Business Manager, Aroostook Home Health
Richard Solman, Esq., their attorney

[1] See HO exhibit # 3

APPEARING ON BEHALF OF THE AGENCY:

Carole Kus, BMS Manager, Case Mix Program – by speakerphone

ITEMS INTRODUCED INTO EVIDENCE:

BY THE HEARING OFFICER:

HO 1. Copy of 7/8/04 Notice of Hearing
Ho 2. Copy of 7/6/04 Order of Reference
HO 3. Copy of 7/1/04 Hearing Report
HO 4. Copy of 5/11/04 fax cover sheet – Tanya Sleeper to Ron – Classification and Carol Cus (sic)
HO 5. Copy of 2 pages from 6/23/03 Medical Eligibility Determination Form; 1 page from 6/23/04 (sic) Medical Eligibility Determination Form; 6/24/02 Medical Eligibility Determination Form; 2/26/02 fax cover sheet – Tanya Abbott to Virginia Longley and 6/28/02 fax cover sheet – Carole Kus to Tanya Abbott
HO 6. Copy of 6/23/03 Medical Eligibility Determination Form with handwritten notes in right margin
HO 7. Copy of 5/12/04 fax cover sheet – Tanya Sleeper to Carole Kus
HO 8. Copy of 5/12/04 fax cover sheet – Carole Kus to AHHS
HO 9. Copy of 5/12/04 fax cover sheet – Carole Kus to AHHS
HO 10. Copy of 5/12/04 request for Informal Review by Aroostook Home Health
HO 11. Copy of 5/27/04 Authorization of Designee – Chris Zukas-Lessard
HO 12. Copy of 6/7/04 Informal Review Decision
HO 13. Copy of 6/16/04 hearing request
HO 14. Copy of 6/24/04 acknowledgment of hearing request – Mr. Bivins
HO 15. Copy of 7/22/04 rescheduling letter

BY THE APPELLANT:

1. Medical Eligibility Form – June 24, 2002
2. Physician Orders – June 24, 2002
3. Fax Cover Sheet – June 26, 2002
4. Medical Eligibility Form – June 23, 2003
5. Physician Orders – June 23, 2003
6. Fax Cover Sheet – May 12, 2004
7. June 2003 – April 2004 Invoices and Remits
8. Summary of Unpaid Invoices – Post 6/23/03

OTHER DOCUMENTS IN THE HEARING RECORD:

1. October 5, 2004 closing argument by Richard Solman

RECOMMENDED FINDINGS OF FACT:

1. [confidential] is [confidential] and is eligible for MaineCare services, including Private Duty Nursing and Personal Care Services as set forth in Chapter II, Section 96 of the MaineCare Benefits Manual.

2. Aroostook Home Health Services (Aroostook) is an agency authorized by the Department to provided services, including Private Duty Nursing (PDN) and Personal Care Services, to eligible MaineCare recipients.

3. Aroostook began providing PDN services to [confidential] in June 2002. His continued medical eligibility for those services was due for a re-determination by June 23, 2003.

4. The rules governing medical eligibility for PDN services require, among other things, that a particular form approved by the Department – Medical Eligibility Determination form (MED) – be used to determine program eligibility and to develop a Plan of Care for PDN recipients.

5. Aroostook completed a re-determination of [confidential] continued medical eligibility for PDN services by completing a MED form, and developed a physician approved Plan of Care based on the MED form, on June 23, 2003.

6. Aroostook faxed the June 23, 2003 MED form to the Department within 72 hours of June 23, 2003.

7. The Department has no record of the June 23, 2003 MED form being received until a copy was faxed to the Department on May 11, 2004.

8. Between June 2003 and early 2004 Aroostook was having billing problems (rejected bills) for services provided to [confidential] due to the possibility that another insurance carrier would provide coverage for the PDN services being provided to him by Aroostook.

9. After the billing problems around the third party liability issues were resolved, Aroostook re-submitted bills for services provided [confidential] after June 23, 2003. Those bills were, initially, rejected due to minor incorrect coding. Those minor coding errors were resolved and Aroostook, again, re-submitted the bills for services provided after June 23, 2003. Those bills were, again, rejected on the grounds that classification for [confidential] was missing – i.e. the June 23, 2003 assessment form was not in the Department's files.

RECOMMENDED DECISION - BASED ON EVIDENCE AND TESTIMONY PRESENTED AT HEARING:

I, respectfully, recommend that the Commissioner find that the Department's action in this matter was not correct. I, therefore, respectfully recommend that the Department's denial of payment for services provided to [confidential] by Aroostook Home Health Services between June 23, 2003 and May 10, 2004 be reversed and payment for those services (totaling $22,866.93) be made.

REASON FOR RECOMMENDED DECISION:

There is no dispute that Aroostook provided PDN services to [confidential] between June 2003 and May 2004 and that Aroostook's bills for the services provided were rejected by the Department based on the possibility that another medical insurance provider (TriCare) would cover the services being provided. That issue was resolved in early 2004 and Aroostook then submitted bills for services provided back to June 2003. It was only then that the Department notified Aroostook that it would not pay those bills because [confidential] medical eligibility re-determination, and plan of care, had not been completed when it was due in June 2003. Aroostook does not dispute that a reassessment of [confidential] medical eligibility for PDN services was due in June 2003 in order for MaineCare reimbursement for services to continue.

The only factual disputes in this matter are whether the June 23, 2003 MED form was sent to the Department within the time frame set by the rules and, if not, whether the Department can refuse payment for services provided by Aroostook for that reason.

Rules governing the PDN Program are found at Chapter II, Section 96 of the MaineCare Benefits Manual.

Section 96.01 of the rules defines the Medical Eligibility Determination (MED) Form as the form approved by the Department for medical eligibility determinations and authorization for the plan of care based upon the assessment results. Sections 96.01 and Section 96.03 (E) (3) state, in pertinent part, that for all members under age 21 the PDN provider shall conduct the medical eligibility determination.

Sections 96.03; 96.04 of the rules state that MaineCare coverage of PDN services requires prior authorization from the Department or its Assessing Services Agency (ASA). Beginning and end dates of an individual's medical eligibility determination period correspond to the beginning and end dates for MaineCare coverage of the plan of care authorized by the ASA or the Department.

Section 96.06 –1 of the rules states that an eligibility assessment, using the Department's approved MED assessment form, shall be conducted by the Department, the ASA, or the PDN provider, as applicable.

96.06-1 (E) (2) (a) of the rules states that services for members under age 21 require prior classification by the Department and that the Department shall not approve a classification period longer than one year.

Section 96.06-2 (A) of the rules states in order for the reimbursement of services to continue uninterrupted beyond the approved classification period, a reassessment, and prior authorization of services, is required and must be conducted within the timeframe of 5 days prior to, and no later than, the reclassification date. For members under the age of 21 the MED assessment tool shall be submitted to the Bureau of Medical Services, Quality Improvement Division within seventy-two (72) hours of completion of the MED form, for initial assessments or reassessments. MaineCare payment ends with the reassessment date, also known as the classification end date.

Mr. Solman argued that "…the regulations do not specify any consequence for the failure to timely submit the MED form to the Bureau".[2] That argument is not convincing in light of Section 96.06 (A) (2) of the rules. That rule clearly states that in order for reimbursement of services to continue uninterrupted beyond the classification date a reassessment, and prior authorization of services, is required and must be conducted no earlier than 5 days prior to, and no later than, the reclassification date and for MaineCare members under age 21 the MED assessment form shall be submitted to the Department within 72 hours. There is no dispute that a reassessment for [confidential] was due no later than June 23, 2003. Therefore, in order for MaineCare reimbursement for PDN services to continue, uninterrupted, a reassessment had to be completed no later than June 23, 2003 and the reassessment (MED) form had to be submitted to the Department within 72 hours of being completed. For that reason, Mr. Solman's argument fails.

Having reached the conclusion that the Department can refuse payment for services provided to [confidential] if a reassessment form was not completed by the end of his certification period, and submitted to the Department within 72 hours, a Recommended Decision in this matter comes down to whether Aroostook completed a reassessment of [confidential] continued medical eligibility for PDN services by June 23, 2003 and whether Aroostook submitted the reassessment (MED) form to the Department within the regulatory 72 hour time period.

I am convinced that Aroostook completed the required MED assessment on June 23, 2003. Tanya Sleeper is currently the Executive Director of Aroostook Home Health Agency, and was their Director of Nursing between November 1999 and

[2] See appellant's closing argument, page 3

November 2002. She has extensive medical assessment experience and does "in-house" training around assessment and billing issues. At hearing she demonstrated a thorough understanding of the rules and procedures required to ensure uninterrupted MaineCare payment for the PDN services being provided to [confidential] by Aroostook Home Health Services. Her testimony was straightforward and precise. She gave a clear picture of her agency's standard operating procedures relating to eligibility determination and billing matters. Simply stated, I found her testimony to be highly credible.

At hearing Carole Kus testified "I don't believe so but anything's possible" in response to the question from Attorney Solman: Is it possible that the June 2003 form was sent, but got lost by DHS? Ms. Kus also confirmed that, in June 2003, the Department did not send written authorization for services to providers and, although she randomly reviewed MED forms received by the Department, she did not provide acknowledgment to the provider that a MED form had been received or notify providers that a MED form had not been received when due.[3] Although not directly related to the issue at this hearing, in June 2004 the Department changed its procedures in processing assessment forms. Ms. Kus testified that she now reviews all assessment forms received by the Department and now notifies agencies, such as Aroostook, when an assessment form is received. This revised procedure is confirmed by the Department's June 7, 2004 Informal Review Decision.[4] It is not clear from the hearing evidence whether those changes are a direct result of the issues before this hearing.

Aroostook also attributes a large part of their billing problem to the Department's practice of not citing all of the errors on a claim form the first time a claim is rejected. In other words if an error exists in, for example, block 2 of a provider's claim form the claim is rejected. After that error is corrected the same claim may again be rejected if an error exists in block 5 and so on to the point that one claim may be rejected multiple times for multiple errors. That argument has merit. I conclude that it would be more reasonable, and efficient, for all of the errors to be identified the first time a claim is rejected. In other words, the complete billing form would be reviewed for accuracy when it is first received rather than to stop reviewing, and reject, the form once a billing error is discovered, perhaps requiring multiple submissions and rejections before all billing errors are identified. However, the rules do not require the Department to process claims in that manner and this Hearing Officer has no jurisdiction to mandate such a procedure to the Department.

In order to prevail in this matter the Department must support their position that Aroostook did not submit a medical reassessment form for [confidential] by the, stipulated, certification end date of June 23, 2003. The Department simply has not met that burden in this case. Based on the hearing evidence I am convinced that Aroostook completed the required reassessment form within the regulatory

[3] Also see HO exhibit # 12 – Informal Review Decision, page 1
[4] See HO exhibit # 12, page 5 (C)

time frame (on June 23, 2003) and that it is more likely than not that the reassessment form was sent to the Department within the required 72 hour time frame. Ms. Sleeper's credible testimony is given considerable weight in reaching that conclusion. For that reason I, respectfully, recommend that the Department's denial of payment for services provided to [confidential] between June 23, 2003 and May 10, 2004 by Aroostook Home Health Services be reversed and payment for those services be made.

MANUAL CITATIONS:

MaineCare Benefits Manual Sections: 96.01; 96.03; 96.04 & 96.06

RIGHT TO FILE RESPONSES AND EXCEPTIONS:

THE PARTIES MAY FILE WRITTEN RESPONSES AND EXCEPTIONS TO THE ABOVE RECOMMENDATIONS WITHIN 20 DAYS OF RECEIPT OF THIS RECOMMENDED DECISION. THIS TIME FRAME MAY BE ADJUSTED BY AGREEMENT OF THE PARTIES. RESPONSES AND EXCEPTIONS SHOULD BE FILED WITH THE OFFICE OF ADMINISTRATIVE HEARINGS, STATE HOUSE STATION # 11, AUGUSTA, ME 04333-0011. THE COMMISSIONER WILL MAKE THE FINAL DECISION IN THIS MATTER.

SIGNED:

Hugh B. Hooper
Hearing Officer

DATE: 11/8/04

pc: Anthony Lahey, Aroostook Home Health Services, 22 Birdseye Avenue, Caribou, ME 04736
Richard D. Solman, Attorney at Law, Solman & Hunter, P.A., 709 Main Street, P.O. Box 665, Caribou, ME 04736
Carole Kus, BMS
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