STATE OF MINNESOTA
IN COURT OF APPEALS
A21-1477

In the Matter of the
Surveillance and Integrity Review (SIRS) Appeal
by Nobility Home Health Care, Inc.

Filed August 29, 2022
Affirmed
Gaïtas, Judge

Minnesota Department of Human Services
File No. 36590

Ll. Rhyddid Watkins, Martin Hild, PA, Aurora, Colorado (for relator Nobility Home Health Care, Inc.)

Keith Ellison, Attorney General, Drew D. Bredeson, Assistant Attorney General, St. Paul, Minnesota (for respondent Minnesota Department of Human Services)

Considered and decided by Gaïtas, Presiding Judge; Cochran, Judge; and Bryan, Judge.

NONPRECEDENTIAL OPINION

GAÏTAS, Judge

In this administrative appeal, relator Nobility Home Health Care, Inc. (Nobility)—a provider of Personal Care Assistant (PCA) services—challenges the final decision of the commissioner of human services determining that Nobility committed recordkeeping abuses that resulted in improper reimbursements for care and ordering monetary recovery of overpaid funds. We affirm.

FACTS

Nobility is a health-services vendor that receives reimbursement from respondent Minnesota Department of Human Services (DHS) for PCA services provided to Medicaid recipients. To ensure statutory and regulatory compliance, DHS's Surveillance and Integrity Review Section (SIRS) conducts audits of completed reimbursements. If a SIRS audit demonstrates noncompliance by a preponderance of the evidence, the commissioner may order recovery of overpayments and impose sanctions. *See* Minn. Stat. § 256B.064 (2020) (providing the grounds for and describing the imposition of recovery and sanctions); Minn. R. 1400.7300, subp. 5 (2021) ("The party proposing that certain action be taken must prove the facts at issue by a preponderance of the evidence.").

Between 2016 and 2019, SIRS received information regarding potential regulatory noncompliance by Nobility. With Nobility's cooperation, SIRS audited Nobility's completed reimbursements. The audit confirmed some of the alleged violations and revealed additional "significant and repeated violations on behalf of Nobility and its PCAs," including:

A. Expired care plans
B. No care plans for clients
C. No start dates documented on care plans
D. No end dates documented on care plans
E. No month-to-month usage on care plans
F. Responsible parties not documented on care plans, or wrong responsible parties documented
G. Emergency plans not documented in care plans
H. Usage of hours not documented in care plans
I. Back up staffing plans not documented
J. Illegible time sheets
K. AM/PM designations undocumented in time sheets
L. Provider ID not documented in time sheets

M. Responsible party signatures missing from time sheets
N. No time sheets for certain dates of service
O. PCA overlap with other PCAs
P. PCA overlap with other PCA agencies
Q. PCA overlap with other employers

Based on the SIRS audit, DHS determined that Nobility had engaged in three categories of wrongdoing: (1) violations related to the care of one recipient, E.B.; (2) timesheet violations related to the care of other recipients; and (3) deficiencies in the care plans of other recipients.

The first category of violations—violations related to E.B.'s care—included "no provider ID on the timesheet[s], expired care plan, illegible timesheet[s], no end dates documented on the care plan, PCA overlap with other PCAs, no timesheet for a date of service, PCA overlap with work for another agency, and no a.m./p.m. markers on reported hours." Although E.B.'s care plan had lapsed, Nobility PCAs had continued to log hours of care for E.B. And despite the hours of documented PCA care, E.B.'s home reportedly was dirty and had not been vacuumed in months. Investigators also suspected that a single timesheet signed by E.B. had been photocopied and reused.

The second category of violations concerned Nobility's failure to ensure that its timekeeping records for other recipients contained complete information. These violations included "no provider ID documented on timesheet[s], no responsible party signature on timesheet[s], and no a.m./p.m. markers accompanying time entries on timesheet[s]."

The third category of violations concerned care plans. As a PCA vendor, Nobility was required to maintain care plans for each care recipient. The audit found miscellaneous deficiencies in Nobility's care plans for multiple recipients.

In July 2019, DHS sent Nobility a Notice of Overpayment. The notice alleged a total overpayment of $325,709.45, which was later amended to $330,319.18. DHS sought $273,035.80 in overpayment recovery for the violations related to E.B.'s care and $57,283.38 in overpayment recovery for timekeeping violations related to other care recipients. Additionally, DHS assessed a $5,000 fine for the third category of violations—those involving care-plan deficiencies.

Nobility agreed that it had received $1,530.72 in overpayments for E.B.'s care, and it did not challenge the $5,000 sanction. But Nobility appealed DHS's request to recover the remaining alleged overpayment and requested a contested-case hearing.

At a contested-case hearing before an administrative law judge (ALJ) in February 2021, a SIRS investigator testified about her findings and DHS submitted documentary evidence to support its overpayment claims. DHS argued to the ALJ that the evidence established that Nobility's violations constituted "abuse," as defined by DHS rules: "submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect" and "failing to develop and maintain health service records as required [by law]." *See* Minn. R. 9505.2165, subp. 2(A)(1), (7) (2021). Nobility contended that DHS had no authority to seek monetary recovery, that DHS did not notify Nobility that DHS would seek monetary recovery, that the violations were isolated recordkeeping errors, and that DHS failed to prove that E.B. did not receive PCA services. The ALJ determined that the preponderance of the evidence showed that Nobility had engaged in abuse and that DHS was entitled to its requested overpayment recovery.

In a final agency order, the commissioner adopted the ALJ's findings of fact and conclusions of law. The order requires Nobility to pay DHS overpayment balances of $271,505.08 for the violations involving E.B.'s care and $57,129.66 for the timekeeping violations involving other care recipients.

Nobility appeals the commissioner's decision.

DECISION

Nobility raises two arguments on appeal. First, Nobility argues that the commissioner has no statutory authority to recover overpayments that resulted from mere "paperwork errors," and is instead limited to imposing a fine of no more than $5,000. Second, Nobility contends that the commissioner erred in determining that Nobility's documentation errors constituted "abuse" under the statute authorizing the commissioner to recover overpaid funds.

Before turning to Nobility's arguments, we identify our standard of review. An administrative agency's decision enjoys a presumption of correctness; the appellate court defers to the agency's expertise and special knowledge in its field. *In re Annandale NPDES/SDS Permit Issuance*, 731 N.W.2d 502, 513 (Minn. 2007). But if an agency's decision is based on an error of law, lacks substantial supporting evidence, or is arbitrary and capricious, we may remand to the agency for further proceedings, or reverse or modify the decision. Minn. Stat. § 14.69 (2020). The party challenging an agency decision bears the burden of proof. *In re Excelsior Energy, Inc.*, 782 N.W.2d 282, 289 (Minn. App. 2010).

I. The commissioner has statutory authority to recover overpayments made due to documentation errors that constitute "abuse."

Nobility argues that, under Minnesota law, the commissioner is limited to imposing a maximum sanction of $5,000 for Nobility's "paperwork errors," which Nobility characterizes as its "first recordkeeping offense." According to Nobility, the commissioner's order for overpayment recovery is therefore unlawful.

Nobility correctly observes that the commissioner may impose a fine for a vendor's "failure to fully document services" according to the standards set forth by statute and Minnesota Rules chapter 9505. *See* Minn. Stat. § 256B.064, subd. 2(f). Under Minnesota law, "[t]he commissioner may assess fines if specific required components of documentation are missing." *Id.* Nobility also accurately states that the maximum fine for such errors is $5,000. "The fine for incomplete documentation shall equal 20 percent of the amount paid on the claims for reimbursement submitted by the vendor, or up to $5,000, whichever is less." *Id.*

But the commissioner is not limited to imposing fines for documentation errors that also constitute "fraud, theft, or abuse" within the meaning of the statute. If a vendor engages in "fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance," the commissioner may impose a variety of sanctions (including a fine) and also "may obtain monetary recovery from a vendor who has been improperly paid either as a result of [the] conduct . . . or as a result of a vendor or department error, regardless of whether the error was intentional." *Id.*, subds. 1a(a)(1), 1b,

1c(a). Here, the commissioner determined that Nobility engaged in "abuse," allowing for the remedy of overpayment recovery. *Id*., subd. 1c(a).

Nobility contends that "paperwork errors" cannot be "abuse," however. According to Nobility, documentation errors fall outside the scope of the plain meaning of the term "abuse."

We need not speculate about the meaning of the term "abuse" because an agency rule defines it. The relevant agency rule defines vendor abuse as "a pattern of practices that are inconsistent with sound fiscal, business, or health services practices, and that result in unnecessary costs to the programs or in reimbursements for services that are not medically necessary or that fail to meet professionally recognized standards for health service." Minn. R. 9505.2165, subp. 2(A) (2021). In addition to this general definition of the term, the rule identifies many practices that constitute abuse, including documentation errors. Those practices include "submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect," "submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs," and "failing to develop and maintain health service records as required under part 9505.2175."[1] Minn. R. 9505.2165, subp. 2(A)(1), (3), (7).

Nobility argues that the applicable statute (section 256B.064) and the agency rule defining abuse (rule 9505.2165, subpart 2) are inconsistent. It contends that, because the

[1] Rule 9505.2175 requires a vendor to "document each occurrence of a health service provided to a recipient" by recording the date(s) and time(s) spent providing such services, including recipient and vendor signatures, and providing a recipient care plan. Minn. R. 9505.2175, subps. 1, 2, 7(H)(9) (2021).

statute allows the commissioner to impose sanctions for documentation errors, such errors cannot also constitute abuse. According to Nobility, this purported conflict between the plain language of the statute and the agency rule invalidates the agency rule. *See Billion v. Comm'r of Revenue*, 827 N.W.2d 773, 781 (Minn. 2013) (invalidating an agency rule that was broader than a corresponding statute).

The interpretation of statutes and administrative rules presents questions of law, which an appellate court reviews de novo. *J.D. Donovan, Inc. v. Minn. Dep't of Transp.*, 878 N.W.2d 1, 4-5 (Minn. 2016). An appellate court generally defers to an agency's interpretation of its rules if the language is ambiguous. *St. Otto's Home v. Minn. Dep't of Hum. Servs.*, 437 N.W.2d 35, 40 (Minn. 1989). However, no deference is required if the language is unambiguous. *In re Rate Appeal of Benedictine Health Ctr.*, 728 N.W.2d 497, 503 (Minn. 2007).

When interpreting a statute, a court must "give effect to all of its provisions." *In re Schmalz*, 945 N.W.2d 46, 50 (Minn. 2020). DHS rules instruct that PCA vendor rules and the statute here—section 256B.064—should be read together. *See* Minn. R. 9505.2160, subp. 1 (2021) ("Parts 9505.2160 to 9505.2245 must be read in conjunction with . . . Minnesota Statutes, chapter[] . . . 256B . . . .").

The statute, reviewed in its entirety, provides the commissioner with multiple means of addressing various vendor problems. As Nobility notes, the statute allows the commissioner to sanction documentation errors that result in overpayments. Minn. Stat. § 256B.064, subds. 1a(a)(7), 2(f). But it also authorizes overpayment recovery in a variety of circumstances, all of which may involve documentation deficiencies. Overpayment

recovery is permitted where a vendor has engaged in "fraud, theft, or abuse," where there was an unintentional vendor error, or even due to DHS's own error. Minn. Stat. § 256B.064, subd. 1c(a) ("The commissioner may obtain monetary recovery from a vendor who has been improperly paid either as a result of conduct described in subdivision 1a or as a result of a vendor or department error, regardless of whether the error was intentional. Patterns need not be proven as a precondition to monetary recovery of erroneous or false claims, duplicate claims, claims for services not medically necessary, or claims based on false statements.").

The rule recognizes that some documentation deficiencies amount to abuse. Documentation deficiencies that constitute abuse include "submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect," "submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs," and "failing to develop and maintain health service records as required under part 9505.2175." Minn. R. 9505.2165, subp. 2(A)(1), (3), (7).

Considered together, the relevant parts of section 256B.064 and rule 9505.2165, subpart 2, are complementary rather than conflicting. The statute gives the commissioner several tools for addressing vendor problems. In turn, the rule elaborates on practices that constitute one such problem—abuse.

Because Nobility does not identify any conflict between the statute and the rule, we reject its argument that the plain language of the statute renders the rule invalid. Under the statute and the rule, the commissioner can recover overpayments caused by documentation

deficiencies that constitute abuse.[2] *See* Minn. Stat. § 256B.064, subds. 1a, 1c; Minn. R. 9505.2165, subp. 2(A).

II. The commissioner did not err by determining that Nobility's violations constituted abuse, authorizing the commissioner to order overpayment recovery.

Nobility argues that the commissioner erred by determining that Nobility's violations constituted abuse.[3] It contends that the commissioner did not allege or prove that any abuse occurred.

In considering whether the record supports an agency's decision, we apply a substantial-evidence analysis. *In re Grand Rapids Pub. Utils. Comm'n*, 731 N.W.2d 866, 871 (Minn. App. 2007). The substantial-evidence analysis requires the appellate court "to determine whether the agency has adequately explained how it derived its conclusion and whether that conclusion is reasonable on the basis of the record." *In re NorthMet Project Permit to Mine Application*, 959 N.W.2d 731, 749 (Minn. 2021) (quotation omitted). If

[2] Nobility contends that the commissioner's decision is arbitrary and capricious because it does not explain why some conduct was sanctioned while other conduct was used as a basis for overpayment recovery. We reject this argument. Nobility never challenged the $5,000 fine assessed for care-plan deficiencies, and thus, this issue was not before the ALJ or the commissioner. We also see no inconsistency in the decision to sanction care-plan violations but to order overpayment recovery for timekeeping violations that constituted abuse.

[3] Nobility also contends for the first time on appeal that it did not receive notice that the basis for overpayment recovery was abuse. But the Notice of Overpayment cited to section 256B.064 and rules 9505.2160 to .2245, which authorize overpayment recovery for abuse. Moreover, Nobility failed to raise its notice argument during the proceedings below. We therefore decline to further address it. *See Thiele v. Stich*, 425 N.W.2d 580, 582 (Minn. 1988) (stating that arguments not raised in the proceedings below will not be considered on appeal).

the agency's decision is supported by substantial evidence, the appellate court must affirm. *In re Excess Surplus Status of Blue Cross & Blue Shield of Minn.*, 624 N.W.2d 264, 279 (Minn. 2001).

We first observe that Nobility does not dispute the pertinent facts.[4] Those facts show that E.B. had an expired care plan but Nobility PCAs continued to report care for E.B.; a PCA working for Nobility was paid for services to E.B. that were provided while the PCA was also working for other employers; timesheets for E.B.'s care did not appear to contain E.B.'s original signature; and timesheets for other care recipients were illegible, incomplete, ambiguous, and unsigned.

Although Nobility acknowledges the violations that the commissioner found, it contends that these violations did not amount to abuse under Minnesota law. *See* Minn. Stat. § 256B.064, subds. 1a, 1c; Minn. R. 9505.2165, subp. 2(A). We disagree. As noted, abuse includes "submitting repeated claims, or causing claims to be submitted, from which required information is missing or incorrect," "submitting repeated claims, or causing claims to be submitted, for health services which are not reimbursable under the programs," and "failing to develop and maintain health service records as required under part 9505.2175." Minn. R. 9505.2165, subp. 2(A)(1), (3), (7). The undisputed facts show that

[4] At oral argument, counsel for Nobility asserted that the reimbursement requests Nobility submitted to DHS were not incomplete or inaccurate. However, the commissioner's finding of abuse did not relate to Nobility's reimbursement requests; the abuse finding concerned the gross deficiencies in the underlying documentation of services provided. In any event, because Nobility did not make this argument in its principal brief, we do not address it further. *Fontaine v. Steen*, 759 N.W.2d 672, 679 (Minn. 2009) ("[T]his court does not consider matters . . . not raised or argued in an appellant's principal brief.")

Nobility submitted repeated claims based on timesheets that were incomplete or incorrect. *See* Minn. Stat. § 256B.0659, subd. 28(a)(4) (2020) (requiring complete documentation of timesheets for each PCA and activity sheets for each services recipient). The undisputed facts show that Nobility was reimbursed for PCA services provided to a recipient without a valid care plan and services that were not properly documented—services that are not reimbursable. *See id.*, subd. 7 (2020) (listing care-plan requirements); Minn. R. 9505.0335, subp. 2(D) (2021) (providing that PCA-services recipients must have care plans for PCAs to receive reimbursement). And the undisputed facts show that Nobility failed to maintain legally required health-services records. *See* Minn. R. 9505.2175, subps. 2(C), 7(H) (2021) (requiring time records); Minn. R. 9505.2175, subp. 2(G) (requiring care plans). Accordingly, substantial evidence in the record supports the commissioner's determination that "the pattern and practices of Nobility are deemed abuse and, therefore, DHS is required to seek an overpayment."

Affirmed.