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

In the Matter of	)	
	)	
ANCHORAGE COMMUNITY MENTAL	)	
HEALTH SERVICES	)	OAH No. 18-1025-MDA
___________________________________	)	

DECISION

I. Introduction

Anchorage Community Mental Health Services (ACMHS) is a Medicaid provider which serves children and adults with mild, moderate or severe mental and behavioral health issues. The Department of Health and Social Services (DHSS) Medicaid Program Integrity Unit (Program Integrity) conducted an audit of ACMHS's billings for calendar year 2010. The purpose of the audit was to determine the accuracy of $4,604,295.39 in Medicaid payments to ACMHS from January 1, 2010 to December 31, 2010. The audit was performed by Meyers & Stauffer, LC (M & S).

The audit reviewed a random sample of 110 billing claims to determine compliance with regulations.[1] When an overpayment was found, it was statistically extrapolated over the total billings to arrive at a total overpayment figure. The contested overpayment findings fell within two categories: 1) nine claims[2] in which ACMHS Residential Support Services progress notes (RSS Reports) utilized "a standardized form with check the boxes for the caregivers to mark as opposed to a format to collect narrative information from the service providers"; and 2) two psychotherapy claims[3] related to the provision of group services to a two-year-old attending a therapeutic preschool.

Program Integrity provided notice to ACMHS regarding its claims finding. After extensive review and negotiation, Program Integrity issued a final demand for repayment of $1,845,087.89, the result of extrapolating the eleven overpayments across the larger audit

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[1] Agency Record (AR) p. 102.

[2] These claims are D656001, D656030, D656038, D656053, D656054, D656081, D656082 and D656090. AR p. 172.

[3] These are claims D656049 and D656050. They document care to the same recipient minor on different dates of service. AR pp. 173, 188

population.[4] ACMHS appealed the final audit findings and requested a hearing to challenge the disallowed claims.[5]

ACMHS put forth two legal arguments in support of its request to overturn the RSS Report overpayment findings: 1) properly read, the RSS Report complied with former 7 AAC 43.1990(74) and 7 AAC 43.1990(1) by distinguishing the RSS and providing notice of active treatment such that use of the designated dialogue format, if error, should be deemed a non-monetary error; and, 2) DHSS was estopped from seeking repayment because State authorities participated in drafting the form and approved its use. As to the two psychotherapy claims, ACMHS argued that they properly documented allowable treatment per American Medical Association (AMA) guidelines.

This decision finds that the RSS Reports sufficiently annotated the services rendered and active treatment provided to satisfy 7 AAC 105.230(d)(6). Even if they did not, equitable estoppel precludes Program Integrity from seeking repayment for the billings because ACMHS received approval from the Department for use of the form. Program Integrity's findings based on these timesheets are reversed.

The audit findings based on failure to properly document group therapy services provided through a therapeutic preschool are likewise reversed. Program Integrity's primary stated concern-- use of the adjective "discontinuous" in some of the progress notes rendered the billing unreliable-- was not persuasive. Expert testimony established the word has no clinical significance. The progress notes detailed interaction between the therapist, child, and pre-school group as required by AMA standards. Further, there was no allegation ACMHS failed to provide the service in the duration billed.[6]

II. The RSS Report Portion of the Audit

A. Factual Background

RSS are services designed to provide structured support, supervision, and monitoring of high-risk clients in the community. The service recipients are severely emotionally disturbed or chronically mentally ill children or adults who would otherwise be at risk of institutionalization.

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[4] AR pp. 167-244.

[5] AR pp, 1-42, 169-73, 199-200.

[6] It is important that services be properly documented as well as provided, but the lack of any concern regarding the quality of care or true dispute regarding the amount of time spent eliminates any separate concern of unjust enrichment.

Staff services provide crisis prevention and intervention. Staff must always be in place due to the unpredictable nature of the service recipients. They must also document the services provided even when direct intervention is not necessary.[7]

In 2010 ACMHS documented the provision of RSS services using a "check-the-box" or "designated dialogue" format. It had done so since 2001.[8] The format is used to insure the RSS providers include sufficient detail to distinguish their activities from "daily supervisory activities normally provided by or within an assisted living facility" or other designated residence, according to ACMHS.[9] RSS providers are often entry level care providers with less medical and language sophistication. The designated dialogue format insures they comply with assigned duties by providing a checklist reminder and uniformity in how approved activities are provided. Use of the designated dialogue format also eliminates issues related to illegible handwriting.[10]

7 AAC 105.230(d)(6), which addresses the required recordkeeping for RSS, states that there must be an "annotated" case note recording the date, time, length of each service and notice of the "active treatment" provided.[11] The regulation does not, however, either define the word "annotated" nor establish a required format to do so.[12]

The ACMHS RSS Report includes the care provider identification, the name of the recipient, the date, time, and duration of service on a standardized form. The form also contains a list of the services and active treatment performed by the care provider. The services provided are designated with an "x" or checkmark selecting activities from a preset list of choices. An activity which is performed but not on the list, is handwritten. A narrative description of the care provider's actions is not required, but the form does provide space to do so.[13]

B. Issues in dispute

This category covers nine claims: D656001, D656030, D656038, D656053, D656074, D656081, D656082, and D6560105.[14] Program Integrity found all nine claims should be disallowed in their entirety. The overpayment findings were based primarily upon Program

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7 Testimony of John Sperbeck, Jerry Jenkins, and Timothy Brown.
8 *Id.*
9 Testimony of John Sperbeck describing the requirements of former 7 AAC 43.1990(1) and (74) (Repealed).
10 Testimony of John Sperbeck, Jerry Jenkins, and Timothy Brown.
11 During the audit period, active treatment was defined in former 7 AAC 43.1990(1) (Repealed).
12 *See* 7 AAC 160.990, Definitions; s*ee also*, 7 AAC 105.100- 7 AAC 160-990, Medicaid Coverage and Payment.
13 AR p. 152.
14 AR pp. 181-198.

Integrity's interpretation of the interplay between former 7 AAC 43.1990(74) and 7 AAC 43.1990(1) with 7 AAC 105.230(d)(6). It argued that read together the regulations required an "annotated" case note sufficient to distinguished RSS from normal supervisory activities provided by or within the living facility and demonstrate "active treatment" occurred. Program Integrity concluded the RSS Reports did not comply with the regulations because the reporting format was "inherently" inadequate to "annotate" this information.[15]

Because each RSS Report was rejected for the similar reason, the hearing on these claims focused primarily on the propriety of the format rather than the contents of individual claims.[16] Program Integrity argued the form did not meet regulatory requirements established in former 7 AAC 43.1990(74) and 7 AAC 43.1990(1) because the form did not include written narratives from which details of active treatment could be gleaned. ACMHS countered that the regulation did not include a requirement for a narrative description or specify how the work performed be "annotated." It argued compliance with the regulations exists so long as "active treatment" is communicated in the information provided. The RSS Reports satisfied the regulations because they did demonstrate active treatment when properly read. ACMHS argued at worst, the RSS Report format should be regarded as substantial compliance with the regulations and no monetary penalty assessed.

In addition, ACMHS asserted that Program Integrity was collaterally estopped from imposing overpayments based on use of the RSS Report. The State Division of Behavioral Health (DBH) solicited the form from ACHMS in 2001. The form was the product of extensive work with DBH and the Division of Senior and Disabilities Services (SDS) to define the parameters of RSS and provide proper documentation. The RSS Report was specifically designed to capture the key elements of service. It was revised twice in response to feedback received from SDS authorities. For almost a decade prior to the 2010 audit, SDS accepted and paid claims based on the directed dialogue format.

Critically, in 2008 a Clinical Chart Quality and Assurance Review (quality review) conducted by the DHSS specifically intended to provide ACMHS with "a measure of protection from fiscal audits for clinical documentation" approved the exact form used in 2010.[17] The

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[15] Testimony of Allan Hansen.

[16] Individual claims were used to highlight certain points.

[17] Testimony of James Meyers.

quality review was conducted by Michael Campbell, Licensed Clinical Social Worker (LCSW), State of Alaska, DHSS-BH, and Connie Greco, LCSW, former DHSS supervisor and private contractor.[18] ACMHS reasonably believed use of the RSS Report was approved as a result of consultation and the quality review.[19]

Thus, one issue at the hearing was whether the RSS Report contained sufficient information to comply with the annotated case note requirement of 7 AAC 105.203(d)(6). That is, whether the RSS Report properly annotated the active treatment as defined in former 7 AAC 43.1990. The second issue was whether Program Integrity could be estopped from overpayment demand even if the RSS Report format was inadequate.

C. Hearing Testimony Regarding the RSS Reports

Allan Hansen, Manager of M & S, testified concerning how the audit was conducted and the basis for the overpayment findings for use of the RSS Reports. He is trained in mathematics and actuarial science and has extensive experience in conducting Medicaid audits. He was qualified as an expert in Medicaid auditing.

M & S concluded the RSS Report progress notes "captured information that inherently could not demonstrate" the services provided met regulatory definitions. As an example, Mr. Hansen discussed two claims where the RSS Report designated dialogue showed the care recipient had been "redirected" to avoid safety concerns, but did not specify whether the redirection was physical or verbal. M & S essentially concluded failure to require a narrative description meant the RSS Reports could not constitute an "annotated" case note for purposes of 7 AAC 105.230(d)(6).[20]

Mr. Hansen acknowledged that the regulations do not define the word "annotate." Nor do they prohibit the designated dialogue format used by ACMHS. He also acknowledged that designated dialogue forms are sufficient to satisfy other types of claim requests. However, it was his position that using a "check the box' format is not an adequate substitute for a narrative recital. Mr. Hansen was unable or unwilling to define how detailed or grammatically complete a narrative would need to be to comply with the regulation. He was unaware of any historical

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18 Ex. BB.

19 Testimony of John Sperbeck and Jerry Jenkins. Ex. BB, p. 2, Ex. N, Ex. CC.

20 Testimony of Allan Hansen.

background regarding development of the RSS Report or participation by DBH and SDS in development of the form.[21]

Doug Jones, the Manager for Program Integrity at the Department, testified he oversees the audit process conducted by retained services such as M & S. He described the audit process in some detail, including why the audit findings were delayed in this case. The RSS Report format was the source of his concern. It did not include enough detail on what type of services and interventions occurred. He was informed during the audit process that ACMHS believed the RSS Report had been approved by DHSS. Current DHSS employees could not confirm the accuracy of that claim, however. He did not speak with Michael Campbell or Connie Greco, the former State employees named by ACMHS as having knowledge of those facts. However, he was familiar with who they were, and agreed they would have had authority to provide guidance on regulatory compliance or approve a form.[22]

Timothy Brown, Mental Health Clinician III, also testified for Program Integrity. Since 2012 he has reviewed billings and performed internal agency audits of Medicaid providers in the behavioral mental health field. He provided extensive testimony regarding the nature of RSS services, when and how they can be approved, and the wide variety of conduct they cover. He testified that the overpayment conclusion rested "on the form itself" because it did not provide enough detail on the services provided. He acknowledged that other providers have a range of forms for RSS documentation including "a few" others who use the check the box or designated dialogue format. He was unaware of any discussions between State agencies with ACMHS regarding use of the RSS Report or its development until after the appeal was filed.

In 2014, while audit approval was pending, he informed ACMHS that he thought the RSS Report could be improved. He was told then regarding the history of its development. He did not thereafter request ACMHS amend the form, although he could have. Nor did the Department issue written guidelines or amend the regulations to impact or change the use of designated dialogue forms for RSS. He testified given the known history, including his own inaction, he understood why ACMHS reasonably believed the RSS Report format had been approved by the Department.[23]

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21 *Id.*
22 Testimony of Doug Jones.
23 Testimony of Timothy Brown.

ACHMS called numerous witnesses to discuss the history behind use of the designated dialogue format in the RSS Report form and its prior acceptance by SDS. These included John Sperbeck, current Regional Manager for Alaska Housing and supervisor at ACMHS from June 1987 to June 2015, as well as Jerry Jenkins, Chief Executive Officer for ACMHS from 2003 to 2018.

Alaska is one of the few states that provides this type of recipient support service. In most other places, the service population would be cared for only in an institutional setting. The service population is highly acute, unpredictable, and often dangerous.[24] When DBH sought to deinstitutionalize this population and permit residency in Assisted Living Facilities in 2000-20001, Mr. Sperbeck met with Ken Taylor at the Department of Corrections (DOC) and state officials with DBH and SDS to identify how to insure safety of the service recipient and the elderly or fragile populations with whom they would be housed. RSS services were developed as a response. RSS services are highly variable based on the need of the specific care recipient. Thus, it became necessary to distinguish RSS services from other forms of personal care services provided in residential facilities even though the services can appear similar.[25]

ACMHS was solicited for ideas on how to do so. It submitted the designated dialogue form in 2001. Designated dialogue forms were already in use throughout the mental health field and had a history of acceptance by SDS. The format was selected to insure the provider could simply and quickly relay the necessary information and demonstrate active treatment.[26]

Multiple discussions took place with State officials, including those tasked with insuring regulatory compliance, regarding the form's contents and how to document active treatment. ACMHS made two minor modifications between 2001 and 2010 as the result of continued discussions with SDS officials.[27] It is not disputed that ACMHS would have changed the RSS Report format if requested.[28]

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[24] Testimony of Jerry Jenkins and John Sperbeck.

[25] Testimony John Sperbeck. (Mental Health Clinician III Brown, called by Program Integrity, provided similar, extensive testimony regarding the nature of RSS services, when and how they can be approved, and the wide variety of conduct they cover.)

[26] Testimony of John Sperbeck and Jerry Jenkins.

[27] *Id.*

[28] *Id.*

In 2008 the Division did a quality review of ACMHS.[29] The purpose of the review was to provide ACMHS "a measure of protection from fiscal audits."[30] The review was conducted by Michael Campbell and Connie Greco, both with actual authority from DHSS to provide advice regarding regulations and issue form variances.[31] The Campbell-Greco report concluded the 2008 RSS Report form met then existing reporting requirements for clinical documentation.[32] Testimony from James Meyers, corroborated with documentary evidence, established that the RSS Report submitted in the 2010 audit was identical to the 2008 form reviewed and approved by Campbell-Greco.[33]

Mr. Sperbeck testified that the designated dialogue format used in the RSS Report satisfies the regulatory requirement for an annotated case note to document active treatment. RSS care providers are different from other types of care attendants. They are approved primarily to protect the physical safety and well-being of the care recipient and those around him. They must be familiar with their clients and able to detect and defuse potential escalation. They must be able and willing to physically intervene when necessary. The work is not well-paid, is emotionally draining, and often physically dangerous. In addition, the care provider must be present at all times even if an active intervention is not necessary.[34]

The work is usually performed by entry level applicants or those just beginning a health care career. They are typically unfamiliar with medical terminology. English is often their second language. The expectation they could draft narratives similar to those prepared by trained nurses or other professionals is unrealistic. What is critical is that they document "active treatment" was provided.[35]

ACMHS argued the designated dialog format provides for that. Mr. Jenkins and Mr. Sperbeck walked through specific disputed claims to demonstrate how, read appropriately, the RSS Report conveys the same information as any grammatical sentence.[36] Per their testimony, active treatment was reported. The forms assessed the appearance of the care recipient and their emotional state. They demonstrate a readiness for intervention and what intervention was taken.

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29 Ex. BB.
30 *Id.*
31 Testimony of Jerry Jenkins and Doug Jones.
32 Ex. BB.
33 Exs. BB., N., and C.
34 Testimony of John Sperbeck and Jerry Jenkins.
35 *Id.*
36 Testimony of John Sperbeck.

In addition, the format avoids the well-known and wide-spread problems caused by illegible handwriting. Thus, they argued that the RSS providers do make and record the proper observations and that information is readily gleaned from the report contents.[37]

D. Discussion

i. Interpretation of 7 AAC 105.230(d)(6)

Although there was some dispute at the hearing, this decision concludes that the 2010 RSS Report form used in support of claims D656001, D656030, D656038, D656053, D656054, D858081, D656082, and D656090 is the same as the RSS Report form reviewed and approved by Campbell and Greco in 2008. Mr. Meyer's credible testimony and the corroborating details from Ex. BB, N, and CC established that fact by a preponderance of the evidence.

The question of whether a designated dialogue format satisfies the "annotated case note" requirement of 7 AAC 105.230(d)(6) has not previously been addressed in Alaska. This is a question of regulatory interpretation.[38]

7 AAC 105.230(d)(6) provides the clinical record must include:

> annotated case notes identifying each service or supply delivered; the case notes must be dated and either signed or initialed by the individual who provided each service.

7 AAC 105.230 became effective February 1, 2010. Prior to that time the requirements for clinical record keeping were covered in former 7 AAC 43.030(d)(4), unchanged since 1997, which required the clinical record to:

> include annotated case notes, signed, dated, or initialed by the individual who provided the service, for the service delivered.

These two provisions are substantively equivalent, and both contain the critical phrase "annotated case notes."[39] Where the government re-adopts previously used statutory or regulatory language, it is generally held to adopt all prior interpretations and legislative gloss associated with the language. Statutes that have developed specialized meaning through caselaw or usage are presumed to have that same specialized meaning and the

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[37] Testimony of John Sperbeck and Jerry Jenkins.

[38] Administrative regulations are generally interpreted using the same principles applicable to statutes. *See, generally, Kelly v. Zamarello*, 486 P.2d 906 (Alaska 1971).

[39] The original intent of 7 AAC 43.030(d)(4) was not argued by the parties. However, adoption of the same substantive language in the successor regulation leads to the conclusion DHSS did not intend to change permitted use of the RSS-type box-checking already in place.

enacting body is presumed to be aware of existing interpretations when it enacts or modifies the law.[40]

Thus, by continuing to use the same language in 2010 that had been in place since 1997, the Department demonstrated an intent to continue with interpretations previously used regarding annotated case notes. Given that there has been no change in the regulatory language requiring an "annotated case note" since the Department approved the RSS Report form in the 2008 quality review and there is nothing in the legislative history to demonstrate a substantive change was desired with the 2010 regulatory rewrites, the 2010 RSS Report format does not violate 7 AAC 105.230(d)(6).

Program Integrity has not identified anything in the legislative history regarding 7 AAC 105.230(d)(6) to counter or rebut this presumed intent. Although Alaska no longer strictly applies the "plain meaning" rule of statutory construction, the plainer the language the more convincing contrary intent must be.[41] Program Integrity concedes that the word "annotate" used in the regulation is not elsewhere defined. It does not argue that the meaning "plainly" appears in the language, structure or legislative history of the regulation other than the history described by ACMHS.

In Alaska where the meaning of a term is disputed and no regulatory or agency guidance exists, the word is construed according to common usage.[42] The dictionary defines "annotate" as "to note, mark, to provide critical or explanatory notes for (a literary work, etc.)."[43] There are two possible reasonable readings of "annotate" even from dictionary definition -- one meaning is that the note, mark or explanation must be written in a narrative form and the other is the idea a "mark" is consistent with the ability to check mark and adopt a listed selection. 7 AAC 105.230(d)(6) is far from self-explanatory as to what constitutes appropriate annotation given these two reasonable interpretations. Thus, the dictionary definition would be ambiguous if applied in this circumstance.

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40 *E.g., Alaska Conservation Found. v. Pebble Ltd P'ship*, 350 P.3d 273, 281 (Alaska 2015)(citing *Shea v. State, Dep't of Admin., Div. of Ret. & Benefits*, 267 P.3d 624, 633 n. 33 (Alaska 2011)*; see also, Young v. Embley*, 143 P. 3d 936, 945 (Alaska 2006)(stating presumption that legislature is aware of common law when enacting statutes); *Joseph v. State,* 293 P. 3d 488, 492 (Alaska App. 2012)("[T]he legislature is presumed to be aware of pertinent court decisions when it amends a statute.")(citing *Shea*, 267 P. 3d at 633 n. 33).

41 *E.g. Benavides v. State*, 151 P.3d 332 (2006).

42 AS 01.10.040(a); *See, also Young v. Embley*, 143 P.3d. 936 (Alaska 2006).

43 *Webster's New World Dictionary, Second College Ed., p. 56 (1974)*.

The Alaska Supreme Court has previously held that "imprecise, indefinite, or ambiguous statutory or regulatory requirements must be strictly construed in favor of the accused" before an alleged breach may give rise to a civil penalty.[44] Presumably the same rule would apply to recoupment. Thus, even if this decision had not concluded that continued use of identical language in the successor regulation demonstrates an intent for 7 AAC 105.230(d)(6) to allow the same "annotations" permitted in prior 7 AAC 43.030(d)(4), this decision would conclude Program Integrity could not recover for overpayment.

Program Integrity's findings are reversed as to the nine RSS Report claims.

ii. *Equitable Estoppel*

ACMHS also argued equitable estoppel bars Program Integrity from making overpayment findings based on the use of RSS Report form.[45] To successfully invoke estoppel against a governmental agency, four elements must be established:

1) the assertion of a governmental position by either conduct or words,

2) an act which reasonably relied upon the governmental position,

3) resulting prejudice; and

4) estoppel serves the interest of justice so as to limit public injury.[46]

The Office of Administrative Hearings has considered application of equitable estoppel to the Medicaid audit context in a series of cases: *In re Eben-Ezer Homecare, LLC*, OAH Case No. 13-1605-MDA (DHSS 2015); *In re Hearts and Hands of Care, Inc.*, OAH Case No 16-1176-MDA (DHSS 2018); *In re Consumer Care Network, Inc.*, OAH Case No 17-0933-MDA (DHSS 2018) and *In the Matter of U-Care Services*, Case No OAH 17-1236-MDA (DHSS 2018).[47] The cases all involved requests by Program Integrity to recoup overpayment due to use of timesheets where the provider noted "live in" rather than listing specific start and stop times. In the two cases where the provider was unable to demonstrate that the live-in timesheet form was expressly submitted to or discussed with staff members of the SDS, Medicaid Provider Certification and Quality Assurance Program, the decisions concluded equitable estoppel was not

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[44] *Alaska Public Offices Com'n v. Stevens*, 205 P.3d 321, 325 (Alaska 2009)

[45] Because the pertinent language in 7 AAC 105.230(d)(6) is identical to that in the prior regulation, the February 2010 regulatory amendments do not impact this analysis.

[46] *Allen v. State*, 203 P.3d 1155, 1162-64 (Alaska 2009).

[47] Available on-line at https://aws.state.ak.us/OAH/Category/Subcategory?sub=625

established.[48] However, where the provider could demonstrate either that it had consulted with a SDS employee known to have knowledge of the regulatory requirements or that the form was expressly reviewed during the certification process, equitable estoppel was found.[49]

The evidence on this issue consists of testimony from Mr. Sperbeck, Mr. Jenkins, and Mr. Jones, all of whom testified regarding the development of RSS services and the numerous consultations which occurred between ACMHS and SDS on how to establish and document the services. At no time during those consultations did the Department discourage use of the directed dialogue format or require a separate narrative.

In addition, testimony corroborated with documentary evidence[50] established the RSS Report in designated dialogue format was specifically submitted during the 2008 Medicaid Provider Certification and Quality Assurance Program review. That review expressly found the form met "standards to ensure [p]rogress notes document the RSS is being provided correctly."[51] Mr. Meyers provided context from which to conclude the RSS progress notes reviewed and approved by the Division in 2008 were the same as the progress notes identified by M & S during the 2010 audit and flagged for overpayment.

In its closing brief, Program Integrity implicitly acknowledges that the 2008 quality review report constituted express approval of the RSS Report in use at the time. It attempts to evade the import of that acknowledgment by arguing the form approved in 2008 and the form used in 2010 were not sufficiently similar. "Problematically, however, the actual RSS progress note has not been provided so there is no context to conclude the RSS progress note ***reviewed and approved by the Department*** is akin to the progress notes reviewed during this audit that resulted in overpayment."[52] Because this decision resolves the fact question of whether the RSS Report forms were the same in favor of ACMHS, it necessarily follows that the RSS Report documenting the nine 2010 claims was approved by the Department.

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48 *In re Eben-Ezer Homecare*, OAH Case No. 13-1605-MDA (DHSS 2015), Decision at 10 (no evidence the time sheet was "ordinarily reviewed in the certification process"); *In re Hearts and Hands of Care*, OAH Case No 16-1176-MDA (DHSS 2018), Decision at 5 ("no indication" the timesheet was "expressly reviewed during certification" process) *affirmed Hearts and Hands of Care, Inc. v. State of Alaska, DHSS*, 3AN-18-05154CI, Order Denying Reconsideration and Granting Clarification, dated 4/16/19, pp. 1-2.

49 *In re Consumer Care Network*, OAH Case No 17-0933-MDA (DHSS 2018), Decision at 4-5, 9-10 (verbal consultation with staff member sufficient); *In the Matter of U-Care Services*, OAH Case No 17-1236-MDA (DHSS 2018), Decision at 9-10 (timesheet specifically shown to members of quality assurance and certification unit).

50 Exs. BB, N, and CC.

51 *Id.*

52 Program Integrity Closing Argument dated October 21, 2019, p. 17 (Emphasis added).

ACMHS witnesses were credible. They were knowledgeable, well-prepared, and sincere. No meaningful evidence was presented to contradict their accounts. Accordingly, ACMHS has met its burden of proof to establish the Division through its authorized agents expressly approved the RSS Report format. This satisfies the first element of the estoppel test—assertion of a government position.[53]

ACHMS reasonably relied on action by the Division.[54] ACHMS was solicited to submit the form in 2001. Designated dialogue forms were accepted for other services prior to that time. ACHMS and the Division engaged in consultations before the form was put into regular use. Once in use, there were further discussions which lead to agreed upon modifications of the form.[55] The RSS Report was expressly discussed in 2008 during a Quality Review with Campbell and Greco designed to "ensure the agency has a thorough quality assurance process that provided a measure of protection from fiscal audits for clinical documentation."[56] Program Integrity did not dispute that Campbell and Greco held positions of authority. It was reasonable for ACMHS to believe they could provide regulatory guidance and determine compliance issues. After 2008 the Department did not request the form be changed. It did not issue written guidance or change regulations to provide notice the format was unacceptable.[57] Nor did it do so in conjunction with the 2010 regulatory changes. The reasonable reliance element of equitable estoppel was established.

ACMHS also demonstrated substantial prejudice from its reliance on the governmental position – the third element of estoppel. Had it been advised by the Division at any time from when the format was first submitted in 2001 through 2010 that its timesheets did not comport with regulatory requirements, it could have rectified the alleged deficiency, and avoided findings in an audit that resulted in a disallowance of a significant percentage of its billings. [58]

The fourth element of equitable estoppel is also satisfied. ACMHS acted reasonably when it consulted with Division to develop a form to address new services. It acted reasonably when it participated with the quality review in 2008. "Regulated businesses should be able to

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53 Nor did the Division ever notify the provider that the practice was inadequate during its long usage.

54 This action was taken prior to the 2010 regulatory amendments, but as discussed herein, because the regulatory amendments did not change the pertinent language, the position holds firm.

55 Testimony of John Sperbeck and Jerry Jenkins.

56 Ex. BB, N., and C.

57 Testimony of Mental Health Clinician III Brown.

58 *See, In re Consumer Care Network, infra,* Decision at 9.

rely on the basic competence of government regulators to provide correct guidance when incorrect guidance could invalidate [the business'] billing."[59] This is especially true in a case like this, where the business has a lengthy history of actively seeking guidance from the governmental agency, making changes and accommodations when requested; where the government agency expressly reviewed ACMHS forms and wrote a report indicating they were in compliance;[60] and where the governmental agency failed to notify the business of any new determination the practice was inadequate.[61] Given these facts, estoppel serves the interest of justice so as to limit public injury.

Based on the above discussion, Program Integrity's finding of overpayment for the RSS Report claims based on the use of a "check the box" or "designated dialogue" format is overturned. The revised overpayment claim must be reduced by all calculations related to these claims.

III. The Group Therapy Progress Report Portion of the Audit

A. Factual Background

The ACHMS Little Tykes program provides group therapy and group skills development to young children using a therapeutic preschool model. A therapeutic preschool is a multidisciplinary, intensive day treatment program focusing on an attachment-based classroom milieu and treatment philosophy. Programs meet every weekday in groups supervised by two or more specially trained staff with a limited number of children.[62] The Little Tykes program is currently described as:

> Little Tykes Therapeutic Services provides comprehensive wrap around services for children ages 3-5 and their families. Services are provided in a structured, safe, secure, nurturing environment lead by mental health professionals. In Group Therapy, the children learn to express and manage their emotions so that they will have healthier function in other areas of life including home, community, and school. Support services such as family therapy and caregiver group therapy by staff help parents to understand their children and to master relationship and communication skills to help their child develop into happy, healthy children.

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[59] *Id.* at 10; *see, also, In re U-Care Services, infra*, Decision at 11-12.

[60] Ex. BB.

[61] Mental Health Clinician III Brown, internal Division auditor, agreed that he or prior internal auditors could have requested or demanded changes to the RSS Report format and the failure to do so had an impact because it was reasonable for ACMHS to interpret inaction the Division's inaction after 2008 as continued approval and acceptance.

[62] Testimony of Joshua Arvidson and Kiersten Mortenson.

Evidence based practices used include Child Parent Psychotherapy and Filial Therapy.[63]

This description is consistent with the program parameters as they existed in 2010, except children less than three years old such as B.T., the care recipient in this case, were approved for participation. Although the specifics of the Little Tykes daily schedule have had some variation from year to year, the program has consistently separately addressed group therapy and group skills development and insured that the services were appropriately staffed.[64]

Medicaid providers are required to comply with the AMA Current Procedural Terminology (CPT) billing code requirements. In 2010 the AMA CPT billing code for group therapy was 90835.[65] ACMHS group therapy progress notes are written in a narrative format. The first section addresses the group activity of the day along with the client's participation.[66] The next section sets out data regarding the client. The last section documents the client's emotional state and progress toward her treatment goals.[67]

B. The Hearing on Group Therapy Progress Notes

This category covers 2 claims: D656049 and D656050. The group therapy progress notes contain the name of the recipient, the name of the therapist and their credentials, the duration of services provided, and a multi-paragraph narrative regarding the professional's observations. M & S found both the claims should be disallowed. Initially, the overpayment finding was based on the conclusion it was inappropriate to provide extensive therapy services to a two-year-old, B.T. The progress notes were also alleged to provide inadequate documentation to satisfy the AMA CPT billing code, 90835.[68]

The disallowed claims related to mental health services provided as part of the Little Tykes program, the therapeutic pre-school. In 2010 Little Tykes was a new program in a developing field. By the time of the hearing in 2019, however, there was no legitimate dispute that regardless of the cutting-edge status of therapeutic preschool in 2010, the efficacy of early

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63 https://acmhs.com/what-we-do/child-family-services/little-tykes-early-childhood-services/.

64 Testimony of Joshua Arvidson and Kiersten Mortenson.

65 Testimony of Dr. Emily Edlynn and Kimberly Pullen.

66 Examples of group activities include circle time; singing to introduce new ideas and discussion topics, such as *The Angry Song*; outdoor walks; sharing activities; grief discussion; painting, including foot and finger painting; and school outings. Ex. 20 and 21.

67 Ex. 20 and 21.

68 Testimony of Allan Hansen; Program Integrity Prehearing Brief dated August 29, 2019, pp. 1 & 5.

childhood mental health intervention and group therapy was well established.[69] Billing for children's group therapy is coded under AMA Code 90835 the same as adult group therapy.[70] The hearing, therefore, focused on whether claims D656049 and D656050 contained sufficient documentation to satisfy the billing code.

Program Integrity argued they did not, while ACMHS asserted they did. The thrust of Program Integrity's argument was that appearance of the term "discontinues" in one of the narrative paragraphs of the therapeutic progress notes implied that breaks in service occurred. Inclusion of the term implied that the services were only intermittently provided rending them unreliable. Program Integrity also argued the progress notes did not contain sufficient detail of the therapists' interaction with the specific care recipient as opposed to the group in general.[71] The contents of the individual progress notes were admitted as Ex. 20 and 21.

Allen Hansen testified that in 2010 M & S initially found it impossible to believe that group mental health services as documented in claims D656049 and D656050 could be provided to a two-year-old based on assumptions that her age made her too young to validly participate in or benefit from therapy. However, at the hearing, both he and Doug Jones specifically testified that Program Integrity no longer asserted in 2019 that payment of the group therapy claims should be denied based on the age of the service recipient. Mr. Jones on behalf of Program Integrity did not dispute that group therapy using the therapeutic preschool approach was a valid mental health service. Nor did he claim that group therapy for young children was not recognized by the AMA.[72]

The issue, instead, was solely whether the narratives provided on the progress notes were sufficiently described group therapy to meet AMA standards and coding requirements.[73] Mr. Hansen and Mr. Jones opined that the claim narratives at issue were inadequate to meet those standards regardless of the age of the service recipient. That is, Program Integrity argued the claim should be denied based on the contents of the progress notes regardless of whether the care recipient was two-years or twenty-two years old.[74] The basis for M & S's conclusion the

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[69] Testimony of Dr. Emily Edlynn, Kiersten Mortenson, Kimberly Pullen, and Joshua Arvidson.

[70] Testimony of Dr. Emily Edlynn and Kimberly Pullen.

[71] Testimony of Allen Hansen.

[72] Mr. Hansen testified those issues fell outside the scope of his decisions as an auditor because they were more properly a question of policy.

[73] Testimony of Allan Hansen and Doug Jones.

[74] Given this concession, the testimony of Program Integrity's Child Behavioral expert witness had little relevance to its presentation. Program Integrity called Clinical Psychologist Kimberly Pullen, a former intern at

progress notes did not meet required standards was an alleged failure to demonstrate direct interaction between the therapist and the client as opposed to the therapist and the group.[75] M & S also asserted use of the adjective “discontinuous” in a portion of the narrative description rendered the service provision unreliable.[76] Program Integrity argued, therefore, the claims were properly denied.

Joshua Arvidson and Kiersten Mortenson described the development of the Little Tykes program. The Little Tykes group therapy program is intensive, but three hours is appropriate for this age of group therapy recipients according to experts in neuroscience and child development. There is a difference between group psychotherapy and group skills development for children. The Little Tykes program does offer both. However, the services are delivered at different times by different providers with different credentials specific to the service provided. The reports submitted regarding group therapy do not relate to the group skills development portion of the program; those services were separately billed in 2010 and paid without dispute.

ACMHS witnesses explained use of the word “discontinuous” within the progress report narratives did not render the service billing unreliable. The word has no clinical meaning.[77] In addition, Little Tykes has a mechanism to ensure that if one member of the group’s therapy is interrupted, that time is tracked.[78]

ACMHS licensed in 2011, as an expert in child behavioral services, to support the position the group therapy claims should be denied. She testified she was only hired to render an opinion on whether two-year-old children could validly participate in traditional group counseling. Children less than 6 years old, who she defined as “infants” are incapable of receiving group counseling because they cannot truly appreciate why they are present, engage in self-reflection, or consciously pursue the goal of therapy. Group therapy was inappropriate for any child that age. Thus, in her opinion, the Little Tykes claims, D656049 and D656050 should have been denied.[74] The services provided might qualify as group skills development services, but they were not group therapy per her definition.

Because Program Integrity conceded that two-year-old children could validly receive group therapy, Ms. Pullen’s testimony was given little weight by the ALJ. Her testimony was also successfully impeached on the merits during the hearing. She had no experience with the therapeutic pre-school model. Ms. Pullen had specialty training in play therapy for children, but her practice focused more on PTSD, grief and loss trauma, and the use of EMDR for adults. She was unaware of the details of the Little Tykes program and the services offered prior to the hearing. On cross-examination, she agreed the Little Tykes program as described could meet her definition of group therapy and “infants” such as the child involved in claims D656049 and D656050 could validly receive group therapy within the parameters described if properly documented.

[75] Testimony of Allan Hansen.

[76] Testimony of Allan Hansen.

[77] For example, Mr. Arvidson who edits articles for publication in peer reviewed mental and behavioral health journals, has never seen it used to describe any type of clinical services or to document intermittent provision of services.

[78] Testimony of Joshua Arvidson and Kiersten Mortenson. Examples would be if the child left to attend family therapy, was ill, or need a bathroom break.

Dr. Emily Edlynn testified as the child behavioral expert for ACMHS. She also had sufficient experience in the review of provider notes and audits to qualify as an expert in billing and code compliance.[79] She testified that group therapeutic services for children do differ from therapeutic services for adults because children do not engage in the same form of abstract thinking or expression. Nor do they have equivalent verbal skills. Thus, services for young children are modified to involve modeling, feedback and practical skills in an environment that permits play, interaction, art, and sharing.[80]

It is important for traumatized young children to participate in group therapy because current neurological research proves it reshapes their brains. Interaction with a group is a key component for them to establish their own self-identity, obtain social skills, improve peer development, learn safe boundaries, and practice self-regulation. To the uninformed this can look like skills development, but conducted properly the group dynamic is the psychotherapist's "scaffold" for building mental health.[81]

The assessments Dr. Edlynn reviewed established the propriety of intensive group therapy for the children in the Little Tykes program, including the child assisted in claims D656049 and D656050.[82] The child experienced extensive physical and emotional trauma. Her assessment clearly demonstrated significant mental health issues requiring intervention from a trained provider. The assessment and treatment plan attached to claims D656049 and D656050 were quite specific.[83]

The services described in the related progress notes and therapeutic records themselves complied with AMA definitions for group therapy, according to Dr. Edlynn. The relevant AMA CPT billing code, 90853, does not establish different group therapy requirements by recipient age. The key elements for AMA CPT Code 90853, regardless of group member age, are interpersonal interaction, psychotherapeutic support, and the ability to reminisce. Children at play and in sharing circle engage in interpersonal interaction. The group is guided and directed

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79 Dr. Edlynn received her clinical masters' degree in 2007 from Loyola. She also has a Ph.D. in Pediatrics from Stanford University. Her Post-Doctoral work is in Pediatric Health and Psychology. At the time of the hearing, she had 16 years' experience in child development and mental health, including 12 years' experience conducting internal audits, training staff, and reviewing documents, progress notes, and peer review of professional notations.

80 Testimony of Dr. Emily Edlynn.

81 *Id.*

82 Exs. 20-22. The degree of trauma experience by the children in Little Tykes and the need for intervention was not in dispute.

83 *Id.*

by a therapist using clinically proven techniques. The child's individual mental health needs are known and addressed; the therapist targets behaviors and the child's response. Children very clearly share their memories at a very young age.[84]

Ms. Edlynn described how the progress notes filed with claims D656049 and D656050 satisfied AMA requirements. They reflected individual mental health goals. The notes show group participation, relay of memory, and strategies to assist the care recipient practice mental health skills in different environments, such as a on swimming trip. The progress notes include data on the client's response to therapeutic interventions and interaction with others in the group, not limited to her sibling. There are clear descriptions of the interactions with both the therapist and other members of the group. How these interactions were targeted to map onto the child's treatment plan is also documented.[85] She testified these are the hallmarks of appropriate group therapy progress notes.[86]

Dr. Edlynn discussed details in the progress notes to demonstrate how to correctly review group progress notes involving young children. According to her, the notes in this case were very good examples of how to properly document such group therapy. For example, on September 1, 2010, the child wanted to put an item in the therapist's hair, which was a physical expression of mental health development given her prior abuse. The provider recognized this mental health display and provided feedback to ask permission and wait. That direction was important for the child's identified mental health development goals which included learning safe touching and sharing. Both the intervention and the child's response were described. The child was able to identify her own emotions and practice self-regulation. Thus, the key elements for AMA CPT Code 90853 were present.[87]

The other progress notes contained similar information addressing group participation, memory, and progress. [88] Each one describes a group activity which might be a simple as monitored play or as complex as empathy in a sharing circle or learning to identify emotions through song. The recipient's interactions with other members in the group are described, and

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84 *Id.*
85 *Id.*
86 Ms. Pullen gave similar testimony about the requirements for appropriate group therapy documentation.
87 Testimony of Dr. Emily Edlynn.
88 AR pp. 2410, 2459-2475, 2505-2516, 2478-2503.

her own progress is noted.[89] Dr. Edlynn concluded the Little Tykes program met the AMA definition of group therapy and the progress notes properly documented provision of that service.

Based on her expertise and years of peer review experience, she too, rejected the idea that inclusion of the single word "discontinuous" in the body of the comprehensive progress notes rendered them unreliable. She agreed with other witnesses that the word has no clinical significance. It is not used by professionals to describe intermittent care; Program Integrity's concern was unfounded. The records submitted in support of the claims met therapeutic and reporting standards. Dr. Edlynn concluded the overpayment should be reversed.[90]

C. Discussion.

As for the group therapy progress notes, this decision concludes Program Integrity has not met its burden to prove the notes failed to demonstrate the provision of legitimate group therapy for the duration claimed.[91] Program Integrity's argument on this point distilled to assertions that 1) it was unbelievable a young child could participate in standard one-on-one talk therapy for three hours at a stretch; and 2) there was no way to be certain the time billed was time provided to the child because the word "discontinuous" implied breaks were taken but the durational description did not include documented in and out times. Both assertions are rejected.

M & S initially misunderstood the service provided. Little Tykes consists of play/group therapy not one-on-one counseling. The expert testimony, life experience, and common sense all confirm that small children can engage in those services for time billed. As for the latter point regarding the term "discontinuous," that argument is no different than whether any service required the amount of time billed. No accusation of fraud or some reason to distrust the reporter was made. The claims should not have been denied for that reason.

Testimony by Dr. Edlynn, Mr. Arvidson, and Ms. Mortenson regarding how services are provided and progress notes prepared to meet AMA requirements was persuasive, cogent, and convincing. Dr. Edlynn provided singularly impressive testimony. The ALJ's personal reading each of the progress notes confirmed that each one describes a group activity and the care recipient's interactions with the group and the therapist. Each progress note contains several sentences regarding data on the therapist's observations and assessments relating to the care recipient's therapeutic

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[89] *Id.* (A lay reading by the ALJ reveals much the same.)

[90] *Id.*

[91] See, *e.g., In the Matter of Family Medical Clinic,* OAH Case No. 10-0095 (DHSS 2011), Decision at 7.

progress.[92] The notes show the child interacting with a group in activities designed to facilitate mental health development. She interacts with both her therapist and members of the group; the therapist documents her progress.[93] Inclusion of one word in the lengthy body of the progress notes is insufficient to invalidate their overall compliance. The requirements of AMA CPT 90835 were met.

Program Integrity's findings are reversed as to the two psychotherapy claims.

IV. Conclusion

This decision concludes that the designated dialogue RSS Report form does not violate regulatory requirements for an "annotated" note. Even if it did, Program Integrity's disallowance of the nine claims concerning the RSS Report timesheets is reversed under the doctrine of equitable estoppel.

The disallowance of the two claims related to the provision of group therapy services is also reversed. Sufficient documentation was provided to prove legitimate group therapy services were provided in the duration submitted.

Dated: December 17, 2019

Signed
Carmen E. Clark
Administrative Law Judge

Adoption

The undersigned, by delegation from the Commissioner of Health and Social Services, adopts this Decision, under the authority of AS 44.64.060(e)(1), as the final administrative determination in this matter.

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 15th day of January, 2020.

By: *Signed*
Name: Doniel Wolfe
Title: Regulations & Policy Analyst

[This document has been modified to conform to the technical standards for publication. Names may have been changed to protect privacy.]

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92 AR pp. 2459-2473, 2478-2499, 2501-2516.

93 AR pp. 2410, 2459-2475, 2505-2516, 2478-2503. Exs. 20-22.