

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

In the Matter of the SIRS Appeal of
Metro Therapy Special Children's
Clinic, Inc.

**ORDER GRANTING
DEPARTMENT'S MOTION
FOR SUMMARY DISPOSITION
AND RECOMMENDATION**

On May 5, 2009, the Department of Human Services (Department or DHS) issued a Notice of and Order for Hearing and Prehearing Conference alleging that DHS was entitled to recover \$17,564.12 overpaid to Metro Therapy Special Children's Clinic, Inc. (Metro Therapy).

On November 9, 2009, DHS filed its Notice of Motion and Motion for Summary Disposition, with accompanying documents, requesting that the Administrative Law Judge issue a recommendation granting summary disposition in its favor. DHS asserted that Metro Therapy failed to comply with the applicable rules for seeking reimbursement from DHS for services rendered; specifically, that Metro Therapy failed to obtain and provide the necessary documentation in support of its claims, as required by the federal and state statutes and rules governing the Minnesota Health Care Programs (MHCP).

On November 30, 2009, Metro Therapy filed its Memorandum of Law in Opposition to the Department's Motion for Summary Disposition, accompanied by the Affidavit of Audre Chaput, and associated exhibits.

On December 7, 2009, the Department filed its Reply Memorandum Law in Support of its Motion for Summary Disposition, and Affidavit of Matthew Woodo, with exhibits.

Appearances: Corrie A. Oberg, Assistant Attorney General, on behalf of DHS; Jack E. Pierce, Attorney at Law, on behalf of Metro Therapy.

For the reasons explained in the accompanying Memorandum, the Administrative Law Judge makes the following:

ORDER and RECOMMENDATION

IT IS HEREBY ORDERED: The Department's Motion for Summary Disposition is GRANTED.

IT IS HEREBY RECOMMENDED: That the Department recover \$17,564.12 in overpayments made to Metro Therapy.

Dated: December 14, 2009

s/Beverly Jones Heydinger
Beverly Jones Heydinger
Administrative Law Judge

NOTICE

This report is a recommendation, not a final decision. The Commissioner of Human Services will make the final decision after a review of the record. The Commissioner may adopt, reject or modify the Order Granting Department's Motion for Summary Disposition and Recommendation. Under Minn. Stat. § 14.61, the final decision of the Commissioner shall not be made until this Report has been made available to the parties to the proceeding for at least ten days. An opportunity must be afforded to each party adversely affected by this Report to file exceptions and present argument to the Commissioner. Parties should contact Cal Ludeman, Commissioner, Department of Human Services, P.O. Box 64998, St. Paul, MN 55164-0998, 651-296-2701 to learn the procedure for filing exceptions or presenting argument.

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. 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 the Administrative Law Judge of the date on which the record closes.

Under Minn. Stat. § 14.62, subd. 1, the agency 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

Standard for Summary Disposition

Summary disposition is the administrative equivalent of summary judgment.¹ The standards for summary disposition in a contested case proceeding are equivalent to the standards for summary judgment under Rule 56.03 of the Minnesota Rules of Civil Procedure.² The Administrative Law Judge (ALJ) may recommend summary disposition of the case or any part of the case “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that either party is entitled to a judgment as a matter of law.”³ A genuine issue is one that is not a sham or frivolous. A fact is material if its resolution will affect the result or outcome of the case.⁴

When considering a motion for summary disposition, the ALJ must view the facts in the light most favorable to the non-moving party and resolve all doubts and factual inferences in that party’s favor.⁵ DHS, as the moving party, has the initial burden to show that there is no genuine issue concerning any material fact.⁶ To successfully resist a motion for summary disposition, the non-moving party cannot rely upon general statements or allegations, but must show by substantial evidence that there are specific facts in dispute that have a bearing on the outcome of the case.⁷ “Substantial evidence” refers to the legal sufficiency of the evidence and not the quantum of evidence.⁸ Speculation alone, without some concrete evidence, is insufficient to survive summary disposition.⁹ However, if reasonable minds could differ as to the import of the evidence, judgment as a matter of law should not be granted.¹⁰

Statutory and Rule Background

DHS has laid out the statutory and rule background for its authority to oversee the payment of state and federal funds for health services to the persons who qualify for Minnesota Health Care Programs (MCHP). Medicaid is a program to provide necessary medical care to eligible individuals, jointly financed by the federal and state

¹ *Pietsch v. Bd. of Chiropractic Examiners*, 683 N.W.2d 303, 306 (Minn. 2004); Minn. R. 1400.5500 (K) (2007).

² See Minn. R. 1400.6600 (the Minnesota Rules of Civil Procedure may apply to motions in contested cases as appropriate).

³ Minn. R. Civ. P. 56.03; *Osborne v. Twin Town Bowl, Inc.* 749 N.W.2d 367, 371 (Minn. 2008)(citing *Anderson v. State Dep’t of Natural Res.*, 683 N.W. 2d 181, 186 (Minn. 2005)); *Sauter v. Sauter*, 244 Minn. 482, 484-85, 70 N.W.2d 351, 353 (Minn. 1955)

⁴ *O’Malley v. Ulland Bros.*, 549 N.W.2d 889, 892 (Minn. 1996); *Illinois Farmers Insurance Co. v. Tapemark Co.*, 273 N.W.2d 630, 634 (Minn. 1978); *Highland Chateau v. Minnesota Dep’t of Public Welfare*, 356 N.W.2d 804, 808 (Minn. App. 1984).

⁵ *Osborne*, 749 N.W.2d at 371; *Carlisle v. City of Minneapolis*, 437 N.W.2d 712, 715 (Minn. App. 1988).

⁶ *Thiele v. Stich*, 425 N.W.2d 580, 583 (Minn. 1988).

⁷ *Papenhausen v. Schoen*, 268 N.W.2d 565, 571 (Minn. 1978).

⁸ *DLH, Inc. v. Russ*, 566 N.W.2d 60, 69-70 (Minn. 1997); *Murphy v. Country House, Inc.*, 307 Minn. 344, 351, 240 N.W.2d 507, 512 (1976).

⁹ *Bob Useldinger & Sons, Inc. v. Hangsleben*, 505 N.W.2d 323, 328 (Minn. 1993).

¹⁰ *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250-51 (1986); *DLH, Inc.*, 566 N.W.2d at 69.

governments. In Minnesota, the Medicaid-financed program is referred to as “Medical Assistance” or “MA”. In return for federal funding, the states must comply with the federal requirements, including the rules of the United States Department of Health and Human Services’ Centers for Medicare and Medicaid (CMS).

In Minnesota, DHS receives and administers the federal funds and, as a condition, it must establish and maintain a program of utilization review to safeguard against unnecessary or inappropriate use of Medical Assistance.¹¹ When DHS discovers that a provider of health care services has inappropriately billed MA or erroneously received excess MA payments, DHS may impose sanctions on the provider and recover excess payments.¹²

DHS has enacted rules that establish criteria and procedures for the identification and investigation of suspected Medical Assistance “fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not medically necessary, or false statement or representation of material facts” by a provider, and for the imposition of sanctions.¹³ DHS has created the Surveillance and Integrity Review Section (SIRS) to carry out these responsibilities.

Summary of Undisputed Facts

Metro Therapy is an MHCP provider of rehabilitative services, and its president, Audre Chaput, signed a provider agreement on Metro Therapy’s behalf, agreeing to comply with federal and state statutes relating to the delivery of benefits to individuals and the submission of claims. Specifically, the signator agrees: “to comply with all federal and state statutes and rules relating to the delivery of benefits to individuals and to the submission of claims for such benefits,” “[t]o ensure, when required by law, that the Medical Assistance or General Assistance Medical Care Program is the payor of last resort by ascertaining the legal and financial liabilities of third parties to pay for covered services,” and “to assume full responsibility for the accuracy of claims submitted to [DHS] by the provider or the provider’s agent.”¹⁴

Susan Kurysh is an investigator for SIRS. Among her duties, she investigates providers to monitor compliance with federal and state statutes and rules governing MHCP. On May 16, 2007, she notified Ms. Chaput that she wanted to review 12 recipient files on the following day and faxed Ms. Chaput a list of the requested records.¹⁵ On May 17, 2007, Ms. Kurysh and Margaret Newman, another SIRS investigator, requested copies of the third-party payer denials for the 12 previously-identified recipients, and an additional 17 third-party payer denials.¹⁶

¹¹ See Minn. Stat. §§ 256B.04, subds. 4 and 15 (a).

¹² Minn. Stat. §§ 256B.064 and 256B.0641.

¹³ Minn. Stat. § 256B.04, subd. 10; Minn. R. 9505.2160 to 9505.2245.

¹⁴ Affidavit (Aff.) of Susan Kurysh, Ex. 1.

¹⁵ Aff. of Kurysh, para. 7.

¹⁶ Aff. of Kurysh, para. 8.

Between May 17, 2007 and June 25, 2007, Ms. Chaput submitted some additional documentation concerning the identified third-party denials.¹⁷ On June 25, 2007, SIRS issued a Notice of Agency Action to Metro Therapy to recover overpayment of \$27,336.81.¹⁸

Metro Therapy challenged the Notice of Agency Action, by letter dated July 24, 2007.¹⁹ In response, DHS offered Metro Therapy the opportunity to submit any additional documentation in support of its claims.²⁰ By letter dated September 26, 2007, Metro Therapy submitted additional documentation.²¹ Based on the additional information, DHS reduced its requested recovery from \$27,336.81 to \$20,750.04.²²

On November 19, 2007, Metro Therapy submitted additional information,²³ and after review, DHS reduced its claim for recovery to \$17,564.12.²⁴

The requested recovery included the following claims:

G.A., for services provided from January 5, 2006, to December 28, 2006, - \$9,411.35;

K.B., for services provided from January 9, 2006, to April 24, 2006, - \$707.70;

C.D., for services provided from January 5, 2006, through July 27, 2006, - \$3,545.81;

T.J., for services provided from September 6, 2006, through September 27, 2006, - \$132.50;

M.M., for services provided from January 3, 2006, through May 4, 2006, - \$1,601.58;

N.P., for services provided on August 16, 2006 - \$51.72;

C.R., for services provided on August 9, 2006, - \$51.72;

S.S., for services provided from March 21, 2006, through December 19, 2006, - \$2,061.74.²⁵

During the time period for which DHS seeks recovery of the above amounts, G.A., K.B., M.M., N.P., C.R. and S.S. had medical coverage through HealthPartners. C.D. was covered by HealthPartners from January 1, 2005 to May 31, 2006, and by

¹⁷ Aff. of Kurysh, Ex. 2.

¹⁸ Aff. of Kurysh, Ex. 3.

¹⁹ Aff. of Kurysh, Ex. 4.

²⁰ Aff. of Kurysh, Ex. 5.

²¹ Aff. of Kurysh, Ex. 6.

²² Aff. of Kurysh, Ex. 7.

²³ Aff. of Kurysh, Ex. 8.

²⁴ Aff. of Kurysh, Ex. 9.

²⁵ Aff. of Kurysh, Exs. 3, 7 and 9.

Medica from June 1, 2006 to May 31, 2007. T.J. was covered by HealthPartners and Preferred One.²⁶

DHS asserted that Metro Therapy had been overpaid by \$17,564.12, because DHS will not reimburse the provider when individuals have third-party health coverage and because Metro Therapy failed to provide the necessary documentation of partial payment or denial of payment for claims submitted for services provided to K.B., C.R., and T.J..²⁷

DHS's Position

DHS argues that Minn. R. 9505.0070, subp. 2, requires that a third-party payer's coverage of or liability for a health service must be used to the fullest extent available before an MA payment may be made on the recipient's behalf. Subpart 5 of the same rule states that a provider shall not submit a claim for MA payment until receiving payment, partial payment or a notice that the claim has been denied from the third-party payer. The same provision requires that a provider who submits a claim for payment after a third-party payer has paid a portion or denied a claim shall submit the additional information or records required by DHS to document its payment request. Because Metro Therapy submitted claims for persons who had other health coverage, those claims were improperly paid and must be recovered. It is DHS's position that the recipients must use an in-network provider, in compliance with the terms of their health plan. See Minn. R. 9505.0070. Because the recipients failed to use an in-network provider, their claims are not reimbursable under the program.

The Department asserts that Metro Therapy's submission of claims not reimbursable under the program and its failure to comply with the terms of the Provider Agreement constitute abuse as defined by Minn. R. 9505.2165, and DHS is entitled to recover the sums paid.

Also, Metro Therapy failed to provide the required documentation of partial payment or denials for services to K.B., T.J. and C.R. while those individuals had third-party coverage, as required by Minn. R. 9505.0070, subp. 5. DHS claims that this lack of documentation also constitutes abuse, and that it is entitled to recover the sums paid on behalf of these individuals.

Metro Therapy's Position

Metro Therapy claims that DHS has misstated the reasons why third party payments were denied. Although DHS claimed that the recipients' claims should have been denied because the recipients were seeking care outside of their approved network, Metro Therapy claims that services were denied either because the service was not covered under the recipient's benefit package, or because the number of approved treatment sessions had exceeded the maximum that the health plan allowed for that recipient.

²⁶ Aff. of Kurysh, para. 21 and Ex. 10.

²⁷ See Aff. of Kurysh, Ex. 7.

Specifically, Metro Therapy argues that HealthPartners denied payment for Metro Therapy's service to G.A. and N.P. because their contract did not include habilitative therapy, and not because they were seeking services outside the network. In support of its position, Metro Therapy cites to the Affidavit of Audre Chaput, Exhibit D.²⁸ This letter, dated May 28, 2007, states that habilitative services are not covered under N.P.'s HealthPartners contract, and, by analogy, Metro Therapy claims that the same is true for G.A.. It makes a similar claim, that the services received were not covered by the health plan, for K.B., Michael Molloy, C.R., and S.S., offering Exhibits F, H, I, and L in support.

For T.J., Metro Therapy claims that it was entitled to reimbursement because HealthPartners had paid \$304.65,²⁹ but denied the balance, which Metro Therapy claims DHS was required to reimburse.

For C.D., Metro Therapy claims that HealthPartners had paid for 20 visits for habilitative benefits, but that additional visits were not covered by HealthPartners and should be reimbursed by DHS.³⁰

Metro Therapy argues that DHS has misapplied its rule governing third-party payers.

It claims that in each instance, Metro Therapy did not seek reimbursement for services covered by the third party, but rather it submitted claims only for those services that went beyond the third party payer's coverage. It asserts that it is entitled to "submit a claim for medical assistance payment for the difference between the amount paid by the third party and the amount payable by medical assistance in the absence of other coverage."³¹

Metro Therapy acknowledges that some of the HealthPartners letters denying payment state that the plan does not cover the requested service and that the provider is outside of its network. Metro Therapy argues that these are inconsistent reasons that are simply form-driven. Its claim is that the services were not reimbursed because HealthPartners does not cover them, and thus, that it should be reimbursed.

Analysis

The key provision that governs most of the Department's claims for reimbursement against Metro Therapy is Minn. R. 9505.0070, subp. 2 which states:

A third-party payer who is liable to pay all or part of the cost of a health service provided to a medical assistance applicant or recipient shall be the primary payer. The third party payer's coverage of or liability for a health service provided to a medical assistance applicant or recipient must

²⁸ See also Aff. of Chaput, Ex. E.

²⁹ Aff. of Chaput, Ex. G.

³⁰ Aff. of Chaput, para. 10.

³¹ Minn. R. 9505.0070, subp. 5.

be used *to the fullest extent available* before a medical assistance payment is made on the recipient's behalf.³²

The Department explains that for G.A., K.B., Michael Molloy, N.P. and S.S., the letters from HealthPartners denying service unequivocally stated that HealthPartners would not pay for the services provided by an out-of-network provider. Metro Therapy does not dispute that it was outside of the HealthPartners network for the services provided to these Medical Assistance recipients. Its claim is that HealthPartners denied payment because the services were outside of the HealthPartners' benefit plan. Its argument is not persuasive. The letters are clear that, for each person, payment was denied because the service was not covered, and the reason stated was that the service was covered only when delivered by a provider with a HealthPartners contract.³³ Thus, for each of these claims, the Department has demonstrated that the third-party benefits were not used to the fullest extent available. It is entitled to recover the payment made to Metro Therapy for these individuals.

Metro Therapy also argues that the Department should pay for the services to G.A. and S.S. because the Department had previously determined that the services were medically necessary and had given "prior authorization."³⁴ However, the Department correctly points out that prior authorization is a determination that the services requested for the individual were medically necessary for him. It does not address the question of payment for the service. Metro Therapy offered no evidence that the services were not reimbursable if delivered by a provider within the HealthPartners network. To the extent that Ms. Chaput states in her affidavit that HealthPartners does not provide the same services as Metro Therapy,³⁵ it offers no support for that assertion. A statement in an affidavit about a material fact is insufficient to withstand a claim if it is unsupported by substantial evidence.

For T.J., Metro Therapy claims that it was entitled to payment of the difference between \$304.65 paid by HealthPartners and the "remainder of the benefits."³⁶ It includes in its submission a remittance from PreferredOne Administrative Services. Apparently, Metro Therapy is asserting that it was entitled to the difference between the discounted charge of \$530.35 and \$304.65, a difference of \$125.70.³⁷ However, nothing about Metro Therapy's argument makes sense. First, the third-party payer is PreferredOne and not HealthPartners. Second, the Department is seeking reimbursement of \$132.50 for services provided between September 6, 2006 and September 27, 2006.³⁸ The \$304.65 figure is tied to services in November 2006, as shown in Metro Therapy's Ex. G. Thus, Metro Therapy has offered no cogent explanation or evidence to support its claim.

³² Emphasis added.

³³ Affidavit of Chaput, Ex. C (Asher); Ex. E (Peterson); Ex. F (Baker); Ex. H (Molloy); Ex. L (Sorenson).

³⁴ Affidavit of Chaput, Exs. A and B (Asher); Ex. K (Decision of State Agency on Appeal - Sorenson).

³⁵ Affidavit of Chaput at 12.

³⁶ Metro Therapy Memorandum of Law Opposing Summary Disposition at 3, referencing Affidavit of Chaput, Ex. G.

³⁷ Affidavit of Chaput, Ex. G.

³⁸ Affidavit of Kurysh at 19, and Ex. 3 at page 9 of 14, and Ex. 7.

Metro Therapy disputes the Department's refusal to pay for an occupational therapy evaluation performed for C.R. on August 9, 2006. However, the only documentation it submitted in support of its claim was a denial letter from HealthPartners dated January 10, 2001.³⁹ This is irrelevant to the Department's claim for reimbursement.

For C.D., Metro Therapy's affidavit from Ms. Chaput states: "For C.D. HealthPartners informed Metro Therapy that C.D. was limited to 20 out-of-network visits for habilitative benefits on her health insurance plan." This was its only evidence to support reimbursement. However, in order to be reimbursed when there is a third-party payer, the applicable rule provision states:

[T]he provider who submits a claim for medical assistance payment by the department after a third-party payer has paid part of the claim or denied the claim shall submit with the claim the additional information or records required by the department to document the reason for the partial payment or denial.⁴⁰

Metro Therapy failed to submit any such documentation.

For all of the reasons set forth, Metro Therapy has failed to demonstrate that there are any material facts in dispute or offer any cogent legal argument to support its position. As a matter of law, the Department is entitled to recover the total amount asserted in this proceeding, \$17,564.12.

B.J.H.

³⁹ Compare Affidavit of Chaput, Ex. I (Rogers) and Affidavit of Kurysh, Ex. 3, Attachment A, at 11 of 14.

⁴⁰ Minn. R. 9505.0070, subp. 5.