IN THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

BUILDING BLOCKS PEDIATRICS,	:	
TOTS INC D/B/A KIDDOS'	:	Docket Nos.:
CLUBHOUSE,	:	OSAH-PROP-1508817-67-Baxter
SUNSHINE PEDIATRIC THERAPY LLC,	:	OSAH-PROP-1533655-67-Baxter
RISING STARS CHILDREN'S THERAPY,	:	OSAH-PROP-1533653-67-Baxter
GROW WITH ME PEDIATRIC	:	OSAH-PROP-1533656-67-Baxter
PHYSICAL THERAPY, INC.,	:	OSAH-PROP-1533657-67-Baxter
BUILDING BRIDGES THERAPY, INC.,	:	OSAH-PROP-1533659-67-Baxter
	:	
Petitioners,	:	
	:	
v.	:	
	:	
DEPARTMENT OF COMMUNITY HEALTH,	:	
Respondent.	:	

APR 8 2015

Kevin Westray, Legal Assistant

INITIAL DECISION

The Petitioners appeal determinations by the Department of Community Health ("Department") to deny their requests for administrative review as untimely. On January 22, 2015, this Court consolidated the six cases for hearing and this decision.[1] The hearing in this matter was held on January 12 and 21, 2015. The evidentiary record remained open until March 9, 2014, to allow the parties to file Proposed Findings of Fact and Conclusions of Law. After careful consideration of the evidence, the Department's decision to deny Petitioners' Requests for Administrative Review is hereby **REVERSED** except for Petitioner Grow With Me Pediatric Physical Therapy, Inc.[2]

[1] The Department erroneously submitted the Petitioners' requests for hearing as one case under a petitioner named CIS Group. Not until the hearing did the Court determine that, in fact, each Petitioner requested its own hearing and that there is no such entity called CIS Group.

[2] No specific evidence was presented as to Petitioner Grow With Me Pediatric Physical Therapy, Inc. ("Grow With Me"). Nor does the Court find any record of a stipulation between the parties regarding Grow With Me.

I. FINDINGS OF FACT

A. Background

1.

Each of the Petitioners provides speech, occupational, and physical therapies to children, and a portion of these children are Medicaid beneficiaries. These types of services are provided by the Petitioners through the Department's Children Intervention Services program ("CIS"). (Testimony of Carson.)

2.

Petitioners entered into a contract called a "Statement of Participation" with the Department, which incorporates by reference the following manuals: *Policies and Procedures for Medicaid PeachCare for Kids and Part I* and *Part II Policies and Procedure for Georgia Medicaid Children's Intervention Services* ("Manuals"). The Manuals establish the contractual parameters of the relationship between the Department and participating providers, including specific conditions of participation, covered services, and the cost reimbursement methodology. (Ex. R-1.)

3.

According to the Statement of Participation, the Department is obligated to notify the Petitioners of any modifications to the provisions contained in the Manuals for the services in which a Provider is enrolled as well as provide public notice of significant changes in the Department's methods and standards for setting payment rates for covered services. One method of communication that the Department uses is posting Banner Messages. The Banner Messages that pertain to CIS providers are approved by the Department's witness, Dr. Janice Carson.[3] (Testimony of Carson.)

4.

An accounting and reconciliation of an individual provider's claims is set forth in a Remittance Advice. The information contained in the Remittance Advice is intended to assist the provider in reconciling Medicaid/PeachCare for Kids accounts and to assist the Department in guarding against false or erroneous billings. (Testimony of Carson.)

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[3] Carson is employed by the Department as the Deputy Director for Performance, Quality and Outcomes. She oversees several programs including a portion of the CIS program. (Testimony of Carson.)

5.

Claim processing is carried out for the Department by its fiscal agent. Since 2010, the Department has used Hewlett Packard Enterprise Services ("HP") as its fiscal agent. HP uses the Medicaid Management Information Systems ("MMIS") to process claims. (Testimony of Carson.)

B. Mass Reprocessing

6.

In early 2011, the Department became aware of processing errors, "hiccups," in HP's MMIS system. The Department waited approximately two years to correct these errors and reprocess the affected claims. (Testimony of Carson.)

7.

In the Department's first notice of its intent to fix the MMIS deficiencies, the Department sent **all** CIS providers a Banner Message dated January 18, 2013, alerting them of its pilot program to reprocess CIS claims impacted by the MMIS deficiencies. As the name implies, the pilot reprocessing only applied to a small group of CIS providers who had previously agreed to have their claims reprocessed as a test run for the Department. However, the apparent scope of the Banner Message confused the providers and was never clarified by the Department. The Department likewise appeared to be confused by the Banner Message, as evidenced by Carson's testimony that the Petitioners were encompassed in the test run, which was undermined by subsequent evidence establishing that the Petitioners were not a part of the pilot reprocessing. (Testimony of Carson, Mann, Estes, Conley, Horton, McCullough; Ex. R-8.)

8.

Five months later, another Banner Message dated May 15, 2013, notified all CIS providers that the Department would reprocess claims affected by the MMIS deficiencies from November 2010 to June 30, 2012. The Banner Message failed to notify the providers when the mass reprocessing would take place. (Testimony of Carson; Ex. R-8.)

9.

Simultaneously, the Department initiated a reprocessing of CIS provider's claims for compliance with the National Correct Coding Initiative ("NCCI"). This reprocessing was carried out in response to a mandate issued by Centers for Medicare and Medicaid Services ("CMS") on

September 1, 2010, which required all states to incorporate the NCCI edit methodologies into their Medicaid claims processing systems and to begin editing claims filed on or about October 1, 2010. The Department did not complete the required implementation until September 2013, three years after the mandate, and has not yet conducted a mass reprocessing for all impacted providers. Thus, the Department simultaneously reprocessed some claims for NCCI edits and some for HP errors, which remained unclear to the providers. (Testimony of Carson; Ex. R-9.)

10.

Over 200,000 claims were subject to the mass reprocessing. (Testimony of Carson.)

11.

The Department handled the mass reprocessing as follows:

a. Each provider was assigned an HP representative.
b. The provider was to contact its HP representative through the MMIS web portal.
c. The HP representative worked with the provider to identify claims that needed to be adjusted.
d. The provider created a spreadsheet that identified the impacted claims and reviewed the spreadsheet with its HP representative.
e. The HP representative reached out to policy staff to determine if the claims could be overridden and repaid.

(Testimony of Carson; Ex. R-8.)

12.

On September 17, 2013, the Department sent a Banner Message that stated, in part, "The Part I Policies and Procedures for Medicaid and PeachCare for Kids manual describes the timeframe for adjustments to reprocessed claims." (Ex. R-8.)

13.

At the hearing, Carson referred to Section 204(c) of the Part I Manual, which states:

> [If] the claim has been denied due to erroneous or missing information. Claims in this category must be received . . . within three (3) months of the month in which the denial occurred[.] Denied claims must be resubmitted with corrected information on a new claim form or be resubmitted on the third party administrator's website[.]

This Section relates to claims that have been denied due to *provider* error. The Department admits and the evidence demonstrates that the claims subject to the mass reprocessing were not denied due to provider error, but due to HP error and the newly implemented NCCI edits. (Testimony of Carson; Ex. R-8.)

C. Special Remittance Advice & Recoupment

14.

The Petitioners received the Special Remittance advices on September 13, 2013 ("Special Remittance Advice"). These Special Remittance Advices were not like any other prior Remittance Advices received by Petitioners. A usual and customary Remittance Advice was six to forty pages. The Special Remittance Advice was 135 to 791 pages depending on the particular Petitioner. (Testimony of Estes, Horton, McCullough, Mann, Conley.)

1. Building Bridges Therapy, Inc.

15.

Marla Mann has been the owner of Petitioner Building Bridges Therapy, Inc. ("Building Bridges") for over six years. Upon receipt of the Special Remittance Advice in September 2013, Mann was shocked and confused because it stated the Department was taking back close to $22,000.00 in recoupment for claims Building Bridges had submitted and had been paid for dating back as far as 2010. (Testimony of Mann.)[4]

16.

As instructed, Mann immediately went online to the web portal and asked to be contacted by someone from the Department or HP. (Testimony of Mann.)

17.

In response, an HP representative met with Mann to review the Special Remittance Advice. At the time of the initial meeting, Mann had prepared a list of claims that had been denied and that she could not successfully resubmit. The HP representative took the list of claims and said he would help handle the reprocessing. Mann and the HP representative continued to exchange

[4] It is important to note that all the claims at issue had been submitted, accepted, and paid prior to the mass reprocessing. During the mass reprocessing, the claims were denied as untimely when resubmitted, as instructed, or denied as having been paid twice, which was also not correct. (Testimony of Mann, Estes.)

emails and information, and some claims that were originally denied were successfully adjusted. By January 2014, neither Mann nor the HP representative could make the Special Remittance Advice reconcile with the amount recouped by the Department, and Building Bridges could not account for the remaining $6,000.00 recouped as a result of the mass reprocessing. Mann's last inquiry to HP in January 2014 went unanswered. (Testimony of Mann; Ex. P-3.)

18.

At no point during the repeated emails, conversations, and meetings did the Department's agent, HP, instruct Building Bridges that HP could no longer assist it nor did HP direct Building Bridges to contact another entity for assistance or to submit a DMA 520A form. Although Mann specifically inquired into missing a time deadline, HP did not advise Petitioner to file a request for administrative review. To the contrary, the HP representative continued to request information and assure Mann that the claims were being handled. (Testimony of Mann.)

2. Rising Stars Children's Therapy

19.

Kristi Estes is the owner of Rising Stars Children's Therapy ("Rising Stars"), which has been a Medicaid provider since 2006. Upon receipt of the Special Remittance Advice in September 2013, Estes was shocked because Rising Stars did not receive a payment with the Special Remittance Advice, and instead, the Department recouped approximately $29,000.00 for claims Rising Stars had submitted and been paid for previously. (Testimony of Estes.)

20.

As instructed, Estes immediately went online to the web portal and asked to be contacted by someone from the Department or HP. (Testimony of Estes.)

21.

In response, an HP representative met with Estes and reviewed the Special Remittance Advice. As instructed by the HP representative, Estes had prepared a list of claims that had been denied that Petitioner had attempted to resubmit but were continuously denied. The HP representative took this list of claims and said he would help handle the reprocessing. Estes and the HP representative continued to exchange emails and information, and some claims that were originally denied were successfully adjusted. By January 2014, neither Estes nor the HP representative could make the Special Remittance Advice reconcile with the amount recouped by

the Department, and Rising Stars could not account for close to $10,000.00 recouped as a result of the mass reprocessing. Further, Estes could not even tie the monies taken to specific claims. The HP representative responded to an inquiry sent by Estes in January 2014 with an apology, and an assurance that "[w]e'll get this done so you all can move forward" and that he would contact a superior. Estes waited as instructed. (Testimony of Estes; Ex. P-7.)

22.

At no point during the repeated emails, conversations, and meetings did the Department's agent, HP, instruct Estes that HP could no longer assist her nor did HP direct Estes to contact another entity for assistance or to submit a DMA 520A form. Although Estes specifically inquired into missing a time deadline, neither HP nor the Department advised Petitioner to file a request for administrative review or that Petitioner needed to be concerned about a deadline. To the contrary, the HP representative continued to request information and assure Estes that the claims were being handled. (Testimony of Estes; Ex. P-7.)

3. TOTS, Inc. D/B/A/ Kiddos' Clubhouse

23.

Ashley Horton has been the Medicaid biller and scheduling coordinator for TOTS, Inc. d/b/a Kiddos' Clubhouse ("TOTS") since June 2013. Upon receipt of the Special Remittance Advice in September 2013, Horton was alarmed because TOTS did not receive its monthly payment, but instead, money was recouped from it in the amount of $234,518.34 for claims it had submitted and been paid for previously, some dating back to January 2010. (Testimony of Horton.)

24.

Horton immediately contacted Anita Mills, who was a compliance auditor with the Department at the time, to ask how to handle this extensive remit. Mills told her that there were HP representatives in place and told Horton to send an HP representative her contract information. Horton did as instructed. (Testimony of Horton; Ex. P-4.)

25.

In response, an HP representative met with Horton to review the Special Remittance Advice. Horton went line-by-line through the 791-page Special Remittance Advice with the HP representative. They met again in person and subsequent to that, the HP representative instructed Horton to send any claims she had trouble resubmitting so that the HP representative could

resubmit them and get payment. Horton and the HP representative continued to exchange emails and information, and some claims that originally were denied were successfully adjusted. But by December 2013, neither Horton nor the HP representative could reconcile the claims and numbers on the Special Remittance Advice with the amount recouped by the Department. Tots, Inc. could not account for close to $10,000.00 recouped as a result of the mass reprocessing. Further, Horton could not even tie all of the monies recouped to specific claims. Horton sent another inquiry with information and requesting instruction and assistance to the assigned HP representative in December 2013. The HP representative responded to her inquiry by stating, "I am not sure what happened, but I will turn these in today." Petitioner waited as instructed. (Testimony of Horton; Ex. P-4.)

26.

At no point during these repeated emails, conversations, and meetings did the Department's agent, HP, instruct Horton that HP could no longer assist her nor did HP direct her to contact another entity for assistance or to submit a DMA 520A form. Although, Horton specifically inquired into missing a time deadline, at no point, did HP or the Department advise Horton to file a request for administrative review. To the contrary, the HP representative continued to request information and assure Horton that the claims were being handled. (Testimony of Horton; Ex. P-4.)

4. Building Blocks Pediatrics

27.

Amy Conley has been the owner of Building Blocks Pediatrics ("Building Blocks") for the past 6 years. The Department recouped approximately $6,000.00 for claims Building Blocks had submitted and been paid for previously in the September 2013 Special Remittance Advice. (Testimony of Conley.)

28.

Conley immediately contacted Anita Mills with the Department to ask how to handle the extensive remit. Mills forwarded her email to a person in the Department's recovery section. The Benefits Director directed her to contact an HP representative. Conley did as instructed. (Testimony of Conley; Ex. P-6.)

29.

In response, an HP representative met with Conley to review the Special Remittance Advice. They reviewed the Special Remittance Advice together but were unable to reconcile it with the recouped amount. They met again in person and subsequent to that, the HP representative instructed Conley to send any claims she had trouble resubmitting to the HP representative so that she could resubmit them and get payment. Conley and the HP representative continued to exchange emails and information, and some claims that were originally denied were successfully adjusted. But by January 8, 2014, neither Building Blocks nor the HP representative could reconcile the claims and numbers on the Special Remittance Advice with the amount recouped by the Department, and Petitioner could not account for close to $600.00 recouped as a result of the mass reprocessing and could not even tie the monies taken to a specific claim. Conley sent the Department another email in January 2014 asking for assistance and resolution. The Department responded that it would contact its claims manager, Sheila Maddox, to see if she could assist in getting the claims reprocessed. So, Conley waited as instructed. (Testimony of Conley; Ex. P-6.)

30.

At no point during these repeated emails, conversations, and meetings did the Department or its agent, HP, instruct Building Blocks that HP could no longer assist it nor did HP direct it to contact another entity for assistance. Neither HP nor the Department advised Building Blocks to file a request for administrative review or file a DMA 520. To the contrary, the HP representative continued to request information and assure Conley that the claims were being handled. (Testimony of Conley; Ex. P-4.)

5. Sunshine Pediatrics Therapy, LLC

31.

Becky McCullough has been the owner of Sunshine Pediatrics Therapy, LLC ("Sunshine Pediatrics") for over ten years. Upon receipt of the Special Remittance Advice in September 2013, McCullough was shocked because it stated the Department was taking back money in recoupment from Sunshine Pediatrics for claims it had submitted and been paid dating back as far as 2010. (Testimony of McCullough.)

32.

McCullough immediately contacted Anita Mills with the Department to ask how to handle the remit. Mills told her contact an HP representative to review the claims in question and to potentially reprocess claims that were denied in error. McCullough did as instructed. (Testimony of McCullough; Ex. P-5.)

33.

In response, an HP representative met with McCullough to review the Special Remittance Advice on two different occasions. During the meeting, they went through a spreadsheet and each claim in the Special Remittance Advice. The HP representative resubmitted the claims and used an override in the HP system to get some of the claims to reprocess correctly. McCullough and the HP representative continued to exchange emails and information, and some claims that originally were denied were successfully adjusted. By December 2013, neither Sunshine Pediatrics nor the HP representative could reconcile the claims and numbers on the Special Remittance Advice with the amount recouped by the Department and Sunshine Pediatrics still had approximately $1,400.00 recouped, but not accounted for in the Special Remittance Advice. Eventually, on December 5, 2013, McCullough was able to reach Carson who instructed her to contact her HP representative. Although this exchange occurred right up against the alleged 90-day time deadline, Carson did not instruct McCullough to request an administrative review; she simply directed her back to her HP representative. (Testimony of McCullough, Ex. P-5.)

34.

At no point during these repeated emails, conversations, and meetings did the Department or its agent, HP, instruct Sunshine Pediatrics that HP could no longer assist it nor direct it to contact another entity for assistance or to submit a DMA 520A form. To the contrary, the HP representative and the Department continued to request information and assure Petitioner that the claims were being handled. (Testimony of McCullough; Ex. P-5.)

D. Requests for Administrative Review

35.

Each Petitioner did as instructed and followed the directions given to them by the Department through its Banner Messages and its fiscal agent, HP. That is, the Petitioners reached out to HP, met with HP, provided HP with a list of claims at issue, and provided all documents requested.

Even after following these instructions, the end result was that the numbers were not reconciled and Petitioners were left waiting for a response as to the claims remaining at issue. They never received a response or reconciliation.

36.

After several months of waiting, the Petitioners sought to have an administrative review of the recoupment claims. The Department denied their requests, stating that they were untimely because Petitioners had not filed the requests within 30 days of receiving the Special Remittance Advices. (Ex. R-2.)

37.

Contrary to the Department's statement in the denial letters, Carson testified that the Petitioners had ninety (90) days from the date of the Special Remittance Advice to adjust their claims, and that after that, they would go through the "part one process" and would thereafter have thirty (30) days to submit a request to administrative review. (Testimony of Carson; Ex. R-2.)

38.

The Department did not post the "new" time frame for submitting requests for administrative review in any Banner Message or in the Manuals. Nor did the Department convey the new time frame to the Petitioners either in writing or verbally. (Testimony of Carson.)

39.

Moreover, at the hearing, the Department could not credibly explain the recoupment amount taken from each Petitioner in the Special Remittance Advice. For example, Carson testified that the monies taken from each Petitioner included a recoupment amount by the Department for advances given to each Petitioner in August and September of 2011. The evidence demonstrates that this testimony was clearly incorrect. (Testimony of Horton, Conley, McCullough, Mann, Estes.)

II. CONCLUSIONS OF LAW

1.

The burden of proof is on the Respondent by a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.07(1), -.21(4).

2.

Medicaid is a cooperative federal-state cost-sharing program with the purpose of providing necessary medical assistance to the poor, elderly, and disabled. See 42 U.S.C. §§ 1396-1396(v); 42 C.F.R. § 430.0.

3.

The Medicaid Act also provides for the designation of a "single state agency" to administer or supervise a state Medicaid program. See 42 U.S.C. § 1396a(a)(5). The Department is the state agency designated to administer Georgia's Medicaid program. See generally O.C.G.A. § 49-4-142.

4.

The relationship between Medicaid providers and the Department is established by contract composed of a "Statement of Participation," and the Department's Manuals. HP is an agent of the Department and acts on behalf of the Department.

5.

The Medicaid program reimburses participating providers for items and services provided to Medicaid patients. The Statement of Participation itself is short and contains little detail. The terms and conditions of the relationship are fleshed out by the detailed provisions of written Manuals that are incorporated by reference into the Statement of Participation – *Part I, Policies and Procedures* and *Part II, Policies and Procedures.* Both the Department and participating providers are contractually bound by the terms of the Manuals. See ABC Home Health Servs., Inc. v. Georgia Dep't of Med. Assistance, 211 Ga. App. 461, 463 (1993) ("the relationship between the [Department] and the [provider] is contractual"); Georgia v. Stuckey Health Care, 189 Ga. App. 126, 129 (1989); see also Briarcliff Haven v. Dep't of Human Res., 403 F. Supp. 1355, 1364 (N.D. Ga. 1975.)

6.

Here, the Department denied Petitioners' administrative review of recouped claims because the Petitioners failed to file requests for review within 30 days of receiving their Remittance Advices. Following this logic, Petitioners would have been required to submit requests for review in September and October 2013 during the same time in which the Department and its agent were telling the Petitioners to follow a completely different process of resubmitting claims and when Petitioners were working with a HP Representative. At the hearing, the Department

changed is position and claimed Petitioners had some other, longer deadline to file an administrative review, though it is still unclear what that deadline was.

7.

The changing deadline is not the only flaw in the Department's position. The evidence is clear that the Department's recoupment actions could not be reconciled with actual claims submitted such that the Petitioners could not have requested review of any specific claim.

8.

As such, the Department's position is illogical and wholly unfair. The Department's instructions were inconsistent and misleading, and although the Petitioners followed the instructions as best they could, the Department is attempting to penalize them for their justifiable reliance on the Department's words and actions.

9.

Additionally, the Department's position is unsupported by the law. In Smith v. Dep't of Human Res., 257 Ga. App. 33 (2002), the Court of Appeals addressed a case where a state agency provided misleading communications to the petitioner. The Court refused to affirm a summary judgment ruling denying a Medicaid provider an administrative review based on a failure to provide documents with its appeal because such failure was based on the misleading communications. The Court held:

> We find material questions of fact on the waiver issue. DHR's January 30 letter to Smith was worded in such a way as to indicate that the submission of supporting documentation was optional. The next written communication to Smith . . . contained no mention of her right of appeal. Then, . . . DHR informed Smith that her request for administrative review had been denied because she failed to comply with the mandatory requirement to submit supporting documentation. Under these facts, a jury could find that any waiver by Smith of her appeal rights was tainted by misleading communications sent to her by DHR.

Id. at 36-37. Likewise, the Department's inconsistent and misleading communications to the Petitioners in this case have tainted any alleged waiver of their right to an administrative review.

10.

Through its course of conduct, the Department has waived any requirement for strict adherence to the time frame within which a provider may request an administrative review. See Circle Y Constr., Inc. v. WRH Realty Servs., 427 Fed. Appx. 772, 774 (11th Cir. 2011); Caribbean

Lumber Co. v. Anderson, 205 Ga. App. 415, 417 n.1 (1992) (holding waiver may be established through course of conduct between the parties). The Petitioners trusted and relied on the instructions they received from the Department and followed these instructions at each stage in this process. The Department cannot waive its own policies and procedures and then require the Petitioners to strictly adhere to the same policies and procedures that they were previously instructed to disregard.

11.

The Department has failed to carry its burden in showing that the Department's basis for denial of an administrative review is correct.

III. DECISION

In accordance with the forgoing Findings of Facts and Conclusions of Law, the Department's decision to deny the Petitioners' Request for Administrative Review is **REVERSED** except for Petitioner Grow With Me. Petitioner Grow With Me has ten days to submit documentation that the parties stipulated to facts regarding this Petitioner or that Exhibit P-2 was admitted into evidence.

SO ORDERED, this 7th day of April, 2015.

AMANDA C. BAXTER
Administrative Law Judge