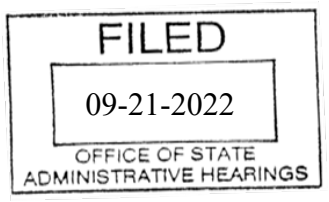
BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

METNURSE HEALTH SERVICES, INC.	:	
	:	**Docket Number.: 2220233**
Petitioner,	:	**2220233-OSAH-DCH-PROP-75-Walker**
	:	
v.	:	**Agency Reference No. P15-03142236B**
	:	
DEPARTMENT OF COMMUNITY HEALTH,	:	
	:	
Respondent.	:	



INITIAL DECISION

I. INTRODUCTION

Petitioner MetNurse Health Services, Inc. (also "MetNurse") appeals the decision by Respondent Department of Community Health ("Department") to recoup $14,040.00 previously paid by the Department for services rendered under the Georgia Pediatric Program ("GAPP" or "GAPP program.") A hearing was held on August 8, 2022, before the Office of State Administrative Hearings. Dr. Okwuadigbo, the CEO of MetNurse, appeared for the Petitioner and Kevin Spainhour Esq. represented the Department. After careful consideration of all the evidence of record in this case, and based upon a preponderance of evidence, the Court makes the following findings of fact, conclusions of law and decision.[1]

[1] This case originally was scheduled for an administrative hearing on June 7, 2022. Subsequently, each party moved to continue the hearing date, and the case was rescheduled to July 13, 2022. Prior to the commencement of the hearing on July 13, 2022, the Petitioner presented additional documentation to the Respondent. The Respondent requested a continuance so that it could review the documents presented by the Petitioner, and the case was rescheduled to August 8, 2022. At the conclusion of the administrative hearing, the undersigned requested the Department file additional legal authority. On or about August 31, 2022, the Department informed the undersigned it had no additional legal authority to present.

II. FINDINGS OF FACT

A. Background

1.

GAPP is a Medicaid program providing in-home services to medically fragile children who require nursing care and/or personal care support services. (Testimony of Susan Herringa; Part II, Policies and Procedures for Manual for GAPP Services January 1, 2020 (also "Manual) at §§ 601, 601.1, 601.3A.)

2.

Providers, such as MetNurse, furnish GAPP recipients with the in-home services, and the Department then reimburses the providers for services rendered.[2] The GAPP Policies and Procedures Manual outlines the documentation and reporting process required for GAPP providers. Per the Manual, enrolled providers must adhere to the requirements as outlined in the Manual and with all applicable federal, state and local laws, rules, and regulations. (Testimony of Ms. Herringa; Manual at §§ 601.2A, 601.G, 602B.)

3.

To ensure that providers comply with the GAPP Manual, the Department may conduct onsite reviews and audits of provider agencies.[3] Alliant Health Solutions ("Alliant") performs

[2] A provider is "an actual or prospective provider of medical assistance under this chapter. The term 'provider' shall also include any managed care organization providing services pursuant to a managed care program operated, funded, or reimbursed by the Georgia Medicaid program." O.C.G.A. § 49-4-146.1(8).

[3] The Manual at § 905.14 provides, in part, as follows:

> In order to ensure compliance with the policies and procedures set forth in this manual, representatives of the DCH may conduct onsite reviews and audits of provider agencies enrolled with the Department. The reviews and audits will be conducted to determine the medical necessity for services, whether services reported have been performed and whether the provision of care meets currently accepted standards of practice, as well as compliance with GAPP policy. The reviews will include in-agency review of clinical and billing records and in-home patient assessments. The DCH or its designee maintains the right to periodically review the need for continuation of services.

the utilization review audits of enrolled providers on behalf of the Department. (Testimony of Ms. Herringa; Manual at §§ 602.5(1), 905.14.)

B. Utilization Review Audit

4.

At the Department's request, Alliant initiated a utilization review audit (the "audit") of MetNurse's provision of services to one patient, M.J., from January 1, 2020, to December 31, 2020. Susan Herringa has been a utilization review nurse for Alliant for thirteen years and conducted the audit at issue in this proceeding. (Testimony of Susan Herringa; Testimony of Dr. Okwuadigbo.)

5.

Following the audit, the Department sent the Petitioner a Notice of Proposed Adverse Action ("Notice"), stating that as a result of Alliant's audit the Department had determined that it made overpayments to MetNurse in the amount of $14,040. A subsequent Administrative Review upheld this determination.[4] (Testimony of Ms. Herringa; Testimony of Dr. Okwuadigbo; Manual at § 602.5(1); Exhibit R-1 at 3.)

6.

Appendix C of the audit's findings indicated that there were 525 claims subject to recoupment. The bulk of the claims at issue fall into three categories: 1) the Physician Plan of Treatment/Letter of Medical Necessity was not in the provider's records, 2) the Nursing Care Plan was not in the provider's records, and 3) documentation of the required Nurse Supervisory

[4] A Notice of the Initial Findings/Proposed Adverse Action was sent to MetNurse on November 8, 2021. The Notice advised MetNurse to submit a Corrective Action Plan that would correct the deficiencies identified but cautioned that an acceptable Corrective Action Plan would not overturn the proposed recoupment. The Petitioner submitted a Corrective Action Plan. Testimony of Dr. Okwuadigbo; see OSAH Form 1.

Visits was insufficient in that the RN and/or LPN did not assess and/or monitor services as required by policy. [5] (Exhibit R-1 at 5.)

1. Physician Plan of Treatment

7.

Providing appropriate care for a member requires communication between the member's physician, nursing staff, certified nursing assistants and/or personal support provider. The Manual mandates that providers maintain a clinical record for members. A member's records must include a current physician plan of treatment ("PPOT") signed and dated by the attending physician and updated every sixty to ninety (60 or 90) days.[6] In the PPOT, a physician identifies a member's diagnoses and addresses "types of services and equipment, required frequency of visits, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures, discharge planning, and other appropriate items." Regular PPOT updates are essential because a member's medical condition can rapidly change and/or deteriorate. (Testimony of Ms. Herringa, Manual at §§ 905.1, 905.2(A),(B).)

[5] Appendix C of the UCR Review Finding Summary listed the types and the number of violations and stated:

> A. The Nursing Care Plan was NOT in the record (127). A. The Physician Plan of Treatment (PPOT)/Letter of Medical Necessity was NOT in the record (127). A. The RN and/or LPN did not assess and/or monitor services) as required by policy (127). A. There is NOT a progress note for each date of service billed (7). B. The Nursing Care Plan did not include an individualized teaching plan as per policy (119). B. The Physician Plan of Treatment (PPOT)/Letter of Medical Necessity was not signed and dated per policy (9). B. The units of service billed were not supported by the units of service documented (9). Total Findings: 525. (Emphasis in original.)

The Petitioner acknowledged that there had been some documentation errors regarding the units of services billed and documented. Additionally, Ms. Herringa testified that the missing PPOTs and Nursing Care Plans would mandate the full recoupment amount without considering any additional violations.

[6] The Manual indicates that this record should be kept by the member. Manual at § 905.1(E).

8.

The provider bears the responsibility for obtaining the PPOT for a GAPP program participant. After performing the audit, Alliant concluded that MetNurse's records did not reflect that it had obtained any of the necessary PPOTs for M.J. for the relevant time period. (Testimony of Ms. Herringa.)

9.

MetNurse maintained that it was unable to secure PPOTs for 2020 because M.J.'s physician's office had closed due to the COVID-19 virus. Although MetNurse attempted to contact M.J.'s physician to obtain PPOTs, Dr. Okwuadigbo testified that these attempts, and additional attempts made by M.J.'s mother, proved unsuccessful. After Alliant's administrative review, but immediately prior to the hearing scheduled for July 13, 2022, MetNurse obtained PPOTs from M.J.'s physician for the periods between 12/10/19 to 2/07/2020; 06/07/2020 to 8/05/2020 and 8/6/2020 to 10/04/2020. Still missing are the PPOTs for 2/10/2020-4/11/2020 and 4/12/2020 to 6/06/2020. [7] (Testimony of Ms. Herringa; Testimony of Dr. Okwuadigbo; Exhibit P-1 at 5, 10, 14, 19.)

2. Nursing Care Plan

10.

A Nursing Care Plan is an extension of the PPOT because it reflects the provider agency's plan to carry out the physician's orders. The Nursing Care plan must indicate the individualized teaching plan to be utilized, provide updates regarding the accomplishments of goals, and be signed and dated by the provider RN. It should be reviewed and revised as often as

[7] Among other reasons, the Department deemed these PPOTs insufficient because they inaccurately listed Aveanna Healthcare, rather than MetNurse, as M.J.'s provider. However, the Department did not appear to dispute that MetNurse had been the provider during the relevant time period and the undersigned finds that this error is not an insufficiency warranting recoupment. See O.C.G.A. § 49-4-151.1(a).

the severity of the client's condition requires but at a minimum of every sixty to ninety (60-90) days. (Testimony of Ms. Herringa; Manual at § 905.5.)

11.

Although MetNurse's records contained a Nursing Care Plan for M.J. dated 8/2/2018-8/1/2019, the records did not contain any updated Nursing Plans of Care during the relevant time period. Moreover, given that a Nursing Care Plan is an extension of the PPOT, and at the time of the audit M.J.'s records did not contain PPOTs for 2020, by default there could not be current Nursing Plans of Care for this time period. (Testimony of Ms. Herringa; Testimony of Dr. Okwuadigbo; Exhibit R-1 at 14-15.)

12.

The Petitioner claimed that M.J.'s records contained Nursing Plans of Care. During the hearing, the Petitioner introduced two documents entitled "Plan of Care Review." The documents contain a column for review dates and a corresponding column for the reviewer's signature. According to Dr. Okwuadigbo, a MetNurse RN reviewed the Nursing Care Plan dated 8/2/2018-8/2/2019 every two weeks and signed the Plan of Care Review to indicate that no changes were necessary to the Nursing Plan of Care. The Petitioner maintains that the PPOTs never changed, so there had been no need to revise M.J.'s Nursing Plan of Care. Moreover, Dr. Okwuadigbo testified that MetNurse only provided M.J. with personal support services, so a Nursing Plan of Care would not have been required. [8] (Testimony of Dr. Okwuadigbo; Exhibits P-4-1, P-4-2.)

[8] "Personal care support personnel provide care to eligible GAPP members such as feeding, bathing, dressing, personal hygiene, preparation of meals, light housekeeping, assisting with mobility & ambulation and other services that must be rendered in accordance with the member's plan of care." Manual at 601.3(B).

13.

The purported Nursing Plans of Care reflect review dates of: 1/18/2019; 3/1/2019; 03/27/2020; 04/10/2020; 04/24/2020; 05/08/2020; 05/22/2020; 06/5/2020; 06/19/2020; and 07/03/2020.[9] The documents do not reflect that any reviews by an RN took place for more than a year, between 3/1/2019 and 3/27/2020. (Testimony of Dr. Okwuadigbo; Exhibits P-4-1, P-4-2.)

3. Supervisory Assessments

14.

The Manual requires that a member's clinical record contain monthly supervisory assessments performed by RNs or, when applicable, LPNs. According to Dr. Okwuadigbo, M.J.'s records demonstrate that MetNurse provided M.J. with biweekly supervisory assessments. (Testimony of Dr. Okwuadigbo; Manual at §§ 901 IVB, 905.1, 905.8.)

15.

The Department agrees that MetNurse maintained an appropriate number of supervisory assessments in M.J.'s files but maintains that the nurse providing the assessment should have documented that he or she spoke with M.J.'s personal care aide to ensure that appropriate services had been rendered and the tasks detailed in the PPOT performed safely and correctly. Given the COVID-19 pandemic, the Department allowed providers to conduct the supervisory assessments via telephone rather than in-person. Notwithstanding this change in policy, the supervisory assessments did not reflect that M.J.'s personal care aide was present during the assessment and/or contacted by nurse. (Testimony of Ms. Herringa, Manual at §§ 901 IVB (5) (stating that supervisory assessments must include observations of Personal Care Support

[9] The member moved and did not remain in the GAPP program until December 2020.

caregiver); see Exhibit R-1 at 28-40, 53-54, 70-71, 88-89, 102-103, 112-113, 142-143, 156-157, 404-431.)

16.

A member's records must include narrative progress notes detailing the care provided to the member. Dr. Okwuadigbo acknowledged that the supervisory assessments did not specifically document observations of or communication with M.J.'s personal care aide. However, he maintains that the aide's progress notes detail these encounters. None of the progress notes tendered by the Respondent and in the record address a nurse's observations of the caregiver, nor did MetNurse provide additional progress notes in support of this assertion. (Testimony of Dr. Okwuadigbo, Manual at § 905.3; see generally Exhibit R-1.)

17.

Dr. Okwuadigbo testified that MetNurse, despite the enormous challenges posed during the COVID-19 pandemic, successfully provided in-home services to GAPP members. Additionally, he notes that the Department did not dispute that MetNurse had provided care to M.J. MetNurse argues that it is unreasonable for the Department to fully recoup the amount billed during the audit period. (Testimony of Dr. Okwuadigbo.)

III. CONCLUSIONS OF LAW

1.

The Respondent bears the burden of proof in this matter. Ga. Comp. R. & Regs. 616-1-2-.07. The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. 616-1-2-.21(4).

2.

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." Moore, 637 F.3d at 1232. 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 the Department as the "single state agency for the administration" of Medicaid. O.C.G.A. §§ 49-2-11(f), 49-4-142.

3.

"Providers of services are not required to participate in a state's Medicaid program, but if they do choose to participate, they must agree to accept payment in accordance with the state plan provisions." Briarcliff Haven, Inc. v. Dept of Human Resources, 403 F. Supp. 1355, 1362-63 (N.D. Ga. 1975). To ensure the proper and efficient payment of claims and management of the program, Medicaid reimburses medical providers for billed services subject to audit and possible recoupment of prior payments. See 42 U.S.C. § 1396a(a)(42)(A); 42 U.S.C. § 1396a(a)(37)(B).

4.

Under 42 C.F.R. § 447.45(f), the Department must conduct post-payment claims review. If it discovers an overpayment in accordance with its policies and procedures, the Department must take reasonable actions to attempt to recover the overpayment in accordance with State law and procedures. 42 C.F.R. § 433.316(b).

5.

The Georgia Medical Assistance Act of 1977, O.C.G.A. §§ 49-4-141 et seq., authorizes the Department to publish terms and conditions governing Medicaid claims for each category of services authorized under the State Medicaid Plan. See O.C.G.A. § 49-4-142(a) ("The

[D]epartment] 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. . . . "). Pursuant to Ga. Comp. R. & Regs. 350-1-.02(3), the Department shall issue "Policies and Procedures Manuals" for each category of service and disseminate this Manual to providers enrolled for that category.

6.

The Manual cautions providers that "services rendered out of compliance with the terms and conditions of the provider's statement of participation and the provisions of [the Manual] will not be covered." See Manual at § 906.C, J. Nonetheless, the Department's ability to recoup prior reimbursements for services provided in a manner inconsistent with the Manual is not unconstrained. Under federal law, the Department's action must be consistent with State law. 42 C.F.R. § 433.316(b).

7.

Georgia code section 49-4-151.1(a) limits the Department's ability to recoup for:

> clerical or record-keeping errors including but not limited to a typographical error, scrivener's error, or computer error; any unintentional error or omission in billing, coding, or required documentation; or any isolated instances of incomplete documentation by a provider of medical assistance regarding reimbursement for medical assistance may not in and of itself constitute fraud or constitute a basis to recoup payment for medical assistance provided, so long as any such errors or instances do not result in an improper payment.

An improper payment includes "payments for services not received, payments that are for the incorrect amount, and instances when the department is unable to discern whether a payment was proper because of insufficient or lack of documentation." Id. Additionally, O.C.G.A. § 49-4-151.1(b) allows a provider "30 calendar days following receipt by the provider of a preliminary

audit review report in which to submit records or documents to correct an error or omission or to complete documentation identified in such review report."[10]

8.

The evidence at the hearing demonstrated that MetNurse had not obtained PPOTs for M.J. for the 2020 period of service. Although MetNurse argued that the Covid-19 pandemic prevented it from obtaining the necessary documentation, this argument is not persuasive. There was no PPOT in the record for January, February or early March 2020, the time period preceding the onset of the Covid-19 pandemic. It strains credulity that MetNurse would not have been able to communicate, by email, telephone or virtually, with M.J.'s physician for the entirety of 2020. Moreover, the PPOTs obtained by MetNurse on July 13, 2022, were far past the 30-day time limit allowed under O.C.G.A. § 49-4-151.1(b). Additionally, the PPOTs covering most of the actual 2020 audit period, those from 2/10/2020-4/11/2020 and 4/12/2020 to 6/06/2020, are still missing.

9.

The failure to obtain a PPOT is not just a minor error. As Ms. Herringa testified, all the services rendered to a member are based on the member's PPOT and Nurses and aides must use current plans of care to guide the provision of services. Without a timely PPOT to detail the services needed, it is impossible for the Department to determine whether a payment was proper as directed by O.C.G.A. § 49-4-151.1(a.) Moreover, the failure to have the PPOTS in place during the audit period would not constitute an isolated instance of incomplete documentation. See Id.

[10] "[T]he department or its agents, in the discretion of the department, may reject the submission of a corrected record or document if the submission would result in an improper payment, or the provider demonstrates a pattern of repeated errors, omissions, or incomplete documentation . . . ." O.C.G.A. § 49-4-151.1(b).

10.

Although MetNurse's records contained a Nursing Care Plan for M.J. dated 8/2/2018-8/1/2019, the records did not contain any updated Nursing Plans of Care for 2020. The scant information provided in the "Plan of Care Review" is insufficient to demonstrate that a Nursing Care Plan was in effect. Pretermitting whether or not such reviews took place, there is no indication that the Nursing Care Plan was reviewed between 3/1/2019 and 3/27/2020. For the reasons stated above, this lack of documentation would prevent the Department from assessing whether a payment was proper, and recoupment is permissible under O.C.G.A. § 49-4-151.1(a).

11.

The Manual at § 901 IVB (5) requires that supervisory assessments include observations of the aide. See also 42 C.F.R. § 484.80(h) (regulating the supervision of home health aides.) The Department seeks recoupment because the supervisory assessments did not reflect that M.J.'s personal care aide was present during the assessment and/or contacted by nurse. During the pandemic, the Centers for Medicare & Medicaid Services[11] waived the requirements of 42 C.F.R. § 484.80(h) including "waiving the requirements for a nurse or other professional to conduct an onsite visit every two weeks to evaluate if aides are providing care consistent with the care plan, as this may not be physically possible for a period of time." See https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf. Nonetheless, there is no indication that the requirements in Manual at §§ 901 IVB (5) (stating that supervisory assessments must include observations of Personal Care Support caregiver) were also waived. Had the Petitioner been able to produce evidence that there actually had been observations as required, its arguments that this was merely a record keeping error would merit

[11] The Centers for Medicare and Medicaid Services is a federal agency within the United States Department of Health and Human Services. In re Universal Health Servs., No. 17-2187, 2019 U.S. Dist. LEXIS 140068, at *53 n.36 (E.D. Pa. Aug. 19, 2019.

consideration under Georgia code section 49-4-151.1(a). However, the record does not reflect that these requirements were met.

IV. DECISION

Although the record does not reflect that either the Department or the Alliant considered the Petitioner's violations under O.C.G.A. § 49-4-151.1, which mandates that not every error made by a provider will result in recoupment, for the above and foregoing reasons, the Respondent's decision to recoup from the Petitioner is **AFFIRMED**.

SO ORDERED, this 21st day of September, 2022.

Ronit Walker
Administrative Law Judge