BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

BEHAVIORAL HEALTH SERVICES OF SOUTH GEORGIA, Petitioner,	:	Docket No.: OSAH-DCH-PROP-1420530-92-Brown
v.	:	
GEORGIA DEPARTMENT OF COMMUNITY HEALTH, Respondent.	:	Agency Reference No.: P13-132

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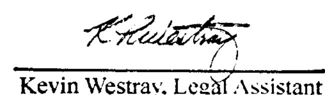

Kevin Westray, Legal Assistant

INITIAL DECISION

I. Introduction

Petitioner, Behavioral Health Services of South Georgia (hereinafter "BHS"), appealed the decision of the Department of Community Health (hereinafter "DCH" or "Respondent") to determine an overpayment to BHS in the amount of $86,373.40 after conducting a Utilization and Compliance Review on November 17, 2011. The hearing on this matter was held before the undersigned Administrative Law Judge on April 9, 2014 at the Lowndes County Judicial Complex in Valdosta, Georgia. George Reinhardt, Esq., represented Petitioner and Tara Dickerson, Esq., represented DCH. For the reasons indicated herein, DCH's action is **AFFIRMED IN PART, REVERSED IN PART, and REMANDED** for a calculation of the overpayment.

This record is sealed to protect medical records of consumers referenced in hearing exhibits or other documents that were submitted for this hearing. Release of any documents other than this decision can occur only upon review and redaction of any consumers' names from the record as well as the name of any caregivers, or personnel, etc., since disclosure of that name in a public record might disclose a person's identity. Neither Petitioner nor Respondent is authorized to utilize any documents exchanged pursuant to this litigation without redaction of the name of individuals referenced.

II. Findings of Fact

Overview of Medicaid Reimbursement

1. Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to meet the costs of necessary medical care and services. 42 U.S.C. §§ 1396 *et seq.*; *Moore v. Reese*, 637 F.3d 1220, 1232 (11th Cir. 2011). Participation is voluntary, "but once a state opts to participate it must comply with federal statutory and regulatory requirements." Id. All states have opted to participate and, thus, each must designate a single state agency to administer its Medicaid plan. Id.; 42 C.F.R. § 431.10(a), (b)(1). Georgia has designated DCH as

the "single state agency for the administration" of the State Medicaid Plan. O.C.G.A. § 49-2-11(f) (2013).

2. Delivery of Medicaid services to eligible members is accomplished through enrolled providers. MEDICAID MANUAL § 101. The Department of Community Health's Division of Medical Assistance (hereinafter "the Division) reimburses participating providers for furnishing covered services to eligible members. MEDICAID MANUAL § 104.

3. Respondent is authorized to publish terms and conditions governing Medicaid claims for each category of services authorized under the State Medicaid Plan.[1] O.C.G.A. § 49-4-142 (a) (2013) ("[DCH] is authorized to establish the amount, duration, scope, and terms and conditions of eligibility for and receipt of such medical assistance as it may elect to authorize pursuant to this article."); see also GA. COMP. R. & REGS. 350-1-.02(3). Pursuant to this authority, Respondent has published *Part I Policies and Procedures for Medicaid/Peachcare for Kids* (hereinafter "the Medicaid Manual") as well as *Part II Policies and Procedures for Community Mental Health Services* (hereinafter "the Community Mental Health Services Manual").

4. Respondent is required by federal regulations to coordinate, administer, and conduct "a comprehensive review of services billed to and paid for by [Medicaid]." MEDICAID MANUAL § 402 (Utilization Review). These Utilization and Compliance Reviews normally entail on-site visits by staff members and a simultaneous review of the provider's records. Respondent delegates its utilization and review functions to Utilization and Compliance Review staff employed by the Georgia Medical Care Foundation.

5. The purpose of Respondent's Utilization and Compliance Reviews is to determine whether:

A) Services rendered were reasonable, appropriate, and medically necessary.
B) Providers comply with Federal and Georgia law, and all Departmental policies and procedures.
C) Documentation adequately supports the services billed and correct payment is reimbursed for services rendered.
D) The quality of services rendered meets professionally recognized standards of health care.
E) Services and items provided were compatible with the provision of appropriate medical care and the services were effectively provided at the most economical level of care available.
F) The coding of diagnoses, procedures, and revenue codes are correct and in compliance with correct coding initiatives and mandates.
G) Correction measures or policy modifications should be recommended based on data or information obtained during the review process.

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[1] Ga. Comp. R. & Regs. 350-1-.02(3), the regulation specifically mentioning Manuals, was promulgated by the Department of Medical Assistance, DCH's predecessor agency. However, after DCH became the state entity responsible for the administration of Medicaid, it succeeded to the rules and regulations governing medical assistance, including those promulgated by the Department of Medical Assistance. See O.C.G.A. § 49-4-155 (2013).

MEDICAID MANUAL § 402.2.

November 17, 2011 Utilization and Compliance Review

6. Petitioner is a public, non-profit health facility organization operated by the South Georgia Community Service Board.[2] Community service boards are state-created entities tasked with providing "mental health, developmental disabilities, and addictive diseases services" *See* O.C.G.A. § 37-2-6 (2013).

7. On November 11, 2011, Respondent notified BHS that it would conduct an on-site Utilization and Compliance Review of its facility. Respondent included in this notification the date and time of the forthcoming audit and identification of the members whose records it sought to review. *Respondent's Exhibit 12; Testimony of Helen Rohrich.*

8. On November 17, 2011, GMCF Utilization and Compliance Reviewers, including Ms. Helen Rohrich, arrived at BHS's facility to conduct the Utilization and Compliance Review. This review was conducted in accordance with *Part I, Sections 402 and 506 of* DMA's Policies and Procedures Manual and "consisted of an analysis of 2,733 submitted claims, corresponding payment records and sixty (60) individual medical records covering dates of service from [July 1, 2010] through [June 30, 2011]." *Respondent's Exhibit 13; Testimony of Helen Rohrich.*

9. As a result of the November 17, 2011 Utilization and Compliance Review, Respondent determined that 1,637 services for which BHS had sought reimbursement were out of compliance with the policies and procedures governing Medicaid reimbursement. The deficiencies relevant for the purposes of this Decision were those relating to BHS's Patient Care Plans and nursing assessments. *Respondent's Exhibit 13; Testimony of Helen Rohrich.*

10. During the Utilization and Compliance Review, Respondent discovered that BHS had not been including Body Mass Index (BMI) calculations as part of the nursing assessments performed on members in its care. Respondent gave BHS no credit for performing nursing assessments that did not include a BMI calculation. Accordingly, Respondent sought recoupment for reimbursements paid to BHS for the performance of such nursing assessments. *Respondent Exhibits 13, 16, 17, and 18; Testimony of Helen Rohrich.*

11. Additionally, in its review of patient care plans maintained by BHS, reviewers discovered that, in many instances, although the patient had signed the care plan, he or she had not included a date next to their signature. Respondent determined Care Plans that did not include a date next to the patient's signature to be non-compliant and sought recoupment of payments previously disbursed to BHS for such care plans. *Respondent Exhibits 13, 16, 17, and 18; Testimony of Helen Rohrich.*

12. Compliance reviewers further noted that BHS had not been administering care in accordance with patient care plans. Although most patient care plans called for nursing assessments to be performed quarterly, BHS could provide documentation in support of only one annual assessment. Respondent sought recoupment of payments for the entire dollar amount of

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[2] BEHAVIORAL HEALTH SYSTEMS OF SOUTH GEORGIA, http://www.bhsga.com/ (last visited April 30, 2014).

care plans for which BHS could not provide documentation to support that nursing assessments were performed at the frequency indicated in the care plan. *Respondent Exhibits 13, 16, 17, and 18; Testimony of Helen Rohrich.*

13. On August 9, 2013, Respondent notified BHS of the conclusions of the Utilization and Compliance Review and that it sought recoupment for overpayments assessed as a result of its discovery of the above-described deficiencies. The total amount of the overpayment for which Respondent sought recoupment was $86,529.05.

Administrative Review of November 17, 2011 Utilization and Compliance Review

14. On or about September 10, 2013, BHS sought Administrative Review of Respondent's action. In its written request for Administrative Review, BHS wrote that it was appealing three of Respondent's findings: (1) failure to provide care in accordance with the plan of care, (2) incomplete documentation, and (3) failure to include consumer signature and date on the plan of care. *Respondent's Exhibit 16.*

15. BHS attributed its alleged failure to provide care in accordance with its patients' plans of care, to conduct on the part of its patients. According to BHS, its patients often failed to present for treatment because they often moved out of the service area, lacked transportation to its facility, or were simply reluctant to comply with their care plans. Moreover, BHS argued, its provision of nursing assessments on an annual basis comported with "prevailing standards" and therefore "[did] not constitute a deviation from customary care guidelines." BHS contended that consumer care plans were subject to frequent change throughout the course of treatment, resulting in nursing assessments "being provided in timeframes other than those established in the original plan of care." *Respondent's Exhibit 16.*

16. With regard to the alleged incomplete documentation of consumers' nursing assessments, BHS contended that BMI, while possibly a "best practice," was not a required element of a nursing assessment. Therefore, according to BHS, its failure to include a BMI calculation in its nursing assessments should not render its documentation incomplete. *Respondent's Exhibit 16.*

17. Finally, BHS contended that care plans lacking a date next to the consumer's signature should not be invalidated, since the error was one on the part of the consumer, and not the provider. BHS further argued that, since the care plan was dated throughout, the absence of a date next to the consumer's signature should be of no consequence. *Respondent's Exhibit 16.*

18. Respondent received BHS's letter on October 8, 2013 and thereafter conducted an Administrative Review. Based on the findings of its Administrative Review, Respondent adjusted the original overpayment amount to $86,373.40. Respondent reaffirmed its prior determinations regarding BHS's failure to provide care in accordance with care plans, failure to include consumer date and signature, and failure to include BMI calculations in its nursing assessments. *Respondent Exhibit 17.*

19. BHS requested an administrative hearing on or about November 13, 2013 and this matter was referred to the Office of State Administrative Hearings. In its written hearing request, BHS specified that the issues to be addressed at the hearing were as follows:

> (1) Whether or not [DCH] may properly recover payments previously made to [BHS] for [BHS's] failure to include a calculation of Body Mass Index (BMI) in nursing assessments, when such a calculation is not otherwise required by rule or regulation to be included as part of the nursing assessment.
>
> (2) Whether or not [DCH] may properly recover payments made to [BHS] for not providing quarterly nursing assessments, even in instances where consumers failed to appear for scheduled appointments or failed to adhere to plans of care.
>
> (3) Whether or not [DCH] may properly recover payments made to [BHS] for consumer's failure to handwrite a date on the consumer's written plan of care when the date was already included within the plan of care.

Petitioner's Request for Hearing dated November 13, 2013.

20. At the hearing of this matter, BHS reiterated the arguments it had previously expressed in its request for an administrative review and its request for an administrative hearing. BHS, through argument of counsel, submitted that Respondent had failed to demonstrate that it was out of compliance with policies and procedures as provided in the notice sent to it on August 9, 2013. BHS argued that Respondent had failed to support its finding of an overpayment in the amount reached after the above-described Administrative Review.

Petitioner's Failure to Obtain Consumer Signature and Date

21. Respondent failed to introduce evidence of a policy requirement that providers ensure that consumers sign *and* date Care Plans. Accordingly, Respondent retracted its determination that the absence of a date next to consumers' signatures on Care Plans constituted non-compliance with policies and procedures. Respondent indicated its assent to a revision of its calculation of an overpayment to reflect this retraction.

Petitioner's Failure to Include BMI Calculations in Nursing Assessments

22. BHS submitted at the hearing that BMI Calculations were nowhere listed as a mandatory element of nursing assessments. Both parties cited the *Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Disease Providers for the Department of Behavioral Health and Developmental Disabilities* [hereinafter "DBHDD Provider Manual], Part I, Section I in support of their respective positions on the issue of whether a BMI calculation is a required component of nursing assessments. The DBHDD Provider Manual includes the following criterion under the emboldened heading "Required Components":

> Nursing assessments should assess health risks, health indicators, and health conditions given that behavioral health conditions, behavioral health medications, and physical

health are intertwined. Personal and family history of Diabetes, Hypertension, and Cardiovascular Disease should be explored as well as tobacco use history, substance use history, blood pressure status and Body Mass Index (BMI). Any sign of major health concerns should yield a medical referral to a primary health care physician/center.

DBHDD PROVIDER MANUAL.

23. BHS contended that use of the word "should" in the rule section, according to principles of statutory interpretation, indicated that inclusion of BMI calculations in nursing assessments was recommended, but not mandatory. BHS contrasted the provision with clearly mandatory provisions in the same subsection that used the term "must." BHS cited the Georgia Court of Appeals case of *Lawrence v. State* for the proposition that "where the [drafter] uses certain language in one part of the statute and different language in another, the court assumes different meanings were intended." *Lawrence v. State*, 305 Ga. App. 199, 202 (2010); DBHDD PROVIDER MANUAL.

24. Respondent asserted that inclusion of the BMI provision under the heading "Required Components" indicated that it was a mandatory element of nursing assessments and stood by its prior conclusion that BHS's failure to perform BMI calculations as part of nursing assessments constituted non-compliance with service code definitions for which recoupment was warranted. DBHDD PROVIDER MANUAL.

25. Pat Myers, Clinical Nurse Manager for BHS, provided descriptive testimony about the nursing assessments performed by BHS. According to Mr. Myers, these assessments obtain data regarding the consumer's blood pressure, height, weight, symptoms, nutrition, and lifestyle. Mr. Myers explained that BHS's nursing assessments are developed by its Medical Director and a team of medical professionals through a policymaking procedure that begins after publication of Respondent's policy manuals. Mr. Myer's opined that use of the term "should" in the DBHDD Provider Manual indicated that BMI calculations were not mandatory and explained that BHS did not perform BMI calculations because staff members were able to obtain the same relevant data through more effective means. *Testimony of Pat Myers.*

Petitioner's Alleged Failure to Abide by Patient Care Plans

26. Ms. Roz Johnson, Chief Clinical Officer with BHS and BHS's interim Chief Executive Officer at the time of the Utilization and Compliance Review, testified that the alleged failure to abide by patient care plans was attributable to a shortcoming with Respondent's electronic forms. *Testimony of Roz Johnson.*

27. Staff members of BHS, with the cooperation of consumers, formulate a care plan at the outset of care. The care plan sets forth objectives and prescribes services, or "interventions," that the provider will perform during the course of the consumer's care. Providers are required to create these care plans using a state-generated electronic form called the Multipurpose Information Consumer Profile (MICP). This electronic format allows users to populate the form using "drop-down" menus. According to Ms. Johnson, the drop-down menu in the appropriate field on the MICP does not include "Annual" as an option for the frequency at which nursing

assessments are performed. Therefore, she testified, staff members with BHS ordinarily select the "Quarterly" option from the drop-down menu, since it is the interval that is closest to what they intend to offer, and include a notation in the form's text box that nursing assessments are to be conducted annually. *Testimony of Roz Johnson.*

28. Petitioner submitted several examples of completed MICPs into evidence. On these MICPs, the author of the form indicated that the consumer, "AA" would receive nursing assessments quarterly. However, the form also includes the notation "Nurse will provide annual NA and labs and will and [sic] educate client on medication side effects and benefits." *Petitioner Exhibit 1.*[3]

29. Ms. Johnson further testified that BHS has notified Respondent of the issue with the electronic MICP, but that the "Annual" option is still absent from the drop-down menu. She testified that BHS has adopted a policy of manually altering the forms to reflect that nursing assessments are performed annually. Annual nursing assessments are the norm at BHS, Ms. Johnson explained, because the field of behavioral health is ill-suited to more frequent assessments. *Testimony of Roz Johnson.*

III. Conclusions of Law

1. The Division is authorized to recoup payments previously made to a provider for any of the following reasons:

A) The Division paid the provider for a claim for a service for which reimbursement is not allowed by the State Plan.
B) The Division paid the provider an amount in excess of the amount allowed under the State Plan or other policy of the Division.
C) A third party paid the provider for a claim (or portion thereof) previously paid by the Division.
D) The Division paid the provider for services, items or drugs that the provider did not perform or provide.
E) The services provided have been determined to be medically unnecessary, of substandard quality or not in keeping with currently accepted standards of medical practice or applicable statutory law by the Division or by any other entity authorized by the Division to make such a determination.
F) The provider has failed to comply with all terms and conditions of participation related to the service(s) for which a claim has been paid.
G) The Division paid for claims submitted by a data processing agent for whom a written Trading Partner Agreement was not on file with the Division at the time of submission.
H) The provider has submitted electronic media billing in violation of the Provider Agreement for Electronic Data Interchange.

[3] For the purposes of this Decision, the examples of MICPs Petitioner submitted at the hearing are collectively referred to as "Petitioner's Exhibit 1."

I) The Division paid for claims at a rate based upon a provider's submitted cost report, or other cost information report, and the cost report data was adjusted based upon review or audit by the Division or its agents.

J) The provider has failed to maintain the proper documentation required pursuant to this Part I or Part II (and Part III where applicable) of the manual or currently accepted standard of medical practice.

K) The drugs or services for which reimbursement is claimed are ordered by a provider or other professional providing services or goods reimbursed by Medicaid/PeachCare for Kids, that either appears on the Department of Health and Human Services, Office of the Inspector General's (OIG) Exclusion List or has been previously terminated or suspended by the Division.

MEDICAID MANUAL § 407 (Recoupment of Reimbursement).

2. The rules governing Medicaid reimbursement for community mental health services are published in Respondent's Community Mental Health Services Manual. COMMUNITY MENTAL HEALTH SERVICES MANUAL § 901. Definitions for specific services or procedures covered by Medicaid are contained in the DBHDD Provider Manual. COMMUNITY MENTAL HEALTH SERVICES MANUAL § 902 (Covered Services). "All procedure codes billed to [Respondent] must match the service definition and be titled and described in the progress notes of the client's record." *Id.* "Services which are not provided in compliance with the services and limitations described in [the Community Mental Health Services Manual] or the [DBHDD Provider Manual] are not eligible for reimbursement." COMMUNITY MENTAL HEALTH SERVICES MANUAL § 903 (Non-Covered Services).

3. According to the DBHDD Provider Manual, Individualized Treatment (Recovery/Resiliency) Planning must:

- Identify and prioritize the needs of the consumer
- Document by consumer or guardian signature that the consumer is an active participant in the planning and process of care (to the degree to which that is possible).
- State goals which will honor achievement of stated hopes, choice, preferences, and desired outcomes of the consumer and/or family;
- Assure goals/objectives are:
    - Related to assessment/reassessment
    - Designed to ameliorate, rectify, correct, reduce or make symptoms manageable; and
    - Indicative of desired changes in levels of functioning and quality of life to objectively measure progress.
- Define goals/objectives that are individualized, specific and measurable with achievable timeframes;
- Detail interventions which will assist in achieving the outcomes noted in the goals/objectives;
- Identify and select services and interventions of the right duration, intensity and frequency to best accomplish these objectives;
- Assure there is a goal/objective that is consistent with the service intent;

- Identify frequency and duration of services which are set to achieve optimal results with resource sensitive expenditures.

DBHDD MANUAL, Part II, Section IV (Documentation Guidelines for Behavioral Health Providers).

4. In formulating care plans, BHS is required to complete an electronic form designed by Respondent. The form does not give BHS's staff members the option to indicate that nursing assessments are to be performed annually. Therefore, staff members routinely choose the most accurate option that the form allows and include the notation that nursing assessments are to be performed annually. The textual notation, which is within the user's control, gives a definitive indication that the provider and the consumer agreed on the annual performance of nursing assessments, negating the contrary indication selected in the drop-down box. Therefore, where a care plan included the notation that nursing assessments were to be performed annually, BHS's documentation of annual nursing assessments satisfactorily demonstrated that it adhered to the care plan. In light of the electronic form's restrictions, the fact that the user selected "Quarterly" or "Monthly" from the form's drop-down menu does not mandate that BHS produce documentation of quarterly or monthly nursing assessments as long as the care plan included the notation that nursing assessments were to be performed annually. Respondent's determination to recoup for BHS's billing for care plans that called for quarterly or monthly nursing assessments where those care plans included a textual indication that annual nursing assessments were to be performed was erroneous and is hereby **REVERSED**.

5. As discussed *supra*, services for which a provider may seek reimbursement from Respondent must comport with their respective definitions in the DBHDD Provider Manual. COMMUNITY MENTAL HEALTH SERVICES MANUAL § 902. The DBHDD Provider Manual defines nursing assessments to include BMI calculations. Although, in some instances, use of the term "should" may indicate a mere recommendation, the drafters' inclusion of BMI calculations under the heading "Required Components" in the section of the Manual setting forth the criteria providers must meet in order for a service to be reimbursed strongly indicates that BMI calculations are a mandatory component of nursing assessments. Accordingly, Respondent's determination to seek recoupment for BHS's billing for nursing assessments that did not include BMI calculations was correct and is hereby **AFFIRMED**.

6. Respondent withdrew its determination to seek recoupment for care plans that the consumer did not date as well as sign. Accordingly, its determination to seek recoupment for BHS's billing for such care plans is **REVERSED.**

IV. Decision

IT IS HEREBY ORDERED that Respondent's adverse action is **AFFIRMED IN PART** and **REVERSED IN PART.** This matter is **REMANDED** to Respondent so that it may recalculate the amount of the overpayment in accordance with the foregoing Conclusions of Law.

SO ORDERED, this 2nd day of May 2014.

BARBARA A. BROWN
Administrative Law Judge