

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE DEPARTMENT OF HUMAN SERVICES

In the Matter of the SIRS  
Appeal of Bluestem Center

**RECOMMENDED ORDER ON  
CROSS MOTIONS FOR  
SUMMARY DISPOSITION**

This matter is before Administrative Law Judge LauraSue Schlatter on cross Motions for Summary Disposition. The Department of Human Services filed its Motion on July 3, 2014. Respondent filed its Motion on July 7, 2014. The Department filed its response to Respondent's Motion on August 6, 2014. Oral argument on the Motions was held on August 22, 2014, at the Office of Administrative Hearings in St. Paul, Minnesota. The motion hearing record closed on that date.

Cynthia B. Jahnke, Assistant Attorney General, appeared on behalf of the Minnesota Department of Human Services (Department). Thomas A. Pearson, Pearson Quinlivan, PLC, appeared on behalf of Bluestem Center (Respondent).

Based on the submissions of the parties and the oral argument, and for the reasons set forth in the Memorandum attached hereto, the Administrative Law Judge makes the following:

**RECOMMENDED ORDER**

**IT IS HEREBY RECOMMENDED THAT:**

1. Respondent's Motion for Summary Disposition is **GRANTED**.
2. The Department's Motion for Summary Disposition is **DENIED**.

Dated: September 26, 2014

s/LauraSue Schlatter  
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LAURASUE SCHLATTER  
Administrative Law Judge

## NOTICE

This Report is a recommendation, not a final decision. The Commissioner of Human Services (the Commissioner) will make the final decision after a review of the record. Under Minn. Stat. § 14.61, the Commissioner shall not make a final decision until this Report has been made available to the parties for at least ten (10) calendar days. The parties may file exceptions to this Report and the Commissioner must consider the exceptions in making a final decision. Parties should contact Debra Schumacher, Administrative Law Attorney, P.O. Box 64941, St. Paul, MN 55164, (651) 431-4319 to learn the procedure for filing exceptions or presenting argument.

The record closes upon the filing of exceptions to the Report and the presentation of argument to the Commissioner, or upon the expiration of the deadline for doing so. The Commissioner must notify the parties and Administrative Law Judge of the date the record closes. If the Commissioner fails to issue a final decision within 90 days of the close of the record, this Report will constitute the final agency decision under Minn. Stat. § 14.62, subd. 2a. In order to comply with this statute, the Commissioner must then return the record to the Administrative Law Judge within ten (10) working days to allow the Judge to determine the discipline imposed.

Under Minn. Stat. § 14.62, subd. 1, the Commissioner is required to serve its final decision upon each party and the Administrative Law Judge by first class mail or as otherwise provided by law.

## MEMORANDUM

### Medicaid Program

Medicaid is a jointly financed federal and state program established under Title XIX of the United States Social Security Act.<sup>1</sup> Its purpose is to provide necessary medical assistance to eligible persons who have insufficient income and resources to pay for the cost of their medical care.<sup>2</sup> The federal government shares the cost of providing medical assistance with states that elect to participate in the Medicaid program.<sup>3</sup> In return, the states must comply with federal statutes and the rules issued by the Centers for Medicare and Medicaid (CMS) of the U.S. Department of Health and Human Services.<sup>4</sup> CMS regulations require states to have surveillance and utilization control programs in order to guard against the “unnecessary or inappropriate use of Medicaid services and . . . excess payments.”<sup>5</sup> In order to discover and correct

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<sup>1</sup> 42 U.S.C. §§ 1396-1396w-5 (2013).

<sup>2</sup> See 42 U.S.C. § 1396-1; see also *Atkins v. Rivera*, 477 U.S. 154, 156 (1986) (“In Massachusetts, persons who lack sufficient income, measured on a monthly basis, to meet their basic needs automatically qualify for Medicaid.”).

<sup>3</sup> See 42 U.S.C. §§ 1396a and 1396b.

<sup>4</sup> See 42 U.S.C. § 1396a and 42 C.F.R. § 430.10 (2013); see also *Atkins*, 477 U.S. at 156-57 (“The Federal Government shares the costs of Medicaid with States that elect to participate in the program. In return, participating States are to comply with requirements imposed by the Act and by the Secretary of Health and Human Services.”).

<sup>5</sup> 42 C.F.R. § 456.3(a) (2013).

inappropriate use of Medicaid payments and excess payments, states must conduct post-payment reviews.<sup>6</sup>

The Medicaid program in Minnesota is administered by the Department and is a Minnesota Health Care Program (MHCP), commonly referred to as Medical Assistance (MA).<sup>7</sup> Because the Department receives and administers federal funds, it must establish and maintain a program of utilization review in order to prevent the unnecessary or inappropriate use of MA, and to determine whether excess MA payments are being made.<sup>8</sup> If the Department discovers that a provider has inappropriately billed MA or erroneously received excess payments, state law permits the Department to impose sanctions on the provider and/or recover the excess payments.<sup>9</sup>

In order to safeguard against inappropriate use of MA and excess MA payments, the Department has created the Surveillance and Integrity Review Section (SIRS) and promulgated rules to monitor providers' compliance with federal and state rules, regulations, and statutes.<sup>10</sup> SIRS conducts post-payment reviews or audits of claims submitted for MA payments.<sup>11</sup> These investigations are necessary to prevent fraud and abuse, as well as to detect instances of improper payment of MA funds due to error or inadvertence.<sup>12</sup> The Department is entitled to recover from a provider funds improperly paid as a result of error, regardless of whether it was the Department's or the provider's error, and regardless of whether the error was intentional.<sup>13</sup>

## Facts and Procedural History

The facts of this case are undisputed. Respondent is an MHCP offering a range of mental-health services related to child and family health and development.<sup>14</sup> Respondent employs a variety of health providers, including physicians, nursing assistants, nurse practitioners, psychiatric nurses, psychologists, social workers, marriage and family therapists, a licensed alcohol and drug counselor, an occupational therapist, and a licensed professional counselor.<sup>15</sup>

Respondent uses the Current Procedural Terminology (CPT) codes published by the American Medical Association (AMA) to describe and bill for the services it provides.<sup>16</sup> The Department, likewise, follows the CPT to determine the accuracy of

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<sup>6</sup> 42 C.F.R. § 456.23 (2013).

<sup>7</sup> See Minn. Stat. ch. 256B (2014).

<sup>8</sup> Minn. Stat. § 256B.04, subd. 15(a); see also 42 C.F.R. §§ 456.1-.725 (2013).

<sup>9</sup> See Minn. Stat. §§ 256B.064 and 256B.0641.

<sup>10</sup> See Minn. R. 9505.2160-.2245 (2013).

<sup>11</sup> See 42 CFR § 456.23 (requiring post-payment reviews); Minn. Stat. § 256B.04, subd. 15(a) (requiring post-payment reviews).

<sup>12</sup> See Minn. R. 9505.2200, subp. 1 and 9505.2215, subp. 1(A).

<sup>13</sup> Minn. Stat. § 256B.064, subd. 1c(a).

<sup>14</sup> Respondent's Memorandum in Support of Motion for Summary Judgment at 1.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 2.

coding on claims of services submitted for reimbursement to the Medicaid program.<sup>17</sup> The parties agree that under the CPT, which has been adopted by the CMS, “new patient” visits are billed at a higher rate than visits by established patients.

In 2013, the Department’s SIRS staff audited Respondent. On December 10, 2013, the Department issued a Notice of Agency Action (NOAA) indicating that the Department had overpaid \$413.26 for services provided by Respondent.<sup>18</sup> The Department stated that “six of fifteen claims of CPT code 99205 [relating to new patients] were established patients with prior visits with providers of the same specialty (mental health) as evidenced by prior claims paid.”<sup>19</sup> The Department, therefore, sought reimbursement of \$413.26 from Respondent.

Respondent appealed the decision, and the Department submitted the matter for a contested-case hearing.<sup>20</sup> The parties thereafter filed cross Motions for Summary Disposition.

### **Summary Disposition Standard**

Summary disposition is the administrative equivalent of summary judgment, and the Office of Administrative Hearings has generally followed the summary judgment standards developed in judicial courts in considering motions for summary disposition regarding contested case matters.<sup>21</sup> “A motion for summary judgment shall be granted when the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue of material fact and that either party is entitled to judgment as a matter of law.”<sup>22</sup>

The Administrative Law Judge’s “function on a motion for summary judgment is not to decide issues of fact, but solely to determine whether genuine factual issues exist.”<sup>23</sup> Accordingly, an Administrative Law Judge deciding a summary disposition motion must not make credibility determinations or otherwise weigh evidence relevant to disputed facts.<sup>24</sup>

“[T]here is no genuine issue of material fact for trial when the nonmoving party presents evidence which merely creates a metaphysical doubt as to a factual issue and which is not sufficiently probative with respect to an essential element of the nonmoving

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<sup>17</sup> Department’s Memorandum in Support of Motion for Summary Disposition at 5.

<sup>18</sup> Department’s Exhibit (Ex.) 4.

<sup>19</sup> *Id.*

<sup>20</sup> Respondent’s Exs. 6 and 7.

<sup>21</sup> Minn. R. 1400.6600.

<sup>22</sup> *Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn. 1993).

<sup>23</sup> *DLH, Inc. v. Russ*, 566 N.W.2d 60, 70 (Minn. 1997).

<sup>24</sup> *Id.*

party's case to permit reasonable persons to draw different conclusions."<sup>25</sup> A material fact is one which will affect the outcome of the case.<sup>26</sup>

## Analysis

The CMS offers this description of Code 99205, relating to new patients:

Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.<sup>27</sup>

The CPT defines "new patient" as "one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."<sup>28</sup> The parties agree that neither the Minnesota Rules nor the Minnesota Statutes define "new patient" for CPT billing purposes. The parties further agree that there are no material facts in dispute and this case can be decided as a matter of law.

The Department argues that Respondent "cannot bill evaluation and management exams as 'new patient' exams under its provider code for patients who have been receiving services in the preceding three years, regardless of the credentials of the professional providing the service, because [Respondent] elected to be a group provider and seeks reimbursement for all services under its single provider code."<sup>29</sup> The Department essentially argues that because Respondent used a single-provider billing code, once a provider within the group had evaluated a patient, no other provider within that group, regardless of specialty, could evaluate that same patient within three years and code that as a "new patient" visit.

At the motion hearing, the Department argued that because Respondent uses "a single provider type, they are limited in how often they can seek these new

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<sup>25</sup> *Id.* at 71.

<sup>26</sup> *Musicland Grp., Inc., v. Ceridian Corp.*, 508 N.W.2d 524, 531 (Minn. Ct. App. 1993), *review denied* (Minn. Jan. 27, 1994).

<sup>27</sup> <http://www.cms.gov/medicare-coverage-database/staticpages/cpt-hcpcs-code-range.aspx?DocType=LCD&DocID=32007&Group=1&RangeStart=99201&RangeEnd=99205>.

<sup>28</sup> The parties agree that this is the definition of "new patient" from the CPT manual.

<sup>29</sup> Department's Response to Respondent's Motion for Summary Disposition at 2.

assessments.”<sup>30</sup> The Department basically takes a fiscal approach, contending that “when you have a second evaluation for an ongoing patient there is already information provided and available to the physician so the second evaluation does not need to be as thorough as it might necessarily otherwise be.”<sup>31</sup> According to the Department, the second visit should, therefore, not be billed at the higher “new patient” rate.<sup>32</sup>

Respondent, on the other hand, argues that the visits associated with the disallowed charges were properly coded as “new patient” visits because “the disputed claims were for services provided by health professionals having different specialties within the general area of mental health practice.”<sup>33</sup> Respondent contends that, under the CPT, the Department should look at the individual provider, not the group Medicaid provider number, when determining whether a visit was properly coded as a “new patient” visit.<sup>34</sup> According to Respondent, utilizing a “group” provider number is a matter of administrative convenience and is not indicative of the specialties of the individual providers within the group.<sup>35</sup>

The Department cites no legal authority directly supporting its interpretation of the CPT billing requirements.<sup>36</sup> In fact, at the motion hearing, the Department conceded that “there is nothing that expressly deals with this point.”<sup>37</sup> According to the Department, its position is supported by “the provider type and the billing and the CMS guidance.”<sup>38</sup> In its written Motion, the Department quotes the “new patient” language from the CPT, along with a CMS response to a frequently asked question (FAQ), but fails to adequately explain how those sources support its single provider code argument.<sup>39</sup>

The FAQ response states: “Beginning in 2012, the AMA CPT instructions for billing new patient visits include physicians in the same specialty and subspecialty. However, for Medicare [Evaluation and Management] services the same specialty is determined by the physician’s or practitioner’s primary specialty enrollment in Medicare.”<sup>40</sup> The Department seems to imply that because the specialty for Medicare is determined by the “specialty enrollment,” the availability of “new patient” billing for Medical Assistance (Medicaid) should be based on the providers’ group enrollment. But Medicare and Medicaid are different programs, with different rules and regulations. The

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<sup>30</sup> See, digital recording of Motion hearing, held on August 22, 2014.

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> Respondent’s Memorandum in Support of Motion for Summary Judgment at 4.

<sup>34</sup> See, digital recording of Motion hearing, held on August 22, 2014.

<sup>35</sup> *Id.*

<sup>36</sup> See *In re N. States Power Co.*, 775 N.W.2d 652, 656 (Minn. Ct. App. 2009) (“[A] reviewing court may reverse an agency’s decision if it concludes that the agency’s actions were: (a) in violation of constitutional provisions; or (b) in excess of the statutory authority or jurisdiction of the agency; or (c) made upon unlawful procedure; or (d) affected by other error of law; or (e) unsupported by substantial evidence in view of the entire record as submitted; or (f) arbitrary or capricious.”).

<sup>37</sup> See, digital recording of Motion hearing, held on August 22, 2014.

<sup>38</sup> *Id.*

<sup>39</sup> Department’s Memorandum in Support of Motion for Summary Disposition at 6-7.

<sup>40</sup> <https://questions.cms.gov/faq.php?id=5005&faqId=1969>.

omission of any similar reference to Medicaid within the response highlights the defects in the Department's argument.<sup>41</sup>

Moreover, the CPT language supports Respondent's interpretation of the guidance, that is, the Department should look to the individual provider type, rather than the group billing code, when making its determination regarding "new patient" billing.<sup>42</sup> The Department argues that Respondent "chose" the group provider code, the implication being that if Respondent had simply used individual provider codes, these "new patient" visits would have been properly coded.<sup>43</sup> Although the Department's interpretation is reasonable from an efficiency standpoint, the CPT definition was the only guidance available to Respondent. It was reasonable for the Respondent to choose a single group provider code, which was the more administratively efficient choice for it to make. This is particularly true where Respondent had no reason to believe, under the plain language of the CPT, that individual billing codes were required.

Under the CPT guidance, Respondent properly billed the Department for the "new patient" visits. The original providers were "therapists," who subsequently referred the patients to "medical professionals."<sup>44</sup> The medical professionals coded the visits as "new patient" visits because "the 'specialties' in which therapists at Bluestem Center practice [are] not the same as the specialties in which the medical professionals practice."<sup>45</sup> The Department does not dispute this fact.<sup>46</sup> Because the CPT guidance allows for "new patient" billing as long as the patient "has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional *of the exact same specialty and subspecialty who belongs to the same group practice*, within the past three years," Respondent did not violate billing practices.<sup>47</sup>

For these reasons, the Administrative Law Judge recommends that the Commissioner grant Respondent's Motion for Summary Disposition and deny the Department's Motion for Summary Disposition. There are no genuine issues of material fact, and Respondent has demonstrated that it is entitled to judgment as a matter of law.

**L. S.**

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<sup>41</sup> See *Rohmiller v. Hart*, 811 N.W.2d 585, 591 (Minn. 2012) (stating that courts "cannot supply that which the legislature purposely omits or inadvertently overlooks"(quotation omitted)).

<sup>42</sup> See *Hans Hagen Homes, Inc. v. City of Minnetrista*, 728 N.W.2d 536, 539 (Minn. 2007) ("Where the legislature's intent is clearly discernable from plain and unambiguous language, statutory construction is neither necessary nor permitted and we apply the statute's plain meaning.").

<sup>43</sup> See, digital recording of Motion hearing, held on August 22, 2014.

<sup>44</sup> Respondent's Memorandum in Support of Motion for Summary Judgment at 4.

<sup>45</sup> *Id.* at 5.

<sup>46</sup> See, digital recording of Motion hearing, held on August 22, 2014.

<sup>47</sup> Emphasis added.