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

In the Matter of:	)	
	)	OAH No. 17-0481-MDA
A. CARE COORDINATION	)	
	)	

FINAL DECISION

A proposed decision was issued in this case on December 4, 2017. The Department of Health and Social Services, Medicaid Program Integrity Unit (Program Integrity) submitted a proposal for action objecting to a portion of the proposed decision. After consideration of that proposal for action, the undersigned, by delegation from the Commissioner of Health and Social Services and in accordance with AS 44.64.060(e)(5), rejects, modifies, or amends the interpretation or application of a statute or regulation in the decision as follows and for these reasons.

Regulation 7 AAC 130.240(c)(4) requires that a Medicaid Care Coordinator have a minimum of two contacts per month with a Medicaid recipient or his/her legal representative, one of which muse be in-person.[1] The proposed decision directs Program Integrity to allow Claims D129003, D 129008, and D129032 based upon an interpretation of the applicable regulation 7 AAC 130.240(c), which would allow a Medicaid Care Coordinator to fulfill the regulatory requirement, for the contact which is not required to be in-person, by leaving a voicemail message (Claim D129003), sending an email (Claim D129032), or by cursory telephonic contact with the representative stating he would call the Care Coordinator back, but with no indication that he did so (Claim 129008). That interpretation is rejected. The regulation contemplates a meaningful contact with a Medicaid recipient or his/her legal representative. Merely leaving a message, sending an email, or an agreement for a follow-up conversation, without any record that there was a response is insufficient. Accordingly, the proposed decision is revised as follows: Claims D129003, D129008, and D129032 are disallowed in their entirety.

The remainder of the proposed decision is unchanged.

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[1] The regulations referred to in the decision are those in effect during calendar year 2012, the time period for the audit that gave rise to this action. The current version of the regulation requiring two monthly contacts is located at 7 AAC 130.240(b)(2)(A).

Notice of Appeal Rights

Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 11th day of January, 2018.

By: *Signed*
Deborah L. Erickson, Project Coordinator
Office of the Commissioner
Department of Health and Social Services

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

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[PARTIALLY REJECTED PROPOSED] DECISION

I. Introduction

Alexandria Miles is the owner and operator of a Medicaid provider known as A. Care Coordination that provided Medicaid Care Coordination services to Medicaid-eligible persons. The Department of Health and Social Services, Medicaid Program Integrity Unit (Program Integrity) audited Ms. Miles's Medicaid billings for calendar year 2012 to determine if she had been overpaid by the Medicaid program.

The audits were performed on a random sample, consisting of 65 of Ms. Miles's billing claims. The results of the audited sample were then statistically extrapolated to arrive at a total figure. The audit identified a total overpayment of $58,692.64.[2] The evidence in this case shows that Ms. Miles was able to produce documentation supporting her billings on Claims D129003, D129008, and D129032.[3] Accordingly, these claims should be allowed. However, the disallowance of the remaining claims is upheld, because Ms. Miles was not credible when she testified that the supporting documents for the remaining claims were destroyed in a flood. Program Integrity is to recalculate the amount of Ms. Miles's obligation after allowance of Claims D129003, D129008, and D129032.

II. Procedural Background

Following an audit of Ms. Miles's Medicaid billings for calendar year 2012, Program Integrity notified Ms. Miles that she had been overpaid a total of $68,110.09 by the Medicaid program, and that she was required to repay that amount. The repayment amount was based upon its review of 65 sampled billing claims. Ms. Miles requested a hearing to challenge the

[2] The audit initially found an overpayment of $68,110.09. On October 31, 2017, Program Integrity revised the overpayment findings to reduce the amount, based upon it having information in its possession that allowed it to eliminate overpayment findings based upon six of the sampled claims. *See* Notice of Revised Overpayment Findings, dated October 31, 2017.

[3] The claim numbers, D129001 etc., are the numbers used by M & S as its desk reference numbers. *See* Administrative Record (AR) 85 – 87. All references to billing claims in this decision use the desk reference numbers for the sake of consistency.

repayment requirement. That hearing began July 27, 2017. While this case was in the hearing process, the Division reviewed its documents and allowed six of the claims which had been previously disallowed (Claims D129001, D129014, D129028, D129040, D129044, and D129052); this resulted in a revised overpayment amount of $58,692.64.[4] The hearing resumed on November 3, 2017.

Ms. Miles represented herself and testified on her own behalf. Program Integrity was represented by Assistant Attorney General Scott Friend. T. Allen Hansen, who is one of the principals of Myers and Stauffer, LLC, the accounting firm which performed the audit, testified on behalf of Program Integrity. Suzanne Phelps, an audit analyst with Program Integrity, and Douglas Jones, the manager for Program Integrity, also testified.

III. Facts[5]

Alexandria Miles, who did business as A. Care Coordination, a sole proprietorship, was a care coordinator for Alaska Medicaid recipients in calendar year 2012. She submitted a total of 288 claims for her care coordination services to the Alaska Medicaid program during that year, for which she was paid $68,982.37.[6]

On May 4, 2016, Program Integrity sent Ms. Miles a letter informing her that her business had been selected for an audit of its 2012 Medicaid billings. That letter further informed her that the audit would be conducted by Myers & Stauffer, LLC (M & S). Ms. Miles was contemporaneously notified by M & S that it had randomly selected 65 of the 2012 Medicaid claims for the audit, and that she was required to provide copies of her supporting documentation for these claims.[7]

Ms. Miles was closing her care coordination business down in the spring/summer of 2016. Her father had recently passed away and her mother had been diagnosed with breast cancer. She was in the process of moving out of Alaska to be closer to her mother. She had her house up for sale. She testified that she had moved her Medicaid records out of her home office into the utility closet located on the ground floor of her home, both to tidy up the home for showing to prospective buyers, and to make sure that they would not have access to her clients' protected health information. The utility closet contained her boiler. She testified that she left

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4 *See* Notice of Revised Overpayment Findings, dated October 31, 2017.
5 The following facts were established by a preponderance of the evidence.
6 AR 132.
7 AR 78 – 93.

home at approximately 8:00 a.m. the morning of May 9, 2016, and that when she returned home at approximately 10:30 a.m., she had a boiler leak with high pressure water coming up from below. She called a plumber.[8] The plumber's invoice shows that he was called at 10:15 a.m. The plumber completed working on the boiler at 11:45 a.m., and billed Ms. Miles a total of $350.50: $80.50 for parts and $270 for labor. The invoice reads that there was a leaking boiler, the problem was diagnosed as a bad expansion tank, and that the tank and boiler relief valve were replaced.[9]

Ms. Miles testified that the utility closet, hall, and home office were flooded, that there was water coming like a "fire hose" from the well, and that there was an inch to an inch and one-half of standing water in the utility room, which completely soaked and ruined the bottom part of her Medicaid billing documents, as they were stacked on the floor. The ruined and illegible records included her 2012 documents; they were not salvageable, and she destroyed them. She believes the leak occurred the same day she found out about the audit. The damage was limited to her paperwork and the carpeting, and she did not hire anyone to help her with cleanup or repairs. She knew the records were destroyed the same day the leak occurred.[10]

Ms. Miles contacted and spoke to Ms. Stockburger with Program Integrity on May 9, 2016. In that conversation, Ms. Miles requested an extension on responding to the audit because she "received notice today that her mom is in the final stages of an illness."[11] Ms. Miles acknowledged that she probably did not mention the flooding to Ms. Stockburger, which she attributed to her being disconcerted over her father's recent death, her mother's illness, and needing to move.[12] On May 11, 2016, Ms. Miles contacted Mr. Hansen with M & S asking for an extension in responding to the audit, where she referred to the boiler leak damaging some of her documents.[13]

Ms. Miles only kept paper copies of her records. She billed for her visits/contacts with her clients on a monthly basis, and did not bill based upon each individual contact. She was the only one who kept a copy of her documents.[14]

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8 Ms. Miles's testimony.
9 AR 4.
10 Ms. Miles's testimony.
11 Ex. 14, p. 1 (May 9, 2016 5:03 p.m. e-mail from Ms. Stockburger to Mr. Hansen).
12 Ms. Miles's testimony.
13 Ex. 14, pp. 2 – 3.
14 Ms. Miles's testimony.

Ms. Miles provided M & S with a very limited response to its request for documentary support for the 65 sample claims on July 1, 2016.[15] That response contained a copy of a financial statement audit, not a Medicaid audit, performed on her company by BDO for calendar year 2012. The BDO financial statement audit documents provided by Ms. Miles contained 16 pages of "contact document" forms hand-filled out by Ms. Miles, reflecting contacts with various clients in 2012.[16]

M & S issued its preliminary findings on November 16, 2016, which were provided to Ms. Miles. Ms. Miles was given an opportunity to provide additional documentation or comments in response to those findings.[17] She did not.[18] M & S issued its final report on January 30, 2017, a copy of which was sent to Ms. Miles on February 3, 2017.[19] It found that Ms. Miles failed to provide any documentation to support her billings for the two contacts required to be made each month with her Medicaid clients. In addition, M & S found that the additional documentation that Ms. Miles supplied with regard to five of the billing claims did not support her billings.

M & S found that the 16 pages of "contact document" forms contained in the BDO documents supplied by Ms. Miles pertained to Claims D129003, D129008, D129028, D129032, and D129062. M & S initially found that while the provided documentation showed one of the required monthly contacts with regard to each of these claims, it did not demonstrate that she made the second required monthly contact. Claim D129028 was one of the claims subsequently allowed by Program Integrity. This left four claims, for which documentation was provided by Ms. Miles, which M & S disallowed. With regard to Claims D129003, D129008, and D129032, M & S disallowed these claims because it found that the submitted documents showed one face-to-face contact was made with the respective client, and that a telephone message was left for either the client or his/her representative. However, there was nothing showing an actual second contact occurred.[20] With regard to Claim D129062, M & S disallowed this claim because, while there was documentation of both a face-to-face contact and a subsequent contact, this

15 AR 142.
16 AR 176 – 191.
17 AR 69 – 76.
18 AR 132.
19 The entire report, which includes preliminary analysis and findings, is located at AR 51 – 141.
20 AR 130 – 131.

documentation was undated; it was not possible to determine whether Ms. Miles had the second monthly contact with the client.[21]

M & S then cited to Alaska Medicaid regulation 7 AAC 130.240(c)(4), which requires that a Medicaid care coordinator must have a minimum of two contacts each month with his/her client, and that one of those contacts must be a face-to-face contact. M & S then disallowed each of these four claims because Ms. Miles did not maintain records supporting her billings for services, as required by 7 AAC 105.230(a) and (b), and did not provide them upon request, as allowed by 7 AAC 105.240.[22]

Based upon the lack of any response to its request for documents supporting almost all the claims; its findings with regard to Claims D129003, D129008, D129032, and D129062; and M & S disallowing all the claims, except for the six claims which it did allow; Program Integrity performed a statistical extrapolation and found that Ms. Miles had been overpaid a total of $58,692.64 in 2012, out of the $68,982.37 she had been paid.[23]

A review of Claims D129003, D129008, and D129032 show Ms. Miles provided a one-page form for each, which was filled out by hand. The documentation for Claim D129003 shows that a telephone message was left for the client's legal representative on February 3, 2012 and that one face-to-face visit occurred on February 20, 2012.[24] The documentation for Claim D129008 shows that the client was visited on June 4, 2012 and that her legal representative was telephoned the same day. The documentation provides that Ms. Miles read a note to the representative, and that "[h]e's at his construction sight *(sic)* … and too loud for me to hear him well. Will call me back tonight when he gets home."[25] The documentation for Claim D129032 shows that the client was visited on August 7, 2017, and that Ms. Miles "called then emailed info" to the client's legal representative.[26]

The documentation provided by Ms. Miles for Claim D129062 also consisted of the one-page form, which was filled out by hand. The documentation for Claim D129062 only shows a face-to-face contact occurred on September 4, 2012. Unlike the documentation for Claims

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21 AR 131.
22 AR 131.
23 AR 132 – 133, as modified by Program Integrity in its Notice of Revised Overpayment Findings, dated October 31, 2017.
24 AR 178. Interestingly enough, the area on the form for the client signature is signed by someone who is neither the client nor the legal representative. *Id.*
25 AR 183.
26 AR 185.

D129003, D129008, and D129032, there is nothing on the form showing a telephone call to a legal representative or the client during that same month.[27]

IV. Discussion

This case began as an audit which requested Ms. Miles provide documentation for 65 of her 2012 Medicaid billing claims. The final audit findings were based in part on a failure to provide information on 60 of those claims, and an incomplete response to five of those claims. Program Integrity subsequently determined it had enough information in its possession to allow six of the claims: Claims D129001, D129014, D129028, D129040, D129044, and D129052. Ms. Miles did not dispute the disallowance of one claim, Claim D129002, due to a duplicate billing finding. Accordingly, this discussion will only address the remaining claims, which consist of those for which absolutely no documentary response was provided, and those claims for which Ms. Miles provided some documents.

In order for a business to receive payment from the Medicaid system for services provided to Medicaid recipients, that business must be enrolled as a Medicaid provider with the Department.[28] A Medicaid provider is required to comply with all applicable federal and state requirements.[29]

Medicaid providers are required to keep a copy of their records for seven years from the date of service.[30] If a Medicaid provider does not supply a copy of a record, after it is requested, the record "may [be] consider[ed] . . . to be nonexistent."[31] A recoupment action "may" then be brought to "recover an overpayment . . . based on a determination of the record's nonexistence."[32] The Medicaid program requires care coordinators to provide, and pays them for, a number of services to their clients. The required services include "ongoing care coordination services," which in turn includes a minimum of "two contacts each month with the recipient, one of which must be face-to-face."[33]

M & S requested copies of Ms. Miles's records for this audit. She did not provide supporting records for almost all of those claims. Based upon this failure to provide, M & S

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27 AR 191.
28 7 AAC 105.210(a).
29 *See* 7 AAC 105.220.
30 7 AAC 105.230(e).
31 7 AAC 105.240(d)(1).
32 7 AAC 105.240(d)(2).
33 7 AAC 130.240(c)(4).

disallowed these claims, except as discussed above. Of the five claims Ms. Miles provided records for, M & S disallowed four of those because the supplied documents failed to establish that she had complied with the requirement for the two minimum monthly contacts with each client.

Ms. Miles's overarching defense was that her records had been destroyed by a flood in the home where the records were kept. Ms. Miles presented her testimony on this point and a copy of an invoice. Ms. Miles was frankly not credible for several independent reasons. First, a flood of the magnitude she described, at least an inch and one-half of standing water and water spraying like a "fire hose," is unlikely to have occurred from an expansion tank leak that was resolved, per the plumber's invoice, with the replacement of only $80.50 in parts and $270 in labor. Second, Ms. Miles testified she knew the paperwork had been destroyed the day of the flood. Yet, she called Ms. Stockburger with Program Integrity the same day as the flood, asking for an extension to provide the requested paperwork, without mentioning the flood. It is exceedingly unlikely that this was something that she would have failed to mention, even given her family circumstances (mother's illness, father's death, planned move), since the flood and water damage had just occurred that morning. Third, mere wetting would not ordinarily wholly destroy a set of records of this volume. Some remnant of the records would be available to show to Ms. Stockburger. Yet, Ms. Miles had nothing – not even a mess of wet paper – to show Program Integrity. Accordingly, it is more likely true than not true that the requested documents were not destroyed by a flood in Ms. Miles's home.

A review of the general Medicaid regulations that govern all providers shows that they require a provider to maintain records that identify the recipient, the specific services provided, and the date of the services.[34] The provider must also "retain records necessary to disclose fully to the department the extent of services provided to recipients."[35] Further,

> [i]f, in a response to a request for a record . . ., the provider does not produce the record on or before the deadline specified in the request or the deadline modified or extended under (c) of this section,
>
> (1) for purposes of an audit . . ., the person making the request **may** consider the record to be nonexistent; and

[34] 7 AAC 105.230(a) – (d).
[35] 7 AAC 105.220(b).

> (2) the department . . . **may** initiate a recoupment, another procedure to recover an overpayment, . . . based on a determination of the record's nonexistence under (1) of this subsection.[36]

Based upon the facts of this case and the regulations cited immediately, Program Integrity has established that Ms. Miles failed to maintain the requested records for the sampled billing claims, for which the State Medicaid agency also had no copies of the supporting documents. Because these were records which were Ms. Miles's responsibility, and which were kept solely by her, *i.e.*, the State Medicaid agency did not have its own copies, Program Integrity has demonstrated that it should exercise its discretion to determine that the documents do not exist, and that Ms. Miles is required to repay the State Medicaid agency based upon those non-existent records.

This does not entirely dispose of this case. There are still four claims for which Ms. Miles provided documents which were at least partially responsive. M & S disallowed each of these because there was insufficient evidence to show that Ms. Miles had the requisite minimum monthly contacts with the client or his/her legal representative. The regulation requires "two contacts each month with the recipient," one of which must be face-to-face.[37] The regulation does not define the term "contact."[38] There is nothing proscribing leaving a message or sending an email as a "contact." A review of Claims D129003, D129008, and D129032 shows that there was either a telephone message, an actual phone call, or an email to the client's legal representative in addition to the face-to-face visit made to the client. Nothing in the regulation specifies that this additional contact must occur on a separate day from the date of the face-to-face visit. Accordingly, these three claims must be allowed. Regarding the remaining claim, Claim D129062, there is nothing in the record showing a second contact with either the client or his/her legal representative, be it by phone or email or a voicemail message. Accordingly, this claim was properly disallowed.

Program Integrity has the burden of proof by a preponderance of the evidence. As discussed above, it did not meet it with regard to Claims D129003, D129008, and D129032, because the documents showed a second contact was made. However, as discussed in detail above, it met its burden regarding the remaining claims.

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36 7 AAC 105.250(d) (emphasis supplied).
37 7 AAC 130.240(c)(4).
38 *Id. See also* 7 AAC 130.319 "Definitions."

V. Conclusion

The disallowance of Claims D129003, D129008, and D129032 is reversed. The disallowance of the remaining claims is upheld. Program Integrity is to recalculate the amount of Ms. Miles's obligation after allowance of Claims D129003, D129008, and D129032.

DATED this 4th day of December, 2017.

By: *Signed*
Lawrence A. Pederson
Administrative Law Judge

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