STATE OF NORTH CAROLINA

COUNTY OF MECKLENBURG

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
11 DHR 11579
11 DHR 11580

M. YAGHI, DDS, P.A.,	)	
	)	
Petitioner,	)	**FINAL**
	)	**DECISION**
v.	)	
	)	
N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES,	)	
	)	
	)	
Respondent.	)	

These contested cases were heard before the undersigned Administrative Law Judge on March 3, 2014 and May 8, 2014 in Charlotte, North Carolina.

APPEARANCES

For Petitioner: Ian Byrne, Esq.
Caudle & Spears, P.A.
Charlotte, North Carolina

For Respondent: Rajeev K. Premakumar
Assistant Attorney General
North Carolina Department of Justice
Raleigh, North Carolina

ISSUE

The issue in these contested cases is whether the Department of Health and Human Services (the "Department") correctly determined that Petitioner had received overpayments based upon two audits conducted by Respondent of Petitioner's paid claim records and extrapolations of those respective audit findings. In the first audit, the Department determined that the overpayment amount was $70,615.71; in the second audit, the Department determined that the overpayment amount was $963,909.00.

EVIDENCE

For Petitioner: Exhibits 1-3 were admitted.

For Respondent: 11 DHR 11579 (PI: 2010-2622)

Exhibits 1-10 and 12-23 were admitted.
Official Notice was taken of Exhibit 11.

11 DHR 11580 (PI: 2010-2623)
Exhibits 1-9 and 12-22 were admitted.
Official Notice was taken of Exhibit 10.

WITNESSES

For Petitioner: Dr. Mohammed Yaghi, DDS

For Respondent: Paula Blake, RDH, Dental Investigator, DHHS-DMA
Dr. Mark Casey, DDS, MPH, Dental Director, DHHS-DMA
Bradford Woodard, MS, Senior Health Data Analyst, DHHS-DMA

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing 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 the witness, any interests, bias, or prejudice the witness may have, the opportunity of the witnesses 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 believable evidence in this case. After considering the testimony of witnesses, exhibits admitted into evidence, and the parties' arguments, the Undersigned makes the following:

FINDINGS OF FACT

1. The Division of Medical Assistance ("DMA"), a division of the Respondent, is responsible for administering and managing North Carolina's Medicaid plan and program. Pursuant to N.C. Gen. Stat. § 108A-54, DMA is authorized to adopt rules, regulations, and policies for program operation.

2. Dr. Mohammad M. Yaghi is a Doctor of Dental Surgery and the president of Petitioner M. Yaghi, DDS, P.A., a dental practice with current and/or former locations in both Charlotte and Belmont, North Carolina. Tr. 2, 302-08. Some of Petitioner's patients receive health insurance coverage under the federal Medicaid program.

3. At all times material to this matter, Petitioner was an enrolled dental provider in the North Carolina Medicaid Program and entered into an Electronic Claims Submission ("ECS") Agreement with DMA as part of its enrollment. (R. Ex. 1, 2010-2622)

4. By entering into the ECS Agreement, Petitioner agreed to

> abide by all Federal and State statutes, rules, regulations and policies (including, but not limited to: the Medicaid State Plan, Medicaid Manuals, and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent) of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the provider and DMA. (R. Ex. 1, 2010-2622)

5. Pursuant to federal and state law, Respondent is empowered to audit healthcare providers such as Petitioner to identify any potential abuses of the Medicaid system.

6. Paula Blake, Dental Investigator for the Program Integrity Section of DMA, testified for the Respondent. As part of her duties, Ms. Blake conducts post-payment reviews of dental claims to ensure compliance with the Medicaid Program. Ms. Blake is a registered hygienist.

7. Post-payment reviews involve both data queries that detect billing patterns and trends amongst providers as well as individual claims reviews by dental investigators.

8. When a provider seeks reimbursement from the Medicaid system, the provider will submit a claim using a billing code that is specific to the services rendered.

9. In reviewing claims for Petitioner, Ms. Blake noticed an anomaly for dental billing code D7971, excision of pericoronal gingiva.

10. On finding this anomaly, Ms. Blake ran a data query across all dental providers for a five-year date span to see the utilization rate for the D7971 code.

11. The data query revealed that the Petitioner's use of the D7971 code was approximately ten times greater than the next highest rate in the State. Petitioner's two practices accounted for two of the three highest uses of the code in the State of North Carolina. Tr. vol. 1, 20.

12. The other practice using the D7971 code at an unusually high rate is Harold and Associates located in Rocky Mount, which recorded the second-highest use of the D7971 code. That practice has not been investigated by Respondent as of the date of this hearing. Tr. vol. 1, 93; Tr. vol. 2, 194-95.

13. According to Ms. Blake, the discovery of Petitioner's exceedingly high use rate of that code warranted further investigation and audits of the Petitioner.

14. Petitioner initially came to Respondent's attention because of the unusually high utilization rate of the D7971 Medicaid billing code. Tr. vol. 1, 19, March 3, 2014. Respondent thereafter issued two records requests to Petitioner: one for the Charlotte

office and one for the Belmont office. R. Ex. 1 (PI 2010-2622); R. Ex. 1 (PI 2010-2623).

15. The two separate Records Request Letters to the Petitioner were dated June 4, 2010. There were two separate records request letters sent to Petitioner's one address because he was providing services in two separate locations and under two separate provider numbers. The files are distinguishable by their file numbers: PI Case #2010-2622 and PI Case #2010-2623. Respondent's exhibits are labeled to correspond to those numbers. (R. Ex. 2, 2010-2622; R. Ex. 1, 2010-2623)

16. The records request notes that federal regulations and the provider agreements require the provider to maintain the proper records for review for a period of five years. They also note that the North Carolina Administrative Code requires dental providers to maintain those records for review for a period of ten years.

17. On receiving the records, Ms. Blake examined each record to look for documentation that substantiated the payment for the services that were billed.

18. Ms. Blake's review of the records found that the claims billed did not meet the policy criteria. Specifically, the records provided "lacked documentation to support that the services billed were in accordance with policy. Refer to DMA Clinical Coverage Policy No.: 4A Dental Services dated January 1, 2005 – November 1, 2009, Section 5." (R. Ex. 3, 2010-2622; R. Ex. 2, 2010-2623)

19. Bradford Woodard, Senior Health Data Analyst at DMA, and an expert in the field of statistics, testified for the Respondent.

20. Mr. Woodard performed a "Disproportionate Stratified Random Sampling Technique," a statistical extrapolation, to determine the overpayment amount for the entire universe of 448 claims in PI 2010-2622. The extrapolated overpayment amount was $70,615.71 with a precision level within 1%. (R. Ex. 16, 2010-2622)

21. Mr. Woodard performed a statistical extrapolation to determine the overpayment amount for the entire universe of 6,075claims in PI 2010-2623. The extrapolated overpayment amount was $963,909.00 with a precision level within 1%. (R.s Ex. 15, 2010-2623)

22. The highest level of precision that can be obtained in statistical extrapolation is to be within 1%.

23. On March 31, 2011, DMA sent a Tentative Notice of Overpayment ("TNO") to Petitioner for each audit for his two offices. The first notice in case PI 2010-2622, related to claims paid by Medicaid for services performed by Petitioner between February 22, 2005 and May 6, 2010 in Petitioner's Charlotte office. R. Ex. 3 (2622). The second notice in case PI 2010-2623, related to claims paid by Medicaid for

services performed by Petitioner between May 3, 2006 and May 3, 2010 in Petitioner's Belmont office. Ex. 2 (2623).

24. The TNOs reflected the amounts determined in Mr. Woodard's extrapolations, for audit 2010-2622 in the amount of $70,615.71 and for audit 2010-2623 in the amount of $963,909.00. (R. Ex. 3, 2010-2622; R. Ex. 2, 2010-2623)

25. Both notices asserted the same alleged billing anomaly: "Inappropriate billing of D7971 - Excision of pericoronal gingiva[.]" Ex. 3 (2622); Ex. 2 (2623). In simple terms, this is an oral surgery that removes gum tissue surrounding the crown of a tooth. Tr. vol. 2, 157.

26. The 2622 notice states: "81 of 86 records provided by your agency lacked documentation to support that the services billed were in accordance with policy . . . 5 out of 86 records provided by your agency lacked documentation to support the claims billed[.]" Ex. 3 (2622).

27. Based on Mr. Woodard's analysis, the 100% error rate observed in the sample, all 448 paid claims were deemed erroneous and Respondent demanded reimbursement of the Medicaid overpayments in the amount of $ 70,615.71. Ex. 3 (2622); R. Ex. 3, 16, 17, & 18 (2622).

28. The 2623 notice states: "77 of 81 records provided by your agency lacked documentation to support that the services billed were in accordance with policy . . . 4 of 81 records provided by your agency lacked documentation to support the claims billed[.]" Ex. 2 (2623).

29. Based on Mr. Woodard's analysis, the 100% error rate observed in the sample, all 6,075 paid claims were deemed erroneous and Respondent demanded reimbursement of the Medicaid overpayments in the amount of $ 963,909.00. Ex. 2 (2623); R. Ex. 2, 15, 16, & 17 (2623).

30. Petitioner requested a Reconsideration Review before the Department Hearing Office. After the Reconsideration Review held on August 16, 2011, the Hearing Officer issued a Notice of Decision upholding both recoupment decisions made by DMA. (R. Ex. 4-5, 2010-2622; R. Ex. 3-4, 2010-2623)

31. The definitions, qualifications, and required processes for Medicaid-covered dental services are found in Clinical Coverage Policy 4A. The section of Policy 4A that applies to procedure code D7971 is Other Repair Procedures. (R. Ex. 7-8, 2010-2622; R. Ex. 6-7, 2010-2623)

32. For procedure code D7971, the description in Policy 4A reads: "Excision of pericoronal gingiva"

    * use for operculectomy
    * not allowed on the same date of service as an extraction for the same tooth
    * not allowed for crown lengthening or gingivectomy
    * requires a tooth number in the tooth number field

    (R. Ex. 7-8, 2010-2622; R. Ex. 6-7, 2010-2623)

33. Thus as stated in Policy 4A, the D7971 procedure code is appropriately used when removing an operculum and is expressly precluded for use for a gingivectomy.

34. An "operculum" refers to the flap of tissue over an unerupted or partially erupted tooth. An "operculectomy" refers to the removal of the operculum. (R. Ex. 10, 2010-2622; R. Ex. 9, 2010-2623)

35. In response to Respondent's record requests, Petitioner generally submitted for each patient an intake form, medical history, a photocopy of the radiographs, and the patient's progress notes. Tr. vol. 1, 106; Tr. vol. 2, 162, 199. In most of the records the attending dentist noted "excision of pericoronal gingiva" or the abbreviation "EPG".

36. Based upon her review of the records, Ms. Blake found that there was no documentation submitted that justified or supported the removal of an operculum for any of the claims reviewed. (R. Ex. 6, 2010-2622; R. Ex. 5, 2010-2623)

37. Ms. Blake acknowledged that she was looking for an operculectomy. Tr. vol. 1, 97. She also acknowledged that the D7971 code did not state that is was to be used only for operculectomy. Tr. vol. 1, 97.

38. Ms. Blake was looking especially for evidence of partially erupted or unerupted teeth in evaluating Petitioner's use of the D7971 billing code. *See, e.g.*, Tr. vol. 1, 115.

39. In determining whether the teeth in question were partially erupted or unerupted, Ms. Blake examined the radiographs (x-rays) that Petitioner had provided in response to the records request, as well as the physician's notes. Tr. vol. 1, 23.

40. Ms. Blake noted that in her review of Petitioner's records that there was no mention of any kind of inflamed tissues, and that there was no record of what method was used to remove that tissue. Tr. vol. 1, 23.

41. In her examination of Petitioner's records, Ms. Blake did not find references to partially erupted teeth or unerupted teeth which would support the D7971 billing code. There generally were references to "EPG" with no further explanation. Tr. vol. 1, 23-24.

42. Dr. Mark Casey is the Dental Director for DMA and an expert in the field of dentistry. Dr. Casey became involved in this review when he was asked by Ms. Blake to examine certain records submitted by Petitioner to provide a clinical opinion. Tr. vol. 2, 200.

43. Dr. Casey, as with Ms. Blake, did not perform any clinical examinations of the patients nor interview them regarding their treatment. Dr. Casey's opinion was based solely on his review of the records provided by Petitioner. Tr. vol. 2, 200, 201; Tr. vol. 1, 91.

44. In reviewing the records, in Dr. Casey's opinion, whether or not the tooth was erupted was important. Dr. Casey also expressed that he expected to see a diagnosis and/or how the procedure was performed. Tr. vol. 2, 168.

45. The records reviewed did not contain a diagnosis or any information on how the procedure was performed.

46. The records reviewed did not contain any information to demonstrate that the teeth in question were either partially erupted or unerupted as would be required to justify a billing under coed D7971.

47. As did Ms. Blake, Dr. Casey observed that in almost every instance the radiographs that he reviewed were not of diagnostic quality. Soft tissue was typically not visible on the images. There were images where it was relatively clear that the tooth or teeth were fully erupted. Tr. vol. 2, 238-39; Tr. vol. 1, 115.

48. It is unusual for an operculum to cover the crown or chewing surface of posterior teeth or anterior teeth.

49. In Dr. Casey's expert opinion, it is inappropriate to use procedure code D7971 on teeth that are fully erupted. A fully erupted tooth is one that has its crown fully exposed above the soft tissue or gum line.

50. In situations where a fully erupted tooth requires soft tissue removal, the appropriate service would be a gingivectomy, which is a Medicaid dental service that requires prior approval. A gingivectomy usually is removal of a portion of the gum around the crown of a tooth in order to repair a cavity. Once that gum tissue is removed, it is permanently lost. A gingivectomy is specifically excluded from billing code D7971.

51. The teeth numbers most commonly affected by operculums are the upper third molars, teeth numbers 1 and 16; the lower left third molar, tooth number 17; the lower left second molar, tooth number 18; the lower right second molar, tooth number 31; and the lower right third molar, tooth number 32. Operculums on any other teeth are exceedingly uncommon.

52. In the records under review, either the teeth in question were not those listed in paragraph 51 above or the teeth repaired were not limited to those listed in #51 and yet were billed under code D7971.

53. It is extraordinarily rare that the maxillary upper central incisors, teeth numbers 8 and 9 would be covered over with an operculum that would require an excision of pericoronal gingiva. Teeth numbers 8 and 9 are the large teeth in the top front of the mouth.

54. Petitioner submitted bills under code D7971 for repair of teeth 8 and 9.

55. Dr. Mohammed Yaghi, Petitioner herein, is an expert in the field of dentistry and testified on his own behalf.

56. Dr. Yaghi was unable to explain why one of his offices utilized the D7971 procedure code at a rate approximately 10 times more than the dental provider with next highest utilization rate of that code. There is no evidence explaining why the area his two offices served would have such an extraordinary high incidence of tooth and gum disease to justify such incredible high use of D7971. Such high numbers would seemingly indicate an epidemic that only his offices were serving.

57. Dr. Yaghi agreed that the D7971 procedure code would only apply if there was soft tissue over partially erupted or impacted teeth.

58. Dr. Yaghi could not recall in his years of practice of dentistry ever seeing an operculum on teeth 8 or 9 as was submitted by his office for payment.

59. Dr. Yaghi testified that he had never seen an operculum that would cover eleven teeth in a row as was submitted by his office for payment.

60. Petitioner's attempted reliance on Remittance and Status Reports received by Petitioner from Respondent is to no avail. Such reports are not part of the review by those involved with post-payment reviews and simply do not apply to post payment review. Neither Ms. Blake nor Dr. Casey would have been part of such reports and would have at the very best very limited or no knowledge of what "pending in-house review" means in the Remittance and Status Reports. Petitioner's Exhibit #2 has no relevance to the post payment review.

61. Similarly, the explanation of benefits charts in Petitioner's Exhibit #3 are not part of the review by those involved with post-payment reviews and simply do not apply to post payment review. Neither Ms. Blake nor Dr. Casey would have been part of such reports and would have at best limited knowledge of their contents. Petitioner's Exhibit #2 has no relevance to the post payment review.

62. Whether or not other billing codes specifically are required by the Medicaid Manual to have more documentation is of no consequence. Most but not all of such other billing codes require prior approval. Tr. vol. 1, 101.

Based upon the foregoing Findings of Fact, this Court makes the following:

CONCLUSIONS OF LAW

1. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law contain Findings of Fact, they should be so considered without regard to the given labels.

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

3. Respondent bears the burden of proof in this contested case hearing pursuant to N.C. Gen. Stat. §108C-12.

4. Pursuant to N.C. Gen. Stat. § 108C-11(a) providers are to cooperate with "site visits, audits, investigations, post-payment reviews, or other program integrity activities" conducted by the Respondent. There is not an issue of the cooperation of Petitioner in this audit and review.

5. The Respondent is to develop and maintain methods and procedures for among other things investigate cases involving overutilization or the use of medically unnecessary or medically inappropriate services. 10A N.C. Admin. Code 22F .0103(a).

6. 10A N.C. Admin. Code 220 .0202, which was in effect at the time of the services in question provided that "[d]entists who provide services under the Medicaid program . . . must provide services in accordance with the rules and regulations of the Medicaid program."

7. The Electronic Claims Submission Agreement executed by Petitioner states: "The Provider shall abide by all Federal and State statutes, rules, regulations and policies of the Medicaid Program, and the conditions set out in any Provider Participation Agreement entered into by and between the Provider and DMA. Ex. 1 (2622).

8. Two DMA publications bear on these proceedings, the Basic Medicaid Billing Guide (2/2005-4/2010), and Clinical Policy No. 4A (1/1/2005-11/1/2009).

9. Section 3-3 of the Basic Medicaid Billing Guide states:

> The following principles of documentation are adopted from Medicare policy:
>
> 1. The medical record must be complete and legible.

2. The documentation of each patient encounter must include the date and reason for the encounter as well as relevant history, physical examination findings, and prior diagnostic test results; assessments; clinical impression or diagnosis; services delivered; plan for care, including drugs and dosage prescribed or administered; and legible signature of the observer.

3. Past and present diagnoses and health risk factors must be identified and accessible to the treating and/or consulting physician.

4. The rationale for diagnostic tests and other ancillary services must be documented or apparent in the medical record.

5. The patient's progress, including response to and chance in treatment, must be documented. Reasons for diagnostic revision must be documented.

6. The documentation must support the intensity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision making.

7. The CPT, HCPCS, and ICD-9-CM codes reported on the health insurance claim form or billing statement must be supported by the documentation in the medical record.

(Emphasis added). R. Ex. 9 (2622).

10. The definitions, qualifications, and required processes for Medicaid-covered dental services are found in Clinical Coverage Policy 4A. The section of Policy 4A that applies to procedure code D7971 is Other Repair Procedures. (Respondent's Ex. 7-8, 2010-2622; Respondent's Ex. 6-7, 2010-2623)

11. Clinical Policy No. 4A was in effect at all times relevant to these proceedings. Section 5.3.10 contains code D7971 which states:

Excision of pericoronal gingiva
* use for operculectomy
* not allowed on the same date of service as an extraction for the same tooth
* not allowed for crown lengthening or gingivectomy
* requires a tooth number in the tooth number field
See Ex. 7, 8 (2622).

12. The Code on Dental Procedures and Nomenclature, published by the American Dental Association, states that excision of pericoronal gingiva under the D7971 billing code is

the "[s]urgical removal of inflammatory or hypertrophied tissues surrounding partially erupted/impacted teeth." The same publication defines operculectomy as the "[r]emoval of the operculum." Operculum, in turn, is the "flap of tissue over an unerupted or partially erupted tooth." See Ex. 10 (2622).

13. The D7971 procedure code is appropriately used when removing an operculum and is expressly precluded for use for a gingivectomy.

14. While Clinical Policy No. 4A does not list procedures that are excluded from D7971, operculectomy is the only procedure that is specifically included. According to the Code on Dental Procedures and Nomenclature it only applies to unerupted or partially erupted teeth.

15. Under 10A NCAC 22F .0103(b)(5), DMA "shall institute methods and procedures to recoup improperly paid claims." Under 10A NCAC 22F .0601(a), DMA "will seek full restitution of any and all improper payments made to providers by the Medicaid Program."

16. 10A NCAC 22F .0606 allows for Respondent to use a disproportionate stratified random sampling technique in establishing provider overpayments and to determine the total overpayment for recoupment. Petitioner has not raised an issue of the extrapolation method used, thus the method of statistical extrapolation used by DMA in calculating an estimated overpayment for the entire universe of Medicaid claims submitted by the Petitioner for the two audit periods is valid and proper.

17. There is no evidence that Petitioner's records contained anything to substantiate billing according to D7971. Petitioner's records generally consisted only of a notation of "EPG" or "excision of pericoronal gingiva" which is woefully insufficient.

18. The Court concludes that the Petitioner's use of dental procedure code D7971 for excision of pericoronal gingiva was not supported by the documentation submitted by the Petitioner for the two audits at issue in this case.

19. Petitioner's contention that a notation in the record of "EPG" or "excision of pericoronal gingiva" should suffice is not supported. To do so tells what the dentist did but nothing else. The Basic Medicaid Billing Guide very clearly states that the CPT billing codes shown on the billing statement must be supported by the documentation in the records.

20. Likewise, there should be a diagnosis for each patient. If the diagnosis is not written down, then the reviewer cannot possibly know why the dentist did anything. Similarly, the dentist would not know either. The burden is on the provider to provide adequate records to justify what he or she does.

21. 10A NCAC 22F .0107 provides that all providers "shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement."

22. Thus in post payment reviews, the burden is on the provider to produce certain documentation to validate that the provider has indeed complied with state and federal requirements. While the ultimate burden of proof is on Respondent in the contested case hearing, a provider cannot rest on its laurels in at least the initial phases of the post payment reviews. To hold otherwise would create an untenable standard wherein the provider controls all the information and Respondent is completely at the provider's mercy for information. If the provider fails to give adequate information to Respondent to substantiate the claim, it would not make any sense at all for the provider to then cry foul because the Respondent does not have the information to prove its case. There then would be no reason for a provider to ever provide Respondent with proper documentation. Such a premise is nonsensical.

23. The fact that Dr. Casey and Ms. Blake did not have decent records and proper radiographs is not the problem of the Respondent—it is the fault of the provider in failing to properly document and demonstrate that the procedure performed was justified. Some of the radiographs actually were of sufficient quality and the soft tissue was visible and the teeth were fully erupted and therefore not appropriate for EPG.

24. Petitioner's assertion that a notation that the patient was experiencing pain should be sufficient has no merit. Pain in a tooth could be from any number of causes. Without more information there is nothing to substantiate that a dental patient experiencing pain justified an EPG.

25. Petitioner's contention or inference that there is some fault because Ms. Blake and Dr. Casey did not personally examine or interview Petitioner's clients lacks merit. Such a requirement would also create an untenable scenario forcing Respondent to re-examine every patient for every dentist who submits a claim for reimbursement, thus Big Brother at its worse. Such makes no sense.

26. There is no evidence explaining why the population Petitioner's two offices served would have utilized the D7971 procedure code at a rate approximately 10 times more than any other office in the entire State of North Carolina. There is no evidence that even other providers serving the same area and population have extraordinarily high use rate or D7971. Such an extraordinary high incidence of tooth and gum disease to justify such incredible high use of D7971 would seemingly indicate an epidemic that only his offices were serving. Making such a leap to find Petitioner's extraordinary use of D7971reasonable is not supported by the evidence.

27. The testimony of Ms. Blake and Dr. Casey as to the deficiencies in Petitioner's records and whether the services provided met the criteria established in Clinical Coverage Policy 4A with respect to dental procedure code D7971 is credible.

28. Respondent met its burden of showing by a preponderance of the evidence pursuant to N.C. Gen. Stat § 150B-34 that DMA's identification of the improper overpayment and any subsequent action to recoup such overpayment was proper. Respondent properly identified overpayments in the amounts of $70,615.71 and $963,909.00 for the two audits in this case.

DECISION

The Decision by Respondent Department of Health and Human Services to recoup $70,615.71 and $963,909.00 from audit 2010-2622 and audit 2010-2623 respectively is supported by the evidence and is hereby **AFFIRMED**.

NOTICE

As these contested cases were commenced prior to December 27, 2012, the Agency that will make the final decision in this contested case is the North Carolina 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.

This the 15th day of September, 2014.

_____

Donald W. Overby
Administrative Law Judge