BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGSON REFERRAL BY THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:)
)
EBEN-EZER HOMECARE, LLC) OAH No. 13-1605-MDA
)

DECISION

I. Introduction

A. Summary

This is an appeal under 7 AAC 160.130 of the findings of a Medicaid provider audit. Eben-Ezer Homecare, LLC (which sometimes does business as Eben-Ezer Home Health Care) offers personal care assistant (PCA) services to elderly and disabled Alaskans who are on Medicaid. The Department of Health and Social Services' Program Integrity Unit (Program Integrity) audited Eben-Ezer's billings to the program for the calendar year 2010, during which Eben-Ezer submitted 677 claims[1] and received $277,586.29 from the program. Based on this audit, Program Integrity contends that the department was overcharged by $252,364.73, and it has demanded reimbursement in that amount.[2]

Program Integrity arrived at this figure through a process of statistical sampling and extrapolation in which 57 randomly-selected claims were evaluated. The auditor disallowed all 57 claims in their entirety on the basis of failure to document that the services were rendered as billed and, in some cases, for the additional reason of failure to document medical necessity. The department's extrapolation technique translated this 100 percent failure rate into disallowance of about 91 percent of the overall population of claims for calendar 2010.[3]

In the present case, the audit methodology is not in dispute. Eben-Ezer argues, however, that on both issues—documentation of services rendered and documentation of medical necessity—the materials it submitted ought to be deemed sufficient. This decision agrees with Eben-Ezer on the latter issue, but finds against Eben-Ezer on the former. Eben-Ezer has also raised an estoppel defense, but has failed to establish the elements of that defense. Since the

[1] This figure apparently excludes some Medicare cross-over claims, which were not part of the audit. R. 71.
[2] R. 62-63.
[3] This technique, which is discussed in *In re C Care Services LLC*, OAH No. 11-0015-DHS (Commissioner of Health & Soc. Serv. 2012) (http://aws.state.ak.us/officeofadminhearings/Documents/MDA/DHS110015.pdf), is relatively favorable to providers. This is presumably why a 100 percent failure rate within the sample can result in less than 100 percent reimbursement from the claim population as a whole.

failure to document services rendered is a fundamental defect that encompasses all claims in the audit sample, this decision upholds the results of the audit.

B. Procedural History

The audit began on February 14, 2013.[4] Eben-Ezer was provided with preliminary audit findings on July 24, 2013. It was given an opportunity to respond. After Eben-Ezer did so[5] and the auditors responded to this new material,[6] Program Integrity issued its final adverse determination on September 30, 2013.[7] Thirty days later, Eben-Ezer exercised its right to request a formal administrative hearing.[8] With its appeal letter, it submitted additional signed statements regarding the services rendered by various PCAs.[9] The auditors responded to this second round of new material on November 21, 2013, standing by their original findings.[10] The case was referred to the Office of Administrative Hearings the same month.

After a series of agreed-upon delays for settlement discussions and scheduling difficulties, the case went to hearing on July 14, 2014. Eben-Ezer did not appear and the appeal was noticed for dismissal. However, Eben-Ezer requested a hearing on the proposed dismissal and was able to show good cause for failing to appear. A full hearing on the merits took place on October 20, 2014.

At the hearing, the numbered agency record was admitted in its entirety without objection. Neither party offered any other exhibits. Eben-Ezer presented testimony from its owner, Angeles Dean, as well as from its current office administrator, Luz Cruz. It is important to note that Ms. Cruz was not the administrator at the time of the documentation problems at issue, but she did a good job of articulating Eben-Ezer's position and explaining the gaps she found in the company's records when she took over from the prior administrator. Program Integrity supplied testimony from its auditor and from a quality assurance manager. Following the November hearing, issuance of a decision in this case was further delayed by the need for the administrative law judge to attend to a large volume of critical case referrals from the Medicaid program in late 2014.

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[4] R. 214-233.
[5] R. 853.
[6] R. 10-16.
[7] R. 62.
[8] R. 8.
[9] R. 45-55.
[10] R. 3-6.

In prehearing proceedings, Program Integrity accepted the burden of proof to show that Eben-Ezer failed to meet the program's documentation requirements.[11]

II. Documentation of Services Rendered

The 57 claims in the audit sample are numbered D548001 to D548057. For ease of reference in this decision, they will simply be referred to as claims 1 through 57. The documentation from Eben-Ezer's files in support of these claims is found, in claim order, at pages 236 to 657 of the Agency Record. Supplemental certificates, prepared and submitted in 2013 and purporting to cover all 57 claims, are found at pages 45 to 55 of the record.

The central issue in this case, applicable to all 57 claims, is the allegation that Eben-Ezer has been unable to provide the required documentation to show that it rendered the services for which it billed. However, the calendar year that was audited—2010—coincided with a regulations update in which the particular regulations governing documentation were changed. The update took effect on February 1, 2010. It will therefore be necessary to analyze this issue separately for the claims that fall before and after that date. Since the issue is most straightforward for the post-February 1 claims, those will be examined first.

A. Claims for Services Between February 1 and December 31, 2010

1. Required Documentation

PCA services are billed and reimbursed on the basis of time. When the service level for a year is approved, the agency establishes which activities need assistance (*e.g.,* bathing, toileting, main meal preparation, etc.) and how many times per week the assistance is needed. An aggregate weekly authorized time is then calculated using a set number of minutes per iteration of each activity. Notably, while assistance with a given item might be given a certain number of minutes per instance in calculating weekly time (such as 25 minutes per preparation of a main meal, essentially an average used for calculating the anticipated weekly aggregate), Medicaid does not reimburse time per individual activity. Rather, it reimburses the up to the weekly number of hours allowed, provided the services are being performed and the hours are actually being spent over the course of the week. In other words, there is no need to document that 13 minutes were spent preparing Monday's dinner and 37 minutes preparing Tuesday's; what

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[11] *See* Scheduling Order, Part I (March 3, 2014). The burden to establish any affirmative defenses remained with Eben-Ezer.

Medicaid cares about is that the authorized services are being performed, that the time billed is within the authorized weekly limit, and that the PCA is actually present for the time billed.

Beginning February 1, 2010, a provider billing for such time-based services was required to "maintain a clinical record" recording "start and stop times."[12] Moreover, there was a very specific regulation addressed to the recordkeeping responsibility of PCAs. It provided that "a personal care assistant shall maintain a contemporaneous service record for Medicaid billing [including] (4) a time sheet recording the date, time, and length of each visit and the services provided during each visit . . . ."[13]

These records must be retained for seven years,[14] and if the provider is unable to produce them upon demand, the agency "may deny payment or may initiate a recoupment."[15]

2. Eben-Ezer's Documentation

For several of the 54 sampled claims from the February-December period, Eben-Ezer did not have anything that might be construed as a time sheet in its files.[16] For most claims, however, Eben-Ezer submitted one document, of a certain type, as its time record. Document R. 238, attached in redacted form to this decision as Exhibit A, was acknowledged at the hearing to be a representative example of these time records.[17] It was the time record provided for claim 1.

R. 238, like the others of its type, is a preprinted form listing all of the activities for which PCA assistance can be approved and supplying 16 blank columns next to that list. At the top, someone has entered all of the dates in a half-month pay period; in the case of R. 238, that was only 15 days, and dates have been entered from 3/1 to 3/15. Below each date, a number has been entered next to each activity that was authorized for that patient, corresponding to a number of minutes. For daily activities, an identical number is entered for each day. Thus, exactly 24 minutes has been entered for "Dressing" on all 15 days. The minutes are neatly and uniformly written across the page, all in the same manner and with the same pen, such that it is almost

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[12] 7 AAC 105.230(d)(5) (eff. 2/1/2010).

[13] 7 AAC 125.120(a) (eff. 2/1/2010, Reg. 193). This regulation was further amended in 2012, although the language important to Part II of this case did not change.

[14] 7 AAC 105.230(e).

[15] 7 AAC 105.240(d).

[16] Testimony of T. Allan Hansen (audit manager). Mr. Hansen testified that there were five such claims across the whole sample. However, his firm's report may understate the number of such claims. For example, there seems to be no time sheet of any kind in the 2010 records corresponding to claim 40, an 11/2/2010 service for patient L.E. (the records for this claim are at R. 558-559, and the nearest corresponding "time sheet" is at R. 554, covering no dates after 10/31/10). However, Myers & Stauffer did not make a finding that there was no sheet at all for claim 40. *See* R. 91.

[17] The one exception to this pattern was R. 436, on which the PCA had made check marks next to services performed rather than entering numbers. This is not a material difference for purposes of the holdings that follow.

inconceivable that they were not all written on the sheet at the same time. A PCA, Lorena H., has signed the sheet, certifying that she "worked the hours recorded." There are no start and stop times provided for any shifts that she worked.

Although R.238 is unique, it is notable that many of the other sheets of this type have been filled out using a photocopier. Thus, a close examination shows that every single one of the dozens of minute entries on R. 242 (April 16-30) is perfectly identical in form to every single one of the numbers on R. 245 (June 1-15), R. 248 (June 16-30), and R. 254 (October 16-30). Likewise, the minute entries and even the clinical notes on R. 486 (December 1-15) are simply photocopies of those on R. 485 (November 16-30), or vice versa.[18]

R. 238 and the other documents of its type do not correspond to Eben-Ezer's billings. Thus, R. 238 indicates that 259 minutes (4 hours, 19 minutes) were worked on March 6, 2010. However, Eben-Ezer billed for 20 units (5 hours) of PCA services for that date.[19] Conversely, time is shown on March 7, but there is no billing for that date. The only apparent correlation between R. 238 and anything in the real world is that the total number of minutes per week adds up to the total number authorized for that patient per week.[20]

After the preliminary and final audit reports had been issued and Program Integrity had made its formal repayment demand, Eben-Ezer submitted, with its administrative appeal request, a set of certifications purporting to document the time actually worked by the PCAs.[21] The representative example of these certifications used at hearing was R. 45, intended to correspond, like R. 238, to claim 1. R. 45 claims that Lorena H. provided PCA services from 4:00 p.m. to 9:30 p.m. (five-and-a-half hours) "6 days per week" in 2010. It does not say which days, or indicate that any days or hours might have been missed across the span of the whole year. This document does not agree with the other documents in the record. For March 6, R. 238 claimed 4 hours and 19 minutes worked, whereas R.45 suggests five hours and 30 minutes (unless March 6 was a day off). Eben-Ezer's billing claimed five hours and zero minutes for March 6.[22] The certification is dated October 31, 2013, and is signed by an unidentified client representative and Luz Cruz. Ms. Cruz was the office administrator for Eben-Ezer in 2013, but she did not work for the company in 2010. She had no firsthand knowledge of anything that happened that year, and

[18] The signatures on R. 486 are also photocopies.
[19] R. 239, top line; Hansen testimony.
[20] Hansen testimony.
[21] R. 45-55.
[22] R. 243.

admitted that she could not say how many units of PCA services were rendered to the patient in claim 1 on March 6, 2010 or any other particular date.[23]

3. Audit Finding Sustained

PCA services are time-based services, reimbursed (up to a set maximum) per hour of services actually rendered. Insofar as Eben-Ezer had any records at all, the records it submitted in support of these time-based billing claims fell below the required level of documentation in the following respects:

-- They did not record "start and stop times" for the shifts claimed, as required by 7 AAC 105.230(d)(5).

-- They were not true "clinical records," as required by 7 AAC 105.230(d), in that they were pre-filled or filled by photocopier to show uniform numbers of minutes intended to add up to the weekly maximum, not minutes that had necessarily been spent on the day to which they were attributed.

-- They were not "time sheet[s] recording the date, time, and length of each visit and the services provided during each visit," as required by 7 AAC 125.120(a). They did not record the date of any actual visit, the time of that visit, or the length of that visit. They recorded, instead, what someone thought was authorized.

The supplemental certifications provided in 2013 do not repair this deficiency. They were not "contemporaneous service record[s]" as required by 7 AAC 125.120(a), and they did not record the date of any actual visit. Moreover, they were not true clinical records, having been prepared years later by a person with no knowledge of whether the shifts billed were actually worked. They conflicted with other materials submitted and were wholly without credibility. As blanket claims purporting to encompass 312 workdays in a single sentence, they were not "time sheet[s]" and they did not show "the services provided during each visit."[24]

It is well settled in the area of Medicaid billing that payment will be denied if the required documentation has not been maintained. This is so even if one might be able to infer that it is more likely than not that the services billed, or at least some services, were actually rendered. This principle is fully explored in the in *In re Alaska Children's Services, Inc.,*[25] a recent decision of the Commissioner of Health and Social Services recouping funds from a

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[23] Testimony of Luz Cruz.

[24] Some of them had additional deficiencies. 7 AAC 125.120(a)(5) required every time sheet to have "the signature or legal mark of the recipient or the recipient's legal representative . . . verifying that services were provided as reported." There is no such signature on R. 46 (claim 8), R. 48 (claims 10-15), R. 49 (claims 16-17), R. 50 (claims 18-23), and R. 55 (claims 53-57).

[25] OAH No. 13-0182-MDA (2014) (published at http://aws.state.ak.us/officeofadminhearings/Documents/MDA/MDA130182.pdf).

conscientious provider on the basis of substandard documentation, even though most, and perhaps all, of the claimed services had probably been performed.

The single potential exception to this principle is where failure to comply with some nuance of a documentation requirement is "so insubstantial that the department must consider the records complete."[26] This is far from true in the present case. The point of the documentation requirements is to allow the department to audit individual claims and cross-check them against other information that may be available. In the case of PCA services, for example, the combination of a vulnerable clientele and a lack of close supervision creates significant opportunities for fraud. By requiring providers to specify *exactly when* they were with the client, the department can check a particular claim against observations of the provider in other locations, or shifts worked on other jobs. This helps to pin down malefactors, who might otherwise be able to answer any challenge by claiming, after the fact, that they simply worked different hours. Moreover, by making enforcement possible, it deters misconduct in the first place. Thus, the department's interest in requiring specific and real time records is substantial. Eben-Ezer's failure to maintain them was so pervasive that, if tolerated, it would eviscerate the documentation requirement.

B. Claims for Services Between January 1 and January 31, 2010

Three claims in the audit samples—claims 9, 18, and 53—come from January 2010, when a prior set of regulations was in effect.

1. Required Documentation

For a number of years prior February 1, 2010, the regulations covering provider billing were slightly different from those that took effect on that date. Under the earlier regulatory framework, a provider was required to keep a record of "the specific services provided; . . . extent of each service provided; [and] date on which each service is provided."[27] There was a further requirement for PCAs that, like the successor regulation, provided that "a personal care assistant shall maintain a contemporaneous service record for Medicaid billing [including] (4) a time sheet recording the date, time, and length of each visit and the services provided during each visit . . . ."[28] The main difference between the earlier regulations and the current ones is

[26] *Alaska Children's Services,* Decision at 11.
[27] Former 7 AAC 43.030(b).
[28] Former 7 AAC 775(a).

that the former lacked the very specific requirement for "start and stop times" in support of time-based billings.

As is the case under the more recent regulations, service records had to be retained for seven years.[29] If the provider was unable to produce them upon demand, the agency could "deny payment or . . . initiate a recoupment."[30] Thus, providers under the old regulations were on notice, as are current providers, that maintaining correct documentation was critical to obtaining or retaining payment for the services.

2. Eben-Ezer's Documentation

For claim 18, Eben-Ezer submitted no contemporaneous record at all purporting to be a time sheet.[31] For claim 9, a time sheet was submitted fitting, in all relevant respects, the pattern of R. 238, the example discussed above.[32] The same is essentially true of claim 53.[33]

3. Audit Finding Sustained

For the two January claims for which Eben-Ezer had any records at all, the records it submitted in support of these time-based billing claims fell below the required level of documentation in the following respects:

-- They were not true "clinical records," as required by former 7 AAC 43.030(b), in that they were pre-filled to show uniform numbers of minutes intended to add up to the weekly maximum, not minutes that had necessarily been spent on the day to which they were attributed.

-- They were not "time sheet[s] recording the date, time, and length of each visit and the services provided during each visit," as required by former 7 AAC 43.77520(a). They did not record the date of any actual visit, the time of that visit, or the length of that visit. They recorded, instead, what someone thought was authorized.

The supplemental certifications provided in 2013 do not repair this deficiency. They were not "contemporaneous service record[s]" as required by former 7 AAC 43.775(a), and they did not record the date of any actual visit. Moreover, they were not true clinical records, having been prepared years later by a person with no knowledge of whether the shifts billed were actually worked. They conflict with other materials submitted and were wholly without

[29] Former 7 AAC 43.030(e).
[30] Former 7 AAC 43.032(d).
[31] R. 429-435.
[32] R. 302.
[33] R. 643. There is one quirk to the "time sheet" submitted for claim 53: unlike most other records of this pattern, it does not list time for every single day of the half-month; instead, January 29 and 30 are crossed out. However, Eben-Ezer billed time for January 29. R. 644. Thus, this single departure from the usual pattern simply confirms the complete lack of connection between the purported time sheets and the billing for services.

credibility. As blanket claims purporting to encompass 312 workdays in a single sentence, they were not "time sheet[s]" and they did not show "the services provided during each visit." Finally, the one provided for claim 18 lacked a signature of the recipient or the recipient's legal representative, which was required under former 7 AAC 43.775(a)(5).[34]

For the reasons explained in Part II-A, these deficiencies are not insubstantial and the audit finding must be sustained.

C. Estoppel Defense

At the hearing, Eben-Ezer argued that even if its documentation of PCA time was inadequate under the regulations as they are interpreted now, the department cannot rely on that basis to deny payment because the department had approved Eben-Ezer's method of documentation. In making this argument, Eben-Ezer is tapping into an escape valve that can, in some cases, excuse noncompliance with regulations.

Under certain circumstances, the Medicaid regulations cannot be strictly applied because of the doctrine of equitable estoppel. In order to prevail on this theory, the citizen must prove each one of four separate elements:

> [E]stoppel may apply against the government and in favor of a private party if four elements are present: (1) the governmental body asserts a position by conduct or words; (2) the private party acts in reasonable reliance thereon; (3) the private party suffers resulting prejudice; and (4) the estoppel serves the interest of justice so as to limit public injury.[35]

When these four elements are met, the government may be estopped or partially estopped (that is, limited or prevented) from applying a restriction as written. For example, in *In re M.B.,*[36] a case decided by the Department of Health and Social Services in 2012, an eligibility technician inadvertently misled a Medicaid applicant into putting too little money into her Medicaid Qualifying Income Trust. The agency was found to be estopped from denying Medicaid coverage for that individual for the period when the trust was underfunded as a result of the error.

Eben-Ezer points out that it had to be recertified as a PCA agency every two years. It claims that when it was recertified just prior to 2010, it submitted a blank copy of its "time

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[34] R. 50. A note on this document indicates that the client was unreachable in 2013 because she had moved out of state. This problem would not occur, of course, if the record were maintained contemporaneously, as the regulations require.

[35] *Crum v. Stalnaker*, 936 P.2d 1254, 1256 (Alaska 1997).

[36] Case No. 11-FH-496 (Office of Hearings & Appeals 2012).

sheet" as part of the recertification package, and the department recertified Eben-Ezer without objecting to that sample document.[37]

This line of argument fails to establish the first element of estoppel, for a number of reasons. First, Eben-Ezer does not have a copy of its pre-2010 recertification application, and so it is impossible to verify what that application may have contained and in what context it may have been presented.[38] Second, the evidence is uncontroverted that time sheet format is not ordinarily one of the items reviewed in the recertification process.[39] Eben-Ezer submitted, by its own account, "a huge binder,"[40] and a superfluous document could easily be ignored. Moreover, if presented in blank with nothing filled in, it might not be obvious that a document like R. 238 was a timesheet at all or, if it was, that it could not be adapted through handwritten entries to provide all of the required shift information, at least for one day. Finally, even if Eben-Ezer could establish that, in 2008 or 2009, the department looked at and understood the time sheet and specifically approved it, that approval would relate only to the regulations in effect at the time—the pre-February 1, 2010 regulations. Once a new regulation came into effect in early 2010 specifically requiring "start and stop times," any prior endorsement of a timesheet without those times would be superseded.

For these reasons, the estoppel defense has not been established.

III. Documentation of Medical Necessity

Department regulations, both before and after the February 1, 2010 revision, required all PCA services to be performed in accordance with two key department documents: the Consumer Assessment Tool (CAT), under which the patient's needs have been assessed by a department nurse, and the PCAT[41] Authorized Service Plan, under which the hours of authorized PCA services were calculated based primarily on the needs determined in the CAT.[42] The PCAT Authorized Service Plan showed the services that were supposed to be performed by the PCA in the allotted hours, but did not show all of the underlying findings on the nurse-assessor that went into development of the plan.

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[37] Testimony of Luz Cruz and Angeles Dean.

[38] Dean testimony (admitting she does not have the application). The application might be in department files, but Eben-Ezer did not try to obtain it for the hearing.

[39] Keilman-Cruz testimony.

[40] Luz Cruz testimony (recording at 2:45:20).

[41] Though not defined in the regulation, PCAT stands for Personal Care Assessment Tool. *See* http://dhss.alaska.gov/dsds/Documents/docs/cat-pcatOnlineFlyer.pdf.

[42] Former 7 AAC 125.020(a) (2010-2012 version, Reg. 193); former 7 AAC 43.751(a).

With regard to recordkeeping, the regulations (both before and after the 2010 revision) expressly required the PCA to keep the PCAT Service Plan (only) as part of the contemporaneous service record "for Medicaid billing."[43] There was no regulatory requirement for the PCA to have the underlying CAT, an omission that was presumably deliberate.[44]

For 25 of the 57 claims in the sample, the auditors nonetheless found that, because Eben-Ezer could not provide the CAT, the claims must be disallowed.[45] This formed a second, independent basis for denying those 25 claims, supplementing the time sheet issues discussed above.

At least in formal findings, the auditors did not directly fault Eben-Ezer for not having the CAT *in its files*. Indeed, it seems to have been the department's longstanding practice, when PCA providers are audited, to allow the providers to obtain the CAT from the department's own files at the time of audit, and then pass it on to the auditors.[46] In this case, Eben-Ezer was able to obtain copies of the relevant CAT from the department for 32 of the audited claims, but not for the other 25.[47] The basis for the adverse finding on those 25 claims was that, without the CAT, Eben-Ezer could not fully support the medical necessity of the PCA services it provided.

It is not possible to sustain this audit finding. The CAT is a department document which the department is supposed to maintain. The regulations clearly exclude it from the documents the PCA provider is supposed to maintain for billing. One cannot deny a provider an otherwise proper claim for payment simply because the department has lost a record the department created and was supposed to maintain.

This is not to say that the CAT and medical necessity could not, in other circumstances, form the basis for denial of a PCA claim. For example, if Program Integrity were able to show

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[43] Former 7 AAC 125.120(a)(3) (2010-2012 version, Reg. 193); former 7 AAC 43.775(a)(3). In the most recent version of 7 AAC 125.120(a)(3), which became effective in 2012, the PCA must retain the "personal care service level authorization," but there is still no requirement to retain the CAT "for Medicaid billing" purposes.

[44] When it wants to do so, the department has had no difficulty listing both documents in regulatory requirements. *See*, e.g., former 7 AAC 125.020(a)(1) and (2) (2010-2012 version, Reg. 193). When it listed one, and not the other, in the 2010-2012 version of 7 AAC 125.120(a)(3) and in former 7 AAC 43.775(a)(3), it is almost inconceivable that the department was simply forgetting one of the documents. More likely, the drafters felt that CAT, which is bulky and very difficult to read and which does not, itself, authorize any services, was not a record providers needed to have on hand for billing support.

[45] *See* R. 13-14 (describing final, amended audit finding on this issue).

[46] Hansen testimony (recording at 1:20:00ff.); Testimony of Lynne Keilman-Cruz, Chief of Quality, Division of Senior and Disabilities Services (recording at 2:05:00ff). Ms. Keilman-Cruz indicated that this is partly because, in the period just before the audit window in this case, the department was far behind in sending the CAT documents to PCA agencies.

[47] Testimony of Luz Cruz (recording at 2:18:30).

that PCA services were rendered in a manner inconsistent with the CAT for that patient, that showing could be a basis for denial. There is no such showing here.

Because the medical necessity issue was simply a supplemental basis for disallowing 25 of the sampled claims, and the underlying failure to document the services in the first place remains as a fundamental flaw for all 57 claims, the decision not to sustain the medical necessity finding does not alter the outcome of the case as a whole.

IV. Conclusion

The audit's disallowance of all 57 sampled claims has been sustained for inadequate documentation of services rendered. Eben-Ezer has not challenged the extrapolation of the sample to the entire population of 677 claims submitted in 2010. Accordingly, the Division has shown that, more likely than not, Eben-Ezer Homecare, LLC submitted at least $252,364.73 in overbillings in 2010. The Department of Health and Social Services may recoup $252,364.73 from Eben-Ezer Homecare, LLC.

DATED this 15th day of June, 2015.

By: *Signed*
Christopher Kennedy
Administrative Law Judge

Adoption

The undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 16th day of July, 2015.

By: *Signed*
Signature
Jared Kosin
Name
Executive Director ORR, DHSS
Title

[This document has been modified to conform to the technical standards for publication.]