STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
10DHR08206/11DHR10487/12DHR12145

St. Mary's Home Care Services, Inc., Petitioner, v. North Carolina Division of Medical Assistance Finance Management Section Audit Unit North Carolina Department of Health and Human Services, Respondent.	**DECISION (as to 11DHR10487)** **FINAL DECISION (as to 12DHR12145)**

THIS MATTER came on for hearing before Beecher R. Gray, Administrative Law Judge, on July 15-19, 2013 and September 16-17 and 19-20, 2013 in Raleigh, North Carolina. The contested cases addressed in this decision were consolidated upon the joint motion of the parties.

APPEARANCES

For Petitioner: Robert A. Leandro
Parker Poe Adams & Bernstein, LLP
150 Fayetteville Street
Suite 1400
Raleigh, North Carolina 27601

For Respondent: Brenda Eaddy
Kathleen McCraw
North Carolina Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602-0629

APPLICABLE LAW

The laws applicable to this contested case are N.C. Gen. Stat. Chapter 150B, Article 3, and N.C. Gen. Stat. Chapter 108C, Articles 1, 2, 5, and 12, 10A NCAC 22F, 10A NCAC 22I, and 10A NCAC 22J.

BURDEN OF PROOF

Under N.C. Gen. Stat. § 108C-12(d), the Agency has the burden of proof as to any "adverse determination." The definition of "adverse determination" includes the Agency's decision to recoup funds from the Petitioner. *See* N.C. Gen. Stat. § 108C-2(1).

ISSUE

The issue to be resolved in this case is whether Respondent violated the standards of N.C. Gen. Stat. § 150B-23 when it determined through five individual post-payment reviews that Petitioner was overpaid by Medicaid in the amount of $4,334,056.09.

EXHIBITS

The following Exhibits were allowed into evidence:

Joint Exhibits

1 Pete Jones Deposition in 10-DHR-08002
2 Agency 30(b)(6) Deposition

Petitioner's Exhibits

1 DMA Website – Financial Management Scope of Responsibilities
2 DMA Website – Personal Integrity Section – Scope of Responsibilities
3 Basic Medicaid Billing Guide (April, 2010)
4 Agency's Response to St. Mary's Discovery Requests
5 Agency Prehearing Statement (July 8, 2013)
6 Agency Prehearing Statement (March 12, 2013)
7 Audit Section Letter (December 2, 2009)
8 Audit Section Letter (February 18, 2010)
9 Audit Section Check Sheet (August 11, 2008)
10 Audit Section – Audit Tool
11 CV of Dr. Jeffrey Witmer
12 DMA Program Integrity Section Guide for PCS PACT Form Audits
13 Audit Section Post Payment Review Form
15 DMA Personal Care Services Q & A.
17 PCS Claims Sampling Project Power Point
18 Personal Care Services Financial Operation Summary & Action Plan Power Point
19 Jim Flowers' September 6, 2011 Memo
34 The Greater Choice for Homecare Case Summary
35 The Greater Choice for Homecare Claims Spreadsheet
37 Shipman Family Home Care Case Summary
38 Definition of "Signature" – Black's Law Dictionary
40 St. Mary's Administrative Conference Written Arguments
42 Document showing errors in "conceded" claims [Respondent's Exhibit 24] (illustrative)

Respondent's Exhibits

1A St. Mary's 6601123 Application for Provider Participation 5/28/04
1B St. Mary's 6601123 Medicaid Participation Agreement 6/1/04
1C St. Mary's 6601123 Medicaid Provider change form 1/29/07
1D St. Mary's 6601123 License 2/15/07
1E St. Mary's 6601123 License 12/17/04
1F St. Mary's 6601123 Medicaid Provider change form 12/17/04
2A St. Mary's 6601144 Application for provider participation 5/28/04
2B St. Mary's 6601144 Provider Participation Agreement 6/8/04
2C St. Mary's 6601144 Medicaid Provider change form 12/28/04
2D St. Mary's 6601144 Memo from DMA re: change of Payment Address 1/14/05
2E St. Mary's 6601144 License 6/8/04
2F 10/16/06 Letter to St. Mary's 6601144 authorizing HIV case management services
3 Dr. Kenneth H. Pollock Extrapolation Methodology
4 Diagram of Audit Procedure (illustrative)
5 Description of Medicaid's Coverage of Personal Care Services (PCS)
6 Division of Medical Assistance Clinical Coverage Policy 3C, Personal Care Services (effective October 1, 2007)
7A Initial Records Request for 6601144 7/1/05 Audit dated 2/18/10
7B Second Records Request for 6601144 7/1/05 Audit dated 7/10/10
7C Initial Records Request for 6601144 1/1/06 audit dated 2/19/10
7D Second Records Request for 6601144 1/1/06 audit dated 6/30/10
7E Initial Records Request for 6601144 -1/1/07 Audit dated 2/25/08
7F Second Records Request for 6601144 -1/1/07 Audit dated 9/2/08
7G Initial Records Request for 6601123 – 7/1/06 Audit dated 2/12/10
7H Second Records Request for 6601123 – 7/1/06 audit dated 6/20/10
7I Initial Records Request for 6601123 – 1/1/08 Audit dated 5/18/09
8A Notice of Overpayment Letter - 11/30/09 – 6601123-2008-1
8B Notice of Overpayment Letter - 11/09/10 – 6601123-2006-1
8C Notice of Overpayment Letter - 10/29/10 – 6601144-2006-1
8D Notice of Overpayment Letter - 9/30/09 – 6601144-2007-1
8E Notice of Overpayment Letter - 10/27/10 – 6601144-2005-1
9A Administrative Conference Decision Letter – 6601144-2005-1
9B Administrative Conference Decision Letter 5/19/11
10A Final Notice of Overpayments with Summaries - Audit 6601123-2008-3
10B Final Notice of Overpayments with Summaries - Audit 6601144-2006-2
10C Final Notice of Overpayments with Summaries - Audit 6601144-2007-3
10D Final Notice of Overpayments with Summaries - Audit 6601123-2006-2
10E Final Notice of Overpayments with Summaries - Audit 6601144-2005-2
11A Final Notice of Overpayments with Summaries - Audit 6601123-2008-3
11B Final Notice of Overpayments Audit 6601123-2006-2
11C Final Notice of Overpayments - Audit 6601144-2006-2
11D Final Notice of Overpayments -Audit 6601144-2007-3
11E Final Notice of Overpayments -Audit 6601144-2005-2
12A-E St. Mary's Service Documentation and Summary Information (Summary Information admitted for illustrative purpose only)

19 Dr. Alan Kvanli CV
21 10A NCAC 22I
22 10A NCAC 22J
24 Analysis of potentially "conceded" claims (illustrative)

The Following Exhibits were entered as an Offer of Proof by Respondent:
12F - 12N, 13, 14, 15, 16, 17, 18, 23

WITNESSES

Petitioner presented the testimony of:
1. Schaefer O'Neill (Tr. Vol. 8)
2. Bradford Woodard (Adverse) (Tr. Vol. 8)
3. Jeffery Witmer, PhD. (Tr. Vol. 8)

Respondent presented the testimony of:
1. James Flowers (Tr. Vol. 1)
2. Peter Jones (Tr. Vols. 2-4)
3. Alan Kvanli, PhD. (Tr. Vol. 5)
4. Maria Mapagu (offer of proof)

FINDINGS OF FACT

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents and exhibits received and admitted into evidence, and the entire record in this proceeding, the Undersigned makes the following Findings of Fact. In making the Findings of Fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses by taking into account the appropriate factors for judging credibility, including but not limited to, the demeanor of each witness; any interests, bias, or prejudice the witness may have; the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testified; whether the testimony of the witness is reasonable; and whether the testimony is consistent with all other creditable evidence in the case.

The Parties

1. Petitioner St. Mary's Home Care Service, Inc. ("Petitioner" or "St. Mary's") is a provider of personal care services ("PCS") to Medicaid recipients in North Carolina with offices in Rocky Mount and Charlotte. PCS is a Medicaid service that allows elderly or disabled individuals who are Medicaid eligible to receive assistance with certain Activities of Daily Living ("ADLs") such as bathing, toileting, and dressing. Medicaid recipients also can receive assistance with certain Instrumental Activities of Daily Living ("IADLs"), such as laundry and cooking, as part of the PCS services provided. (Res. Ex. 6, pp. 1 and 8).

2. Respondent is the North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"), which oversees the North Carolina Medicaid program. The Budget Management Section, Audit Unit (the "Agency" or the "Audit Unit") is a subunit of DMA operating under the laws of North Carolina. As a part of DMA, the Audit Unit is charged with settling costs and auditing cost reports from various provider types and organizations. (Pet. Exs. 1 and 3).

3. The parties received notice of hearing by certified mail more than 15 days prior to the hearing, and each stipulated on the record that notice was proper.

Contested Actions

4. The Audit Unit conducted two post-payment reviews of the PCS services provided by St. Mary's from its Charlotte location. The Medicaid Provider Number for St. Mary's Charlotte location is 6601123. For the Charlotte location, the Audit Unit reviewed dates of service provided by St. Mary's between July 1, 2006 and December 31, 2006 ("2006 Charlotte Review") and between January 1, 2008 and June 30, 2008 ("2008 Charlotte Review").

5. The Agency issued written findings for each of the Charlotte reviews. (Res. Exs. 8A and 8B). For the 2006 Charlotte Review, the Agency determined that an extrapolated recoupment of $1,248,538.23 was owed to DMA. (Res. Ex. 8B). For the 2008 Charlotte Review, the Agency determined that an extrapolated recoupment of $1,708,712.48 was owed to DMA. (Res. Ex. A).

6. The Audit Unit also conducted three post-payment reviews of the PCS services provided by St. Mary's from its Rocky Mount location. The Medicaid Provider Number for St. Mary's Rocky Mount location is 6601144. The Audit Unit conducted post-payment reviews of St. Mary's Rocky Mount location for dates of service between July 1, 2005 and December 31, 2005 ("2005 Rocky Mount Review"), July 1, 2006 and June 30, 2006 ("2006 Rocky Mount Review"), and January 1, 2007 and June 30, 2007 ("2007 Rocky Mount Review").

7. On December 2, 2010, Petitioner filed its Verified Petition for a Contested Case Hearing and Motion for a Temporary Restraining Order and Stay of Contested Action in 10 DHR 08206. This petition contested the agency actions dated October 27, 2010 in DMA Audit PCS Review # 6601144-2005; November 24, 2010 in Review # 6601144-2006, and November 9, 2010 in Review # 6601123-2006. An Order enjoining the agency from recouping payments on these audits was granted on December 2, 2010. Petitioner took a voluntary dismissal of 10 DHR 08206 on November 25, 2013. The parties were informed that 10 DHR 08206 would not be unconsolidated and closed separately, as this would necessitate resubmission of all documents from the parties in order to create a complete record for both 10 DHR 08206 and the remaining two cases (11 DHR 10487 and 12 DHR 12145).

8. The Agency issued written findings for each of the Rocky Mount reviews. (Res. Exs. 8C-8E). For the 2005 Rocky Mount Review, the Agency determined that an extrapolated recoupment of $701,674.65 was owed to DMA. (Res. Ex. 8E). For the 2006 Rocky Mount Review, the Agency determined that an extrapolated recoupment of $1,248,538.23 was owed to DMA. (Res. Ex. C). For the 2007 Rocky Mount Review, the Agency determined that an extrapolated recoupment of $369,897.80 was owed to DMA. (Res. Ex. 8D).

9. St. Mary's requested that the Department reconsider the findings for each of these audits. Two Administrative Conferences were held under the provisions of 10A NCAC 22J.

10. Two months after the conclusion of the first Administrative Conference, the hearing officer issued a written decision for the 2007 Rocky Mount Review and the 2008 Charlotte Review. (Res. Ex. 9B). The Administrative Conference Decision reduced the alleged overpayment amount in the 2007 Rocky Mount Review to $346,988.63. (Res. Ex. 10C). The 2008 Charlotte Review overpayment was reduced to $1,288,954.82. (Res. Ex. 10A). St. Mary's timely filed a Contested Case Petition with the Office of Administrative Hearings challenging the Agency's decision, captioned as 11 DHR 10487.

11. Eight months after the conclusion of the second Administrative Conference, the hearing officer issued a written decision for the 2005 Rocky Mount Review, 2006 Rocky Mount Review, and the 2006 Charlotte Review. (Res. Ex. 9A). The Administrative Conference Decision reduced the alleged overpayment amount in the 2005 Rocky Mount Review to $621,722.70. (Res. Ex. 10E). The 2006 Rocky Mount Review overpayment was reduced to $897,766.83. (Res. Ex. 10B). The 2006 Charlotte Review overpayment was reduced to $1,178,623.11. (Res. Ex. 10D). St. Mary's timely filed a Contested Case Petition with the Office of Administrative Hearings challenging the Agency's decision, captioned as 12 DHR 12145.

12. The Parties jointly moved for these cases to be consolidated, which delayed the contested case hearing in 11 DHR 10487. Additionally, the Parties jointly sought several continuances of the contested case hearing in the consolidated cases.

The DMA Audit Unit

13. James ("Jim") Flowers (hereinafter "Audit Chief Flowers") serves as the Chief of the Audit Unit, which is a subdivision of the Budget Section of DMA. (Tr. Vol. 1, p. 37). Peter ("Pete") Jones (hereinafter "Audit Manager Jones") serves as the Audit Manager of the Audit Unit. (Tr. Vol. 2, p. 293).

14. Audit Chief Flowers testified that the Audit Unit's authority to conduct a post-payment review of St. Mary's PCS Medicaid services derives from 10A NCAC 22I. (Tr. Vol. 1, pp. 46 and 48). 10A NCAC 22I(a) states that: "an audit of a provider may be conducted by the Division of Medical Assistance, or by any auditing firm subcontracted by them."

15. The DMA Medicaid Billing Guide and DMA's webpage state that the Audit Unit is responsible for settling costs and auditing cost reports from various provider types including long term care, hospitals, federally qualified health clinics, rural help centers, and local health departments. Financial and statistical data are summarized from the cost reports audited by the Audit Unit to assist DMA in administering the reimbursement to these providers and in rate setting. (Pet. Exs. 1 and 2).

16. Based on the description of the Audit Unit's duties in the Medicaid Billing Guide, the auditing performed by the Audit Unit is limited to audits of cost reports and does not provide that the Audit Unit will conduct post-payment reviews of PCS documentation.

17. The NC DMA Medicaid Billing Guide states that the Program Integrity Section is responsible for conducting post-payment reviews of claims paid by the fiscal agent and identifying overpayments for recoupment. (Pet. Ex. 3). This is consistent with the duties outlined in 10A NCAC 22F entitled "*Program Integrity.*"

18. Audit Manager Jones conducted the initial review of the Rocky Mount 2005 Review and Rocky Mount 2007 Review. (Tr. Vol. 2, pp. 309-310). Audit Manager Jones completely re-reviewed the audit findings for the two audits he conducted prior to sending the notices of overpayment to St. Mary's. He also reviewed the audit findings of the remaining three St. Mary's audits that were completed by his staff. Audit Manager Jones made revisions to these three sets of audit findings prior to sending the findings to St. Mary's. (Tr. Vol. 2, pp. 402-403).

19. The Audit Unit did not provide any formal training or credentialing process to Audit Manager Jones or any of the other auditors involved in this audit. (Tr. Vol. 2, pp. 393-397). Instead, the Audit Unit uses on-the-job training such that new trainees learn by reviewing past audits and conducting audits under a more senior staff member. (Tr. Vol. 2, p. 402). The St. Mary's audits were the first PCS post-payment reviews that Audit Manager Jones had conducted at the Audit Section. (Tr. Vol. 2, p. 408).

20. As Chief of the Audit Unit, Jim Flowers reviewed the post-payment review findings with staff prior to Audit Manager Jones sending out the overpayment notices to St. Mary's. (Tr. Vol. 1, pp. 51 and 62).

Lack of Evidence to Support Audit Section Decision

21. Audit Chief Flowers provided no testimony that indentified or explained any of the specific findings made by the Audit Unit in its post-payment reviews of St. Mary's. Audit Chief Flowers did provide testimony regarding the Audit Unit's interpretation of the PCS policies applied to the St. Mary's post-payment reviews.

22. Despite the fact that Audit Manager Jones conducted, oversaw, and re-reviewed each of the Agency's post-payment review findings, he provided no testimony during his direct examination to identify any documents to support the Agency's decision. Audit Manager

Jones also provided no testimony identifying or explaining any of the specific findings made by the Audit Unit in its post-payment review of St. Mary's.

23. During his cross-examination and redirect, Audit Manager Jones provided testimony regarding the general policies that he believed formed the basis of the Agency's findings. Audit Manager Jones also testified about a limited number of the specific findings identified in Respondent's Exhibit 12. (Tr. Vol. 2, pp. 435-468; Tr. Vol. 3, pp. 650-670; Res. Exs. 12A, 12B, and 12E).

St. Mary's Alleged Violations of Best Practices Correcting Documentation Errors

24. The Audit Section contends that it used "best practices" when determining whether a document reviewed would result in an overpayment. (Tr. Vol. 1, pp. 156 and 207; Tr. Vol. 2, p. 447; Tr. Vol. 4, pp. 707, 742). The best practices that the Audit Section contends St. Mary's were expected to follow are contained in the Clinical Coverage Policy and are not written down or published anywhere to the Agency's knowledge. (Tr. Vol. 1, pp. 156 and 207; Tr. Vol. 3, p. 707). Audit Chief Flowers did not identify any specific documents that the Agency contends violated "best practices." (Tr. Vol. 1, pp. 156-158).

25. The Audit Section contends that "best practices" for documentation should be used by corporations, the military, healthcare providers, and the Agency. (Tr. Vol. 1, pp. 156-157). However, the Agency's own internal documentation relating to this audit did not conform with the documentation best practices described by Audit Chief Flowers in his testimony. (Tr. Vol. 1, pp. 156 and 169-173; Pet. Exs. 9 and 10).

26. Audit Manager Jones testified that violations of "best practices" served as his basis for determining whether the documentation reviewed should have resulted in an overpayment (Tr. Vol. 2, p. 447; Tr. Vol. 3, pp. 532, 625; Tr. Vol. 4, pp. 742). Specifically, Audit Manager Jones stated that St. Mary's failed to follow "best practices" in the way it amended information in documents such as the Physicians Authorization and Certification for Treatment form ("PACT form") and service notes. (*Id.*).

27. The Medicaid Participation Agreement between the Department and St. Mary's provides that St. Mary's is obligated to comply with federal and state laws, regulations, and policies. (Res. Ex. 1, p. 1). It does not contain any provisions relating to best practices. (*Id*.)

28. Audit Manager Jones testified that best practices required St. Mary's to either create a new document or to strike through the corrected portion, enter the correction, sign the name of the individual making the correction, and append an explanation for the correction to the document. (Tr. Vol. 2, p. 449). Audit Manager Jones believes that these best practices create a proper "audit trail" for DMA auditors. (Tr. Vol. 2, p. 429).

29. In making its findings relating to how changes should be made to Physician's Authorization and Certification for Treatment ("PACT") forms and other service

documentation, the Agency also relied on Medicaid Coverage Description Section 6 - Personal Care Services (effective January 1, 1999). (Res. Ex. 5; Tr. Vol. 2, pp. 359-360). Specifically, the Agency relied on Pages 6-12 and 6-16, Step 6.11 of The Medicaid Coverage Description – Section 6 Personal Care Services (effective January 1, 1999). (Res. Ex. 12A). There is no guidance in The Medicaid Coverage Description that directs a Medicaid provider on how to make changes to a PACT form or other service documentation. (Res. Ex. 5).

30. In making its findings relating to how changes should be made to PACT forms and other service documentation, the Agency also relied on Clinical Coverage Policy 3C (effective October 1, 2007). Clinical Coverage Policy 3C sets forth the clinical and administrative policies that govern the PCS program. The Agency relied on this document in its review of all the St. Mary's documents in the audits at issue. (Tr. Vol. 2, pp. 420-421). However, Clinical Coverage Policy 3C (effective October 1, 2007) could only apply to the 2008 Charlotte Review.

31. Clinical Coverage Policy 3C contains no provision that directs a provider on how to make contemporaneous corrections or changes to documentation. (Res. Ex. 6). The Agency cited Clinical Coverage Policy Sections 7.6 and 7.8.1, 7.8.2, and 7.8.3 to support its findings that St. Mary's incorrectly altered or corrected its PACT forms. (Res. Ex. 12(a); Tr. Vol. 2, p. 414).

32. Clinical Coverage Policy Section 7.6 states only that the provider is responsible for the accuracy of the assessment and contains no guidance on how changes or alterations to a document should be made. (Res. Ex. 6, p. 13).

33. Clinical Coverage Policy § 7.8.1 and 7.8.2 involve revision to the PACT plan of care that are identified after services have been certified as necessary because of either a significant or non-significant change in the recipient's conditions. (Res. Ex. 6, p. 14). These sections of the policy contain no guidance on how changes or alterations should be made by a provider during the completion of the PACT prior to certification.

34. Clinical Coverage Policy Section 7.8.3 sets forth the process for changing PACT documentation when an individual who is receiving PCS qualifies for PCS Plus, a more intensive service. (Tr. Vol. 2, pp. 426-427). This section of the policy contains no guidance on how changes or alterations should be made by a provider during the completion of the PACT prior to certification and is not applicable in any manner to this audit.

35. Audit Manager Jones testified that any changes to a PACT require the revisions set forth in Section 7.8. (Tr. Vol. 2, p. 440). Audit Manager Jones believed that this was required even if the document was changed or revised at the time of the document's creation, prior to services being provided or certification of the documentation by the caregiver or nurse. (*Id*.)

36. The Audit Section contends that its position regarding how PACT forms should be changed or altered is supported by the FAQ published by DMA (the "FAQ"). (Tr. Vol. 2, p. 430; Pet. Ex. 15). The DMA FAQ is not contained in Clinical Coverage Policy 3C. (Tr. Vol. 2, p. 431).

37. The DMA FAQ appears to have been published by DMA in March 2009. (Pet. Ex. 15). Although Audit Manager Jones did not know the publication date of the DMA FAQ, he testified that he assumed the publication date to be March 2009. (Tr. Vol. 3, p. 515). The publication date of this document is subsequent to the review periods in all five of the St. Mary's audits. (Tr. Vol. 3, p. 516).

38. Question 27 of the DMA FAQ specifically addresses how changes should be made to a PACT form after the form has been certified, stating "a RN cannot correct an original, signed PACT Form but rather the changes should be done on a copy of the PACT." (Pet. Ex. 15, p. 10). This guidance is consistent with Clinical Coverage Policy 3C and contradicts Audit Manager Jones' contention that RNs are directed to follow certain protocols for correcting or changing a PACT form prior to signing the PACT.

39. Question 27 includes a date of July 2007 below the answer. (Pet. Ex. 15, p. 10). Audit Manager Jones did not know whether this guidance was published in March 2009 or July 2007. (Tr. Vol. 3, pp. 826-827). Even considering the earlier publication date of July 2007, the guidance provided in DMA FAQ 27 is only applicable to the 2008 Charlotte Review. (Tr. Vol. 3, p. 529). The Agency did not limit its use of the DMA FAQ to only the 2008 Charlotte Review but instead generally used this document in making findings in all of the St. Mary's audits. (Tr. Vol. 2, pp. 430-432; Tr. Vol. 3, pp. 528-520).

40. Based on the language of Clinical Coverage Policy 3C and the DMA FAQ, a registered nurse is limited only in how changes are made to the PACT after it is signed. Prior to signing the document, the Agency has provided no direction to providers on how to make corrections to the PACT. Without evidence that a change, correction, or alteration was made after the certification by the physician, the Agency cannot demonstrate that St. Mary's has violated Clinical Coverage Policy 3C or the DMA FAQ.

41. In response to a question regarding how aides should fix mistakes on an original service note, Question 117 of the DMA FAQ states: "Agency policy should establish requirements for documentation. Medicaid requires the notes to be legible and signed. See Policy 3C Section 7.11. Generally, the accepted standard to correct an error in documentation is to strike a single line through the error, initial and date the entry." (Pet. Ex. 15, p. 36). The date under this FAQ is June 2008. (*Id.*).

42. DMA FAQ 117 makes clear that the policy requires legible, signed service notes. To the extent that DMA informed providers of what it believed were generally accepted standards to correct an error, such guidance was not published until June 2008, after the audit period in all five of these audits. (Pet. Ex. 15, p. 36).

43. Although the guidance provided in DMA FAQ 117 is not applicable to the time periods under review, DMA FAQ 117 does not comport with Audit Manager Jones' testimony that the provider should append a written explanation for a change or correction to a service document. (Tr. Vol. 2, p. 449).

44. Audit Manager Jones also provided testimony relating to Respondent's Exhibit 12A, which he contends provides two specific examples of changes or alterations to a PACT form in violation of best practices and Clinical Coverage Policy 3C. (Tr. Vol. 3, pp. 650-660). Specifically, for Recipient L.R., the Agency believed that there were alterations made to the time needed to accomplish the tasks in the plan of care which did not meet "best practices." (*Id*.) Audit Manager Jones believed that--if changes were to be made to the plan of care--an entirely new document should have been created. (Tr. Vol. 2, p. 437; Tr. Vol. 3, pp. 533). The PACT form--which is handwritte--contains changes to the various individual times to accomplish certain activities. However, the total time for the week does not appear to be altered in any way. (Res. Ex. 12A). The Agency does not know if these changes were made during the creation of the PACT, prior to certification. (Tr. Vol. 2, pp. 440-441) The physician certified the plan of care after creation of the plan of care, including the change to the individual task time, indicating that the changes were made prior to certification. (*Id*.) This certification indicates that the physician supports the plan of care, as corrected. (*Id*.)

45. Respondent introduced Exhibit 12A, Bates Number 1530-1531, as the second specific claim for which it believed showed alterations to the PACT plan of care. However during its original review of this document, the Audit Unit made no finding that the plan of care in question had been altered or changed. (Tr. Vol. 3, pp. 729-731; Res. Ex. 12A).

46. The fact that the Agency identified a new finding regarding the alteration of a PACT plan of care that it did not identify as an error in its initial audit demonstrates the subjective and arbitrary nature of this finding.

47. The Audit Section's understanding of the Agency's policy and its reliance on unpublished "best practices" invalidates the Agency's findings and discredits the Audit Unit's ability to properly conduct post-payment reviews of PCS providers.

Physician Authorization After 60 Day Authorization Time Period

48. Audit Chief Flowers testified that when a PACT is signed by the physician after 60 days, it is the policy of the Agency to allow all dates of service, beginning after the date the physician signs the PACT form. (Tr. Vol. 1, pp. 196-197). Audit Chief Flowers testified that he believes his auditors followed this guidance. (Tr. Vol. 1, p. 197).

49. Audit Chief Flowers' testimony is consistent with the Audit Unit's Post-Payment Tool Review Form which states that claims should be allowed after the 60th day once the physician has signed the PACT form. (Pet. Ex. 13, ln. 9). DMA's Program Integrity Section has set forth a similar position in its Audit Tool Review Form. (Pet. Ex. 12, ln. 113).

50. Audit Manager Jones directly contradicted Audit Chief Flowers' testimony and the Audit Unit's Post-Payment Review Form, stating that it was his understanding of the policy that all dates of service would be recouped after the 60th day even if the physician signed the PACT form. (Tr. Vol. 2, pp. 465-466). Audit Manager Jones specifically identified 3 examples of recoupments for which he contends the basis for the Agency's finding is that the physician signed the PACT form after the 60th day. (Tr. Vol. 2, pp. 459, 464-466; Res. Ex. 12E).

51. Audit Manager Jones' understanding of the Agency's physician signature policy is erroneous and in direct contradiction to the testimony of Audit Chief Flowers and the Agency's policy. The specific documents reviewed in Respondent's Exhibit 12E do not evidence an overpayment.

PACTS Authorized by Nurse Practitioners and Physician Assistants

52. The Agency contended that the PACT must be signed only by the primary care physician and, if a nurse practitioner or physician assistant signed a PACT form, the provider was required to maintain documentation that the specific nurse practitioner or physician assistant was under the supervision of the recipient's primary care physician. (Tr. Vol. 1, pp. 181-183). The Audit Unit contends that, without such documentation, recoupment is appropriate for all services provided under the PACT. (Tr. Vol. 1, p. 179).

53. The Agency provided no testimony or evidence regarding the Medicaid recipients or claims for which this finding might apply and provided no evidence to support its interpretation of the policy as requiring the provider to maintain such documentation.

54. Even assuming that the Audit Unit could have provided such evidence, the Medicaid Coverage Description – Section 6 Personal Care Services (effective January 1, 1999) and Clinical Coverage Policy 3C (effective Oct. 1, 2007) contain no provision that requires PCS providers to maintain documentation demonstrating that a nurse practitioner or physician assistant is under the direct supervision of a specific physician. (Tr. Vol. 1, p. 190; Res. Exs. 5 and 6). The Audit Section cited no other documentation to support its understanding of this purported PCS policy requirement.

55. The DMA Program Integrity PCS Audit Guide directly contradicts the Audit Unit's understanding of the policy stating that the PACT form must be authorized by a "primary physician's practice." The Program Integrity Audit guide also states that if the appropriate practice signs page 4 of the PACT authorizing the need for service, there should be no recoupment. (Tr. Vol. 1, p. 191; Pet. Ex. 12, ln. 24).

56. Subdivisions of DMA should not apply different standards to providers when conducting post-payment reviews. Audit Chief Flowers testified that it is important that the Program Integrity Section and the Audit Unit apply the rules in similar ways. (Tr. Vol. 1, p. 210).

57. The Audit Section has no basis for recoupment on this ground and evidences a misunderstanding of DMA's policy.

RN's Use of Stamped Signature

58. The Agency contends that for 32 or 33 recipients reviewed in the St. Mary's audit, the PACT contained a copy of an RN signature stamp in violation of DMA policy. (Tr. Vol. 3, p. 661). The Audit Unit was concerned that the RN signature stamp appeared to be in the same location on each PACT. (*Id*.). The Agency identified only 2 specific recipients for which this finding was made by the Agency. (Res. Ex. 12B).

59. PCS policy allows for the use of stamped signatures. (Tr. Vol. 3, p. 662). PCS policy also allows providers to use electronic signatures. (Tr. Vol., 4, pp. 727, 729). When using an electronic signature, Audit Manager Jones testified that he would expect the signature to be in the same place each time it was used. (*Id*.)

60. The PACT forms that contained the stamped signature related to a single registered nurse employed by St. Mary's--Patti Jones. (Res. Ex. 12B; Tr. Vol.4, p. 711). RN Jones' PACTs were typewritten instead of handwritten and contained her stamped signature affirming the PACT. (Res. Ex. 12B). St. Mary's provided the Audit Unit with an explanation regarding the stamped signature stating that RN Jones had a debilitating medical condition that made it difficult to write and that the use of the stamp was only made as an accommodation to the nurse in question. (Tr. Vol. 4, p. 714; Res. Ex. 40).

61. The agency disregarded this explanation because, on a limited number of documents, RN Jones signed her name using a pen. (Tr. Vol. 4, pp. 714-15). It is unreasonable to reject RN Jones' need to use a stamped signature on the basis that she was able to sign her name on some occasions.

62. A comparison of two of the stamped-signature PACT forms that were admitted into evidence shows that all of the information required for the assessment is unique to the individual recipient being assessed. (Tr. Vol. 4, pp. 716-720; Res. Ex. 12B). The PACTs also show that RN Jones entered distinct typewritten dates to document the date of her certification of these PACT forms. (*Id*.) Additionally, for each of the two PACTs discussed, the physician agreed with the assessment and ordered the service by signing and dating the PACT. (*Id*.) The fact that the PACTs are unique and individualized is critical because it refutes any concern the Audit Unit may have had that the RN was not completing the assessments.

63. The Agency did not consider or review the contents of the documents to determine whether they were unique PACT forms, containing unique clinical information documenting the need for services. (Vol. 3, p. 720).

64. The use of the stamped signature by RN Jones is not a violation of DMA's policy.

Claims the Agency Contends St. Mary's Is Not Challenging

65. Audit Chief Flowers provided no testimony or evidence identifying any claims the Agency contends St. Mary's conceded at the reconsideration hearing. Similarly, Audit

Manager Jones provided no testimony regarding any potential concessions made by St. Mary's at the reconsideration review hearing.

66. The Audit Unit attempted to provide evidence of concessions by introducing an audit spreadsheet that estimated what the extrapolated overpayment would be if the Agency recouped only for those services St. Mary's purportedly "conceded." (Tr. Vol. 5, p. 900; Res. Ex. 24).

67. Dr. Kvanli was asked to testify about the veracity of this document. Dr. Kvanli did not create the document and did not review any of the information contained in the document. (Tr. Vol. 5, pp. 900, 979). Dr. Kvanli could not confirm if the information contained in the spreadsheet was accurate. (*Id*. at p. 979)

68. Respondent's Illustrative Exhibit 24 contains many errors. For example, Petitioner's expert, Dr. Witmer, states that dozens of names listed in Respondent's Illustrative Exhibit 24 as being conceded were not listed as conceded claims in the Administrative Conference Decision. (Tr. Vol. 8, pp. 1577-1582; Respondent Ex. 42). Dr. Kvanli also noted an error in Respondent's Illustrative Exhibit 24. (Tr. Vol. 5, pp. 986-987

69. Respondent's Illustrative Exhibit 24 is unreliable and does not accurately reflect alleged concessions made by St. Mary's prior to the contested case.

70. The Hearing Officer's decision also appears to contain errors. The decision indicated that certain claims were conceded by St. Mary's when the documentation submitted to the Hearing Officer sets forth specific challenges to the findings. For example, the Hearing Officer found that St. Mary's did not challenge the findings for Recipient S.R. [Strata 1-12]. (Res. Ex. 9A, p. 21). Documentation submitted by St. Mary's expressly set forth a challenge to the findings for Recipient S.R.. (Pet. Ex. 40, Bates p. 000192). The Hearing Officer found that St. Mary's did not challenge the findings for Recipient M.F. [Strata 1-4]. (Res. Ex. 9A, p. 32). Documentation submitted by St. Mary's also expressly sets forth a challenge to the findings for Recipient M.F. (Pet. Ex. 40, Bates p. 000191). The Hearing Officer found that for Recipient V.P. [Strata 5-1], St. Mary's had not challenged the Audit Unit's findings. (Res. Ex. 9A, p. 30). St. Mary's expressly challenged the Audit Section's finding for Recipient V.P. [Strata 5-1]. (Pet. Ex. 40, p. 9).

71. The Hearing Officer's findings are inconsistent with the evidence in the record and on their face do not establish by a preponderance of the evidence that the basis for the Audit Section's recoupment was proper or that St. Mary's conceded liability for repayment of these claims. Even to the extent St. Mary's did not challenge certain findings at the Administrative Conference, this does not mean that the Audit Section has established that there was an error or that the error should result in recoupment.

72. The written arguments submitted to the Hearing Officer by St. Mary's expressly reserved St. Mary's right to challenge findings at a later stage in the proceeding. (Pet. Ex. 40, Bates p. 000131). St. Mary's Petition for Contested Case Hearing challenged the findings of the Reconsideration Decisions issued in this case. Nothing in the Petitions for

Contested Case Hearings indicate that St. Mary's was challenging only part of the reconsideration review decisions. The parties entered into no stipulations prior to or during the course of the hearing regarding any conceded claims.

73. The Agency did not provide sufficient evidence to determine that St. Mary's conceded any claims in these audits. To the extent that the Audit Unit attempted to provide such evidence through the introduction of Respondent's Illustrative Exhibit 24, this document contained numerous errors, making it unreliable.

The Audit Unit's Extrapolation of the Post-Payment Review Findings

74. As part of the post-payment review process, the Audit Unit extrapolated the results of the St. Mary's audits. Extrapolation is a process by which the results of a review of a statistical sample of claims are used to estimate the repayment owed by a provider for the entire claims universe billed by the provider during the time period under review.

Audit Unit's Purported Authority to Use Extrapolation

75. Audit Unit Chief Flowers testified that the Audit Unit conducted the St. Mary's audits under the authority of 10A NCAC 22I. (Tr. Vol. 1, p. 104). 10A NCAC 22I is entitled "*Title XIX Reimbursement and Administrative Review Process.*" 10A NCAC 22I does not contain any provision that provides the Audit Unit with authority to extrapolate the results of an audit. (*Id*.)

76. The Audit Unit contends that its authority to extrapolate the results of the St. Mary's post-payment reviews is expressly derived from 10A NCAC 22F .0606, entitled "*Technique for Projecting Medicaid Repayments Through Use of Extrapolation*." (Tr. Vol. 1, pp. 106-108).

77. 10A NCAC 22F, entitled "*Program Integrity*," is a section of the North Carolina Administrative Code that applies to the DMA Program Integrity Section, and DMA Program Integrity is not the Audit Section. (Tr. Vol. 1, pp. 244-245).

78. 10A NCAC 22F .0606 is the only portion of 10A NCAC 22F that was used by the Audit Section during its post-payment review of St. Mary's. (Tr. Vol. 1, pp. 106, 108, and 110). The Audit Section did not follow any of the other requirements for post-payment reviews set forth in 10A NCAC 22F. (*Id*.).

79. 10A NCAC 22F .0606(d) states that when extrapolation is used, the provider may challenge the validity of the findings in the sample in accordance with the provisions found at 10A NCAC 22F .0402. (Tr. Vol. 1, p. 108).

80. The reconsideration of the Audit Unit's decision did not proceed under 10A NCAC 22F .0402, as required in 10A NCAC .0606(d). (Tr. Vol. 1, pp. 105, 108-109). Instead, St. Mary's was provided the opportunity to appeal the Audit Unit's decision under 10A NCAC 22J.

81. The reconsideration process found in 10A NCAC 22F .0402 differs significantly from the appeal rights found in 10A NCAC 22J.

82. 10A NCAC 22F .0402, entitled "*Reconsideration Review for Program Abuse*" sets forth the reconsideration process referenced in the 10A NCAC 22F .0606(d). 10A NCAC 22F .0402(d) states:

> The purpose of the Reconsideration Review includes:
>
> (1) Clarification, formulation, and simplification of issues;
> (2) Exchange and full disclosure of information and materials;
> (3) Review of the investigative findings;
> (4) Resolution of matters in controversy;
> (5) Consideration of mitigating and extenuating circumstances;
> (6) Reconsideration of the administrative measures to be imposed;
> (7) Reconsideration of the restitution of overpayments.

83. Under 10A NCAC 22F .0402, the hearing officer must consider not only whether the post-payment finding was correct but also must determine that the administrative measures imposed were appropriate. 10A NCAC 22J contains no such provision, and the St. Mary's reconsideration review process did not involve any consideration of the administrative measures that should be imposed on St. Mary's, as required by 10A NCAC 22F .0401(d). (Tr. Vol. 1, p. 102).

84. The use of 10A NCAC 22F .0606 also is problematic because this regulation purports to provide appeal rights for "provider abuse." The Audit Unit did not use 10A NCAC 22F .0301, which defines "provider abuse" in determining whether overpayments were appropriate in the St. Mary's review, and it did not consider its findings to relate to "provider abuse." (Tr. Vol. 1, pp. 99, 108-109).

85. The Audit Unit also did not consider any administrative remedy other than recoupment when it conducted the St. Mary's post-payment review, which is required under 10A NCAC 22F. (Tr. Vol. 1, pp. 99-100 and 250-252). Under 10A NCAC 22F .0302, when the Agency finds provider abuse, it is directed to consider administrative remedies that include not only recoupment, but also remedial measures, warning letters, and provider probation.

86. The Agency used the authority found in 10A NCAC 22F to extrapolate but failed to follow the other procedural and substantive requirements of 10A NCAC 22F, which are mandated by the rule when extrapolation is used.

Agency Use of the Pollock Extrapolation Model

87. The Audit Unit sought the services of Kenneth Pollock, PhD to aid in the design of an extrapolation methodology that could be used by the Agency. (Tr. Vol. 1, p. 67). Dr. Pollock is a professor of statistics and zoology in the Department of Zoology at North

Carolina State University in Raleigh, North Carolina. (Tr. Vol. 1, p. 68; Res. Ex. 3). The Agency relied on Dr. Pollock to design the extrapolation model, provide it with statistical information, and determine an acceptable relative standard error. (Tr. Vol. 1, pp. 144-145).

88. Dr. Pollock designed a two-stage extrapolation model for the Audit Section. The Pollock Model uses stratified disproportionate random sampling to select the claims that would be reviewed by the Audit Section. (Res. Ex. 3).

89. The first stage of the Pollock Model requires the Agency to create five strata, each containing twelve randomly-selected Medicaid recipients. Under the second stage of the Pollock Model, the Audit Section selects a random sample of five "claims" from each of the randomly-selected recipients selected for the review. (Tr. Vol. 1, pp. 75, 79-80; Res. Exs. 3 and 4).

90. Neither of the two statistical experts--Dr. Kvanli and Dr. Witmer--who testified in this case ever have seen an extrapolation model similar to the Pollock Model used in a Medicaid or Medicare audit. (Tr. Vol. 5, p. 940; Tr. Vol. 8, p. 1544).

91. Both experts opined that the Pollock Model was a mathematically valid methodology. (Tr. Vol. 5, p. 892; Tr. Vol. 8, p. 1545). Mathematically valid formulas, however, are subject to errors if the required procedures are not followed and the inputs are flawed. (Tr. Vol. 8, p. 1545). Flawed inputs or failure to follow underlying assumptions of a statistically valid mythology will result in invalid and unreliable results. (Vol. 8, p. 1595-1598).

92. The Pollock Model suggests that auditors should consider both overpayments and underpayments. (Res. Ex. 3, p. 5). Under the post-payment review process put in place by the Audit Unit, the Agency did not attempt to identify any underpayments in its findings. (Tr. Vol. 1, p. 139, p. 141; Tr. Vol. 5, p. 991). Identifying underpayments would have the effect of reducing the extrapolation amount determined by the Agency. (Tr. Vol. 5, p. 991).

93. Although Audit Chief Flowers testified that a probe sample was used in the review of St. Mary's cases, the Audit Section's expert witness, Dr. Kvanli, stated in his opinion that a probe sample was not used by the agency. (Tr. Vol. 1, p. 83; Tr. Vol. 5, p.942).

Audit Section's Use of "Claims" and Its Effect on the Required Independence for Extrapolation Audit

94. The Audit Unit's extrapolation purports to select a random sample of paid "claims" submitted by St. Mary's during the relevant audit periods.

95. The Audit Unit determined that a "claim" would consist of consecutive paid dates of services submitted for payment by St. Mary's for a given payment cycle. (Tr. Vol. 1, p. 80). Typically the "claims" selected by the Audit Section contained either five

consecutive dates of service or ten consecutive dates of service. (Tr. Vol. 1, p. 80; Tr. Vol. 8, p. 1552).

96. The Pollock Model does not define what constitutes a claim, and the Audit Section had no knowledge of how claims were adjudicated when it defined claims to be consecutive dates of service. (Tr. Vol. 1, p. 133).

97. As President of SembraCare, Schaefer O'Neill is responsible for submitting requests for payment to Medicaid for over 400 PCS providers in North Carolina. In the last ten years, Mr. O'Neil has requested payment for over 10,000,000 PCS claims in North Carolina. (Tr. Vol. 8, p. 1442).

98. As an expert in electronic submissions and adjudication of Medicaid claims, Mr. O'Neill testified that for the purposes of payment, DMA adjudicates claims based on a request for payment for each individual date of service provided. (Tr. Vol. 8, pp. 1443, 1463, 1470 and 1495). This process commonly is referred to as "claim adjudication." (Tr. Vol. 8, p. 1470).

99. If multiple consecutive claims are submitted for payment by a provider, DMA does not approve or deny payment for these services as a whole. Instead, each date of service is reviewed and analyzed as a stand-alone request for payment. (Tr. Vol. 8, p. 1487). DMA approves or denies each individual date of service separately. (Tr. Vol. 8, p. 1470).

100. Bradford Woodard is employed by DMA as a Senior Data Analyst with the Program Integrity Section. (Tr. Vol. 8, p. 1509). Mr. Woodard's duties include producing random sample of claims to be audited by Program Integrity and creating summary statistical data for audits using extrapolation. (Tr. Vol. 8, p. 1510). Mr. Woodard has worked with DMA on post-payment reviews involving PCS providers. (*Id*.)

101. Mr. Woodard cited 10A NCAC 22F .0606 as the basis for the extrapolation process used in the audits conducted by DMA Program Integrity. (Tr. Vol. 8, pp. 1514 and 1520). DMA Program Integrity defines the term "claim" in 10A NCAC 22F .0606 to mean individual dates of service and not consecutive dates of service. (Tr. Vol. 8, p. 1518; Pet. Exs. 34 and 35). Mr. Woodard testified that he could not recall one example of the Agency selecting consecutive dates of service as a "claim" in a PCS audit. (Tr. Vol. 8, p. 1530).

102. At the time the decision was made by the Audit Unit to define a "claim" to be consecutive dates of service, the Agency was not aware that PCS claims are adjudicated by DMA by each individual date of service. (Tr. Vol. 1, p. 133). Audit Chief Flowers subsequently has learned that DMA approves or denies payment to PCS providers for each individual date of service submitted for payment. (Tr. Vol. 1, p. 132).

103. Dr. Kvanli, DMA's statistical expert, initially had concerns that the Audit Unit had not reviewed claims in the St. Mary's audit. (Tr. Vol. 5, pp. 987-988). To confirm that the Agency properly had considered what constitutes a "claim," Dr. Kvanli spoke with Audit

Chief Flowers about this issue. (*Id.*) Dr. Kvanli relied solely on the statements of Audit Chief Flowers in determining that the Audit Unit had properly defined a "claim" in the St. Mary's post-payment reviews. (*Id.*).

104. Dr. Jeffery Witmer, St. Mary's statistical expert, testified that based on his experience, claims selected by a Medicaid or Medicare audit would not be consecutive dates of service. (Tr. Vol. 8, p. 1553). Dr. Witmer cited DMA Program Integrity as an example of how auditors typically select random, nonconsecutive, independent claims. (Tr. Vol. 8, p. 1555).

105. No one at the Audit Section discussed with DMA Program Integrity how it defined a claim when it conducts post-payment reviews of PCS providers. (Tr. Vol. 1, p. 133). Audit Chief Flowers agreed that it is important that if the Program Integrity Section and the Audit Unit are doing similar audits, they should apply the rules in similar ways. (Tr. Vol. 1, p. 210).

106. The Audit Section's definition of "claim" demonstrated an erroneous understanding of how PCS claims are defined and adjudicated in North Carolina. A PCS claim in North Carolina is billed and adjudicated as one single date of service and not multiple sequential dates of service.

107. Dr. Jeffery Witmer, St. Mary's statistical expert, testified that a critical underlying assumption in the Pollock Model is independence of observations. (Tr. Vol. 8, pp. 1545, 1549-1552, 1556, and 1630-1631). Independence is achieved when each particular determination made for each date of service does not affect the other dates of service reviewed. (Tr. Vol. 8, pp. 1549-1551).

108. The use of consecutive dates of service eliminates independence in the Audit Section's extrapolation process. Defining a claim to be consecutive dates of service makes the individual dates of service dependent inputs. An input is dependent when a single audit decision can affect multiple dates of service contained in the "claim." The Audit Section's decision to define a "claim" to be consecutive dates of service resulted in the dependence of the inputs used by the Agency. (Tr. Vol. 8, pp. 1549-1552, 1556, and 1630-1631).

109. Because the Audit Section's extrapolation included dependent observations among consecutive dates of service, the results of the extrapolation are untrustworthy and not valid. (Tr. Vol. 8, p. 1556). Having dependence among consecutive dates of service completely invalidates the use of the extrapolation methodology designed by Dr. Pollock. (Tr. Vol. 8, p. 1567).

Audit Section's Use of 20% Relative Standard Error

110. The Pollock Model allows for a Relative Standard Error of twenty percent (20%). (Tr. Vol. 1, p. 143; Res. Ex., 3, p. 2). Relative Standard Error is commonly referred to as "Precision". (Tr. Vol. 5, p. 859). Precision is a measurement of uncertainty in a

statistical estimate. (Tr. Vol. 5, p. 859; Tr. Vol. 8, p. 1556). In statistical terms, the higher the precision, the less certain one can be about the results of the extrapolation. Conversely, a lower precision number results in more accurate and reliable results. (Tr. Vol. 8, pp. 1556-1558).

111. Dr. Kvanli testified that in his opinion, the twenty percent (20%) precision threshold set forth in the Pollock Model was acceptable and that precision in the St. Mary's findings was around twelve percent (12%), which he believed was good. (Tr. Vol. 5, p. 872). Dr. Kvanli provided no testimony for why he believed the precision in the St. Mary's audit was good and provided no basis for comparing the precision found in the St. Mary's audit against the precision sought in similar Medicare and Medicaid audits.

112. Dr. Witmer testified that in his experience, he cannot recall ever seeing a target precision close to twenty percent (20%). (Tr. Vol. 8, p. 1558). Typically, in Medicare and Medicaid extrapolation audits, an agency would have a precision goal of no more than five percent (5%). (*Id*.) When the federal government conducts extrapolation audits, its precision goal is between 2.5% and 3.0%. (*Id*.). When DMA Program Integrity uses extrapolation, it has a precision goal of 5%. (Tr. Vol. 8, p. 1522-1533; Pet. Exs. 34 and 37).

113. The Agency did not discuss whether Dr. Pollock's precision goal was comparable to other Medicare or Medicaid audits and is not aware whether Dr. Pollock had any knowledge or did any research about the precision goals that are typically sought in such audits. (Tr. Vol. 1, pp. 142-143).

114. The precision found in the St. Mary's audits exceeds the precision goals used by both the federal government and the DMA Program Integrity Section and is too high to ensure fair and accurate results.

115. The Pollock Model's precision goal of twenty percent (20%) also directly affects the sample size used in the audit. To achieve better precision, larger sample sizes should be selected. (Tr. Vol. 8, p. 1559).

116. A probe audit assists statisticians in determining the size of the sample selected. By conducting an independent probe sample, a statistician could determine how large the sample size should be to achieve good precision. (Tr. Vol. 8, pp. 1544-1545, 1556-1559, 1567, 1637).

117. The sample size selected by the Pollock Model is always made up of five (5) strata consisting of twelve (12) recipients in each strata. (Tr. Vol. 5, pp. 946-947). By having a poor precision goal, Dr. Pollock's model allows for the pre-determined sample size. Because the precision goals in the St. Mary's audits were not in line with the precision goals sought in other governmental audits, this is indicative that the sample size reviewed should have been larger. (Tr. Vol. 8, pp. 1544-1545, 1567, 1637).

118. The Pollock Model allows for a much higher relative standard error (lower precision) than what is typically sought in Medicaid and Medicare audits, including those audits conducted by North Carolina's DMA Program Integrity Section. The precision allowed and achieved in the St. Mary's audit resulted in an arbitrary selection of sample size that was not based on solid statistical practices. (Tr. Vol. 8, pp. 1546-1547).

Audit Section's Failure to Consider Non-Sampling Error

119. In creating this extrapolation model with Dr. Pollock, the Audit Unit did not discuss the possible effects that non-sampling error might have on the extrapolation results. (Tr. Vol. 1, p. 83).

120. Sampling errors are errors that would occur based on the selection of the sample. Non-sampling errors are errors outside the selection of the sample that may affect the results of an extrapolation. (Tr. Vol. 8, p. 1546). An example of non-sampling error could be different auditors having different opinions about what should result in a recoupment or what constitutes a violation of policy.

121. Statisticians should be concerned with both sampling and non-sampling error. (Tr. Vol. 8, pp. 1563-1565). Statisticians worry about non-sampling error because it can have significant implications on the outcome of the extrapolation. (Tr. Vol. 8, pp. 1564-1565).

122. Dr. Kvanli testified that he was not asked to review or comment on possible non-sampling error in the St. Mary's audit and that non-sampling error is not something he would review as a statistician. (Tr. Vol. 5, pp. 966-968).

123. Dr. Witmer strongly disagreed with Dr. Kvanli and opined that all statisticians should be concerned with non-sampling error. (Tr. Vol. 8, p. 1565). Without consideration or review of possible non-sampling error, you cannot know if the results of an extrapolation are reliable.

124. The DMA Program Integrity Section devotes significant time in considering the possibility that an extrapolation it conducted was affected by non-sampling error. (Tr. Vol. 8, p. 1522 and 1566; Pet. Exs. 34 and 37).

125. Without a review of non-sampling error by the Audit Section, the audit results in the St. Mary's case are not reliable.

126. Based on the Findings of Fact 74 through 125 cited above, the Audit Section's extrapolation was not statistically reliable or valid.

To the extent that certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein as Conclusions of Law. Based upon the foregoing Findings of Fact, the undersigned makes the following:

CONCLUSIONS OF LAW

1. All parties properly are before the Office of Administrative Hearings, and this tribunal has jurisdiction of the parties and subject matter.

2. An ALJ need not make findings as to every fact which arises from the evidence and need only find those facts which are material to the settlement of the dispute. *Flanders v. Gabriel*, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612 (1993).

The Audit Unit's Findings

3. N.C. Gen. Stat. § 108C-12(d) provides that Respondent "shall have the burden of proof in appeals of Medicaid providers or applicants concerning an adverse determination." The actions taken by the Audit Unit meet the definition of an adverse determination. *See* N.C. Gen. Stat. § 108C-2.

4. For a vast majority of the claims that were audited in this case, the Agency failed to identify or introduce: (1) the claims reviewed during the audit; (2) the findings for the claims reviewed; (3) any documentation to support the findings; (4) the amount of the recoupment sought by the Agency; and (5) any basis for concluding that the documentation reviewed evidenced violations of law, regulation, or policy.

5. For the limited number of specific claims that were presented by the Agency as Respondent Exhibits 12A – 12E, the Agency failed to provide sufficient evidence to support its purported findings.

6. The Agency's misunderstanding of the policy and use of unpublished "best practices" as a justification for its decision is erroneous, in violation of rule and law, exceeds the Agency's authority, and is arbitrary and capricious.

7. A provider has no obligation to follow "best practices" when documenting services provided to Medicaid recipients, unless such "best practices" have been adopted as policy. The Agency cannot hold a provider accountable for announcements that were not in publication and available to the provider during the time period of the review.

8. The Medicaid Provider Agreement entered into between St. Mary's and DMA creates no obligation for St. Mary's to follow documentation "best practices." Under the Provider Agreement, St. Mary's has an obligation to follow applicable laws, rules, and policies.

9. The Agency failed to meet its burden of proving that St. Mary's violated clinical coverage policy when it made changes or corrections to PACT form plans of care.

10. The Agency failed to meet its burden of proving that recoupment is appropriate for services provided under a physician's order that is entered 60 days after the PACT form is completed.

11. The Agency failed to meet its burden of proving that St. Mary's violated any law, statute, or policy by allowing RN Jones to use a stamp signature.

12. The Agency failed to meet its burden of proving that St. Mary's conceded and waived its right to appeal the Audit Section's findings during the reconsideration hearing.

13. The Agency failed to provide any evidence or any reliable evidence of: (1) the claims that may have been conceded by St. Mary's during the reconsideration review process; (2) the basis of the finding of these conceded claims; (3) the documentation supporting the finding for these conceded claims; (4) the amount of the recoupment sought; and (5) the basis that the documentation reviewed evidenced any violation of law, regulation, or policy for the claims.

14. Respondent failed to meet its burden of proving that St. Mary's failed to follow any applicable laws, rules, or policies or that any recoupment of funds from St. Mary's is appropriate.

15. The Agency substantially prejudiced Petitioner's rights by recouping, and attempting to recoup, funds from St. Mary's based on the results and reconsideration of the five post-payment reviews at issue.

The Agency's Use of Extrapolation

16. 10A NCAC 22I does not grant the Agency the authority to use extrapolation. Instead, the use of extrapolation only is authorized when the Agency operates under the authority of 10A NCAC 22F.

17. The appeal rights afforded to providers under 10A NCAC 22F .0402 are more expansive than the appeal rights afforded to St. Mary's under 10A NCAC 22J.

18. Specifically, under 10A NCAC 22F .0402, the hearing officer must consider the propriety not only of the finding, but it also must consider the appropriate administrative remedy for the finding in question.

19. The Audit Unit does not have authority to conduct audits under 10A NCAC 22I while at the same time using 10A NCAC 22F .0606 to justify its use of extrapolation without applying the protections and procedures set forth in 10A NCAC 22F. In order to use extrapolation under the authority of 10A NCAC 22F .0606, the Agency must apply the other provisions of 10A NCAC 22F, which it failed to do.

20. The Agency's use of 10A NCAC 22F .0606 to support its authority to conduct an extrapolation audit was erroneous, in violation of rule and law, and in excess of its authority.

21. Even if the use of extrapolation had been authorized in these cases, the application of the Pollock Extrapolation Model was not statistically sound.

22. 10A NCAC .0606(c), the only regulation that allows extrapolation in the Administrative Code, allows for extrapolation after a review of a statistical sampling of "claims."

23. The Agency's use of consecutive dates of service to represent a "claim" is erroneous and contrary to the manner in which DMA interprets a claim under the PCS program.

24. The Agency's use of consecutive dates of service to represent a "claim" also is erroneous because it has the effect of invalidating the independence required for a valid and trustworthy extrapolation result.

25. The Agency's use of extrapolation was erroneous because it allowed for a Relative Standard Error or Precision that far exceeded the typical precision goals sought by other Medicare and Medicaid agencies, including North Carolina's DMA Program Integrity Section.

26. The Audit Unit erred by not considering the effects of non-sampling error on its audit results. Non-sampling error is a critical consideration when using extrapolation and is considered in other audits conducted by Medicare and Medicaid agencies, including the DMA Program Integrity Section.

27. The Audit Unit's application of the Pollock Model was not statistically valid.

Extrapolation and N.C. Gen. Stat. § 108C-5

28. N.C. Gen. Stat. § 108C-5 contains certain requirements that the Agency must follow in order to use extrapolation in an audit. N.C. Gen. Stat. § 108C-5 became effective on July 25, 2011 and applied to "audits instituted on or after that date and to final overpayments, assessments, or fines due on or after that date." (*See* S.L. 2011-399, emphasis added).

29. N.C. Gen. Stat. § 108C-2(5) defines a final overpayment to be "the amount the provider owes after appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings…"

30. Although 108C-5 was passed by the General Assembly after the initial audits were completed, these decisions were not final overpayments as of July 25, 2011 and were all at some stage of the reconsideration review process at the time that the law was enacted.

31. Where the language of a statute is clear and unambiguous, the courts must give such language its plain and definite meaning. *In re Total Care*, 99 N.C. App. 517, 520, 393 S.E.2d 338, 340 (1990). Additionally, a court must assume the legislature understood its choice of words when drafting a statute. *Housing Auth. of Greensboro v. Farabee*, 284 N.C. 242, 245, 200 S.E.2d 12, 15 (1973); *see also N.C. Dept. of Revenue v. Hudson*, 196 N.C. App. 763, 768, 675 S.E.2d 709, 711 (2009).

32. By extending the protections of N.C. Gen. Stat. § 108C-5 to audits that were conducted prior to the passage of the statute but had not yet become final overpayments, the General Assembly was unambiguously expressing its intent to apply the statute to providers such as St. Mary's. If the General Assembly had not intended to extend the requirements of N.C. Gen. Stat. § 108C-5 to providers for which an audit had been completed but had not yet become a final overpayment, it would not have included such language in Session Law 2011-399.

33. N.C. Gen. Stat. § 108C-5(i) requires the Department to demonstrate and inform the provider that (1) the provider failed to substantially comply with the requirements of State or federal law or regulation or (2) the Department has credible allegation of fraud concerning the provider.

34. The use of extrapolation is erroneous and in contradiction of N.C. Gen. Stat. § 108C-5(i) because the Agency has failed to demonstrate that St. Mary's failed to substantially comply with the requirements of State or federal law or regulation or that the Department has credible allegation of fraud concerning the provider, as required by N.C. Gen. Stat. § 108C-5(i).

35. N.C. Gen. Stat. § 108C-5(j) states that "audits that result in the extrapolation of results must be performed and reviewed by individuals who shall be credentialed by the Department, as applicable, in the matters to be audited, including, but not limited to, coding or specific clinical issues."

36. The Audit Unit erred and acted in violation of law by conducting an extrapolation audit using individuals that were "trained" only through an apprenticeship process but were not credentialed by the Department in the proper use and interpretation of applicable PCS policies and the services rendered.

37. N.C. Gen. Stat. § 108C-5(q) states that except as required by federal agency, law, or regulation, or instances of credible allegation of fraud, the provider shall be subject to audits which result in the extrapolation of results for a time period of up to 36 months from date of payment of a provider's claim.

38. The Audit Unit erred and acted in violation of law by subjecting St. Mary's to extrapolation audits for time periods that far exceed the 36 month time limitation set forth in N.C. Gen. Stat. § 108C-5(q).

39. For all of the above reasons, the use of extrapolation by the Agency was erroneous, in violation of rule or law, and exceeded the Audit Unit's authority.

40. Petitioner substantially was prejudiced by the Agency's use of extrapolation.

41. N.C. Gen. Stat. §108C-12 requires this tribunal to issue a final agency decision within 180 days of the date of filing of the contested case petition. The time to make a final decision shall be extended in the events delays caused or requested by the Department.

42. Because the Department requested several continuances in these cases and requested these cases be consolidated, requiring a lengthy delay due to the extended time it took the Department Hearing Office to issue its final administrative conference decision, the time for making the final agency decision was extended both as a result of and at the request of the Agency.

43. Under N.C. Gen. Stat. § 108C-12 this final decision is timely.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, Respondent Agency's decision to recoup any funds from St. Mary's is not supported by a preponderance of the evidence and is REVERSED. Any funds recouped by the Respondent Department as a result of the audits that are the subject of these consolidated contested cases shall be returned to Petitioner within thirty (30) days of the issuance of this Final Agency Decision.

NOTICE (11DHR10487)

The Agency that will make the final decision in this contested case is the North Carolina Department of Health and Human Services.

The Agency is required to give each party an opportunity to file exceptions to the decision and to present written arguments to those in the Agency who will make the final decision. N.C. Gen. Stat. § 150-36(a). The Agency is required by N.C. Gen. Stat. § 150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties' attorneys of record and to the Office of Administrative Hearings.

In accordance with N.C. Gen. Stat. § 150B-36 the Agency shall adopt each finding of fact contained in the Administrative Law Judge's decision unless the finding is clearly contrary to the preponderance of the admissible evidence. For each finding of fact not adopted by the agency, the agency shall set forth separately and in detail the reasons for not adopting the finding of fact and the evidence in the record relied upon by the agency in not adopting the finding of fact. For each new finding of fact made by the agency that is not contained in the Administrative Law Judge's decision, the agency shall set forth separately and in detail the evidence in the record relied upon by the agency in making the finding of fact.

NOTICE (12DHR12145)

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statute § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **The appealing party must file the petition within 30 days after being served with a written copy of the Administrative Law**

Judge's Final Decision. In conformity with the Office of Administrative Hearings' rule, 26 N.C. Admin. Code 03.0102, and the Rules of Civil Procedure, N.C. General Statute 1A-1, Article 2, **this Final Decision was served on the parties the date it was placed in the mail as indicated by the date on the Certificate of Service attached to this Final Decision**. N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under N.C. Gen. Stat. § 150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

This the 8th day of January, 2014.

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Beecher R. Gray
Administrative Law Judge