STATE OF NORTH CAROLINA		IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF FORSYTH		12-DHR-7296
SPEAKEASY THERAPY, LLC, Petitioner, vs. N.C. DEPT. OF HEALTH & HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, Respondent.	)	**FINAL ORDER**

This contested case was heard before Eugene Cela, Administrative Law Judge, on December 19, 2012, in High Point, North Carolina.

APPEARANCES

For Petitioner: Curtis B. Venable, Attorney at Law
OTT CONE & REDPATH, P.A.
P.O. Box 3016
Asheville, NC 28802

For Respondent: Thomas J. Campbell, Assistant Attorney General
N.C. Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602-0629

ISSUE

Whether the Department of Health and Human Services (DHHS) Hearing Officer correctly decided to uphold the decision of the Division of Medical Assistance (DMA) to review Speech/Language-Audiology Therapy Services provided to Medicaid recipients by Petitioner Speakeasy, and that Speakeasy received an overpayment of $60,196.50 as the result of the allegedly improperly documented 100 claims for Speech/Language-Audiology Therapy Services delivered to Medicaid recipients.

JURISDICTION

As stipulated by the parties: This matter is in the appropriate form and venue. The matter was filed in a timely and appropriate fashion. All parties necessary are joined.

BURDEN OF PROOF

Respondent bears the burden of proof in this matter, pursuant to N.C. Gen. Stat. §108C-12(d).

DOCUMENTARY EVIDENCE

As stipulated by the parties as to authenticity and admissibility:

The parties agreed to the authenticity and the admissibility of the following:

For Respondent:

1. Medicaid Provider Agreement dated 10/5/10 (executed by Julie Casey)
2. DMA Clinical Coverage Policy 10A (effective December 1, 2009)
3. Records Request Letter dated 3/1/2012
4. A sample of non-compliant medical records submitted for this audit by Petitioner for the following recipients:
   a. Makari Boston DOS 7/13/11 and 8/4/11;
   b. Altavian Carethers DOS 5/25/11, 6/22/11, 6/29/11 and 7/19/11;
   c. Jerry Summers DOS 4/13/11, 4/20/11, 5/4/11, 8/1/11 and 8/10/11;
   d. Jamire Wiley DOS 4/11/11, 5/2/11, 7/13/11 and 7/18/11.
5. Complete and accurate copy of all medical records (other than those specifically identified above) submitted by Petitioner for this audit.
6. Audit tool sample
7. CV for Alicia Browning
8. CV for John Feaganes, DrPH
9. Summary of findings charts prepared by Alicia Browning detail errors based upon review
10. Chart with overpayment amounts based upon initial review of Alicia Browning
11. Charts of paid/overpaid amounts prepared by John Feaganes, Dr. PH
12. RAT-STATS Variable Unrestricted Appraisal dated 4/26/2012
13. Tentative Notice of Overpayment dated 5/10/2012
14. CCME Response to In-Person Appeal dated 6/8/2012
15. CCME Response to In-Person Appeal dated 7/9/12
16. Hearing Officer's Decision dated 7/26/12
17. Diagram prepared by Dr. Feaganes to illustrate statistical concepts (demonstrative)
18. Copy of 21 NCAC 64.0216 (Standard of Practice for Speech and Language Pathologists)
19. December 2010 Medicaid Bulletin from the NC Department of Health and Human Services

For Petitioner:

None.

WITNESSES

Witnesses for Petitioner:

Julie Casey, SLP, owner Speakeasy Therapy, LLC

Witness for Respondent:

Alicia Browning, CCME
John Feaganes, Dr. PH

Expert Witnesses:

The parties stipulated that Alicia Browning possesses the scientific, technical or other specialized knowledge to assist the trier of fact to understand the evidence or to determine a fact in issue and by virtue of the knowledge, skill, experience, training or education of Ms. Browning, she qualifies as an expert in the area of speech-language pathology pursuant to Rule 702 of the North Carolina Rules of Evidence.

The parties stipulated that Julie Casey, SLP, possesses the scientific, technical or other specialized knowledge to assist the trier of fact to understand the evidence or to determine a fact in issue and by virtue of the knowledge, skill, experience, training or education of Ms. Casey, she qualifies as an expert in the area of speech-language pathology pursuant to Rule 702 of the North Carolina Rules of Evidence.

The parties stipulated that John Feaganes, Dr. PH possesses the scientific, technical or other specialized knowledge to assist the trier of fact to understand the evidence or to determine a fact in issue and by virtue of the knowledge, skill, experience, training or education of Dr. Feaganes, he qualifies as an expert in the area of statistics pursuant to Rule 702 of the North Carolina Rules of Evidence.

Based upon the preponderance of the admissible evidence, the undersigned makes the following:

FINDINGS OF FACT

1. Petitioner does not dispute the following findings of an overpayment from the Hearing Officer's decision for the following patients, dates of services, units of service and amount:

Patient's Last Name	First Name	Date of Service	Unit of Service	Amount
A	CA	4/18/2011	1	68.25
A	CA	5/9/2011	1	68.25
A	CA	5/23/2011	1	68.25
A	CA	5/25/2011	1	68.25
B	KHAM	4/5/2011	1	68.25
B	KHAM	4/25/2011	1	68.25
B	KHAM	5/16/2011	1	68.25
B	KHAM	7/20/2011	1	68.25

Patient's Last Name	First Name	Date of Service	Unit of Service	Amount
B	KHAM	8/9/2011	1	68.25
B	KHAM	8/10/2011	1	68.25
D	CA	4/11/2011	1	68.25
D	CA	5/12/2011	1	68.25
F	NO	4/25/2011	1	68.25
F	NO	5/4/2011	1	68.25
F	NO	5/25/2011	1	68.25
H	TE	5/12/2011	1	68.25
H	TE	8/16/2011	1	68.25
K	MI	8/2/2011	1	68.25
K	MI	8/4/2011	1	68.25
K	MI	8/9/2011	1	68.25
N	CA	4/7/2011	1	68.25
R-S	BR	4/4/2011	1	68.25
R-S	BR	7/5/2011	1	68.25
R-S	BR	7/29/2011	1	68.25
R-S	BR	8/9/2011	1	68.25
S	AM	8/4/2011	1	68.25
S	AM	8/22/2011	1	68.25
S	AM	8/29/2011	1	68.25
S	JE	4/20/2011	1	68.25
S	JE	5/4/2011	1	68.25
V-V	MI	7/8/2011	1	68.25
V-V	SA	3/3/2011	1	68.25
V-V	SA	7/29/2011	1	68.25
V-V	SA	8/24/2011	1	68.25

2. Respondent conducted a review of Petitioner's Medicaid Speech/Language-Audiology Therapy services claims with dates of service between March 1, 2011 and August 31, 2011 by reviewing 100 records.

3. During the period reviewed, Petitioner conducted 882 events covered by Respondent, with a total amount paid by Respondent to Petitioner of $60,196.50.

4. Respondent informed Petitioner by a document entitled "Tentative Notice of Overpayment" (Resp. Ex. 13) dated May 10, 2012 of its initial determination that Petitioner had submitted allegedly erroneous claims in 100 out of 100 records.

5. The value of the allegedly erroneous 100 records totaled $6,825.

6. Respondent extrapolated the alleged errors to Petitioner's total amount received ($60,196.50) and alleged a total overpayment of $60,196.50.

7. Subsequent to Petitioner's request, Respondent conducted an informal reconsideration of the original tentative overpayment.

8. Respondent's informal reconsideration upheld the original findings by determining that 100 records were in error, with a total value of $$60,196.50 (Resp. Ex. 16).

9. In providing Speech/Language-Audiology Therapy services, Petitioner documented the planned activities between the patient and the provider of clinical service by producing a Plan of Care for each patient.

10. In providing Speech/Language-Audiology Therapy services, Petitioner documented the activities between the patient and the provider of clinical service by producing a handwritten note for each patient's date of service.

11. Respondent's findings of Petitioner's alleged errors arose from a review of Petitioner's Plans of Care for each patient.

12. Respondent's findings of Petitioner's alleged errors additionally arose from a review of Petitioner's handwritten note for each patient's dates of service.

13. Respondent's found that in each instance that Petitioner's documentation of Plans of Care failed to "include a specific content…."

14. Respondent's found that in all but seven dates of services, Petitioner's documentation of treatment failed to contain a "[d]escription of services (intervention and outcome/client response) performed…."

15. For seven dates of services Respondent found no error with Petitioner's notes, the only issue cited by Respondent concerned Petitioner's failure to "include specific content" for patients' Plans of Care. The seven dates of service:

Patient's Last Name	First Name	Date of Service	Unit of Service	Amount
B	MA	7/13/2011	1	68.25
B	MA	8/4/2011	1	68.25
C	AL	6/29/2011	1	68.25
S	J	4/13/2011	1	68.25
W	JA	5/2/2011	1	68.25
W	JA	7/13/2011	1	68.25
W	JA	7/18/2011	1	68.25

16. Ms. Casey explained the phonological processes of:

- "syllable reduction" occurs when a syllable has been deleted by the patient from a word containing two or more syllables ("*butterfly*" becomes "*bufly*";
- "fronting" occurs when velnar or patatal consonants are replaced by the patient by other sounds in the front of the mouth (*shoe, vision, cheer, juice* change to *sue, vizzin, seer, zuice*, respectively);
- "gliding" typically affects /r/ and /l/ phonemes, which are classified as "liquids" (*my right leg* becomes *my wight weg*);
- "consonant cluster" is two or more consonants in a sequence without any vowels between them, such as the /sp/ combination in *speak, spot*, or the /skr/ combination in *scrape, scream*. A patient may reduce or delete one of the sounds

(*speak, spot,* become *peak, pot*), as a result, these are the instances of "consonant reduction" or "consonant deletion;"

- "vocalization" occurs when the patient replaces, /l/, or /r/ with a more neutral vowel ("*simple*" becomes "*simpo*" or "*paper*" becomes "*abuh*")
- "prevocalic voicing" occurs when the patient voices of an initial voiceless consonant in a word ("*peach*" is pronounced "*beach*");
- "deaffrication" occurs when a patient changes an affricate to a fricative ("*jump*" pronounced as "*zump*)" and,
- "stopping" occurs when the articulators are pressed together instead of allowing space for the air together, a stop consonant /p, b, t/ or /d/ is produced instead (*face, vase* become *pace, base*; *cheer, jeer* become *teer, deer*).

17. Findings of Fact for each of Petitioner's contested Plans of Care and each contested Date of Service are specifically denominated in this Final Order's Attachment A, incorporated herein by reference. No findings are necessary as to the Plans of Care and Dates of Service not contested by Petitioner.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and the subject matter pursuant to 150B of the North Carolina General Statutes.

2. Respondent bears the burden of proof in this matter pursuant to N.C. Gen. Stat. §108C-11(d).

3. The Code requires proper documentation. Likewise, each provider signs a "participation agreement" wherein he or she agrees to operate and provide services in accordance with state law and all manner of rules, regulations, policies, manuals, bulletins and the like which would command proper documentation.

4. The North Carolina Administrative Code has two provisions which are entitled "Recoupment", 10A NCAC 22F .0601 and 10A NCAC 22F .0706.

5. 10A NCAC 22F .0706 speaks to recoupment of overpayments and how the money will be distributed.

6. The Code states at 10A NCAC 22F .0601 "the Medicaid agency will seek full restitution of any and all <u>improper payments</u> made to providers by the Medicaid program." (Emphasis added) "Improper payments" are not defined in the Code; however, in reading *in pari materi* other sections one may discern the meaning and intent.

7. 10A NCAC 22F .0103 also similarly states that the Division shall institute methods and procedures to, among other things, "recoup improperly paid claims."

8. The Administrative Code states at 10A NCAC 22F .0103 that "The Division shall develop, implement and maintain methods and procedures for preventing, detecting, investigating, reviewing, hearing, referring, reporting, and disposing of cases involving fraud, abuse, <u>error</u>, overutilization or the use of medically unnecessary or medically inappropriate

services." (Emphasis added). "Error" is the only misdeed applicable; i.e., there are no allegations of fraud, abuse, overutilization or use of medically unnecessary or inappropriate services.

9. There has been no assertion or allegation in this proceeding that Petitioner was in any way responsible for fraud as defined in N.C.G.S. §108A-63, i.e., there is no allegation or assertion of the Petitioner "knowingly and willfully making or causing to be made any false statement or representation of material fact" or other type of fraud as defined therein.

10. Respondent also moves to extrapolate the result of the audit findings in this action to the entirety of the Medicaid payments received by Petition.

11. N.C. Gen. Stat. §108C-5(i) requires that "[p]rior to extrapolating the results of any audits, the {Respondent] shall demonstrate and inform the provider that (i) the provider failed to substantially comply with the requirements of State or federal law or regulation…."

12. N.C. Gen. Stat. §90-293(3) outlines that

> "The practice of speech and language pathology" means the application of principles, methods, and procedures for the measurement, testing, evaluation, prediction, counseling, treating, instruction, habilitation, or rehabilitation related to the development and disorders of speech, voice, language, and swallowing for the purpose of identifying, preventing, ameliorating, or modifying such disorders.

13. The Principle of Ethics II of the North Carolina Board of Examiners for Speech and Language Pathologists and Audiologists (21 N.C.A.C. 64 .0303) requires, in relevant part, that the "Licensees shall maintain adequate records of professional services rendered."

14. The Board, in 21 N.C.A.C. 64 .0209(a), directs that "[t]he definition of 'adequate records of professional services' required to be maintained by Rule .0303(4) shall include:

> (1) The full name of the patient;
> (2) The nature of the service provided;
> (3) The date services were provided;
> (4) The identification of the person providing the service;
> (5) The identification of the person preparing or signing the record if not by the person providing the service."

15. Respondent proffered the document entitled as "DMA Clinical Coverage Policy 10A (effective December 1, 2009)" as binding upon Petitioner as permitted by N.C. Gen. Stat. §108A-54.2.

16. Respondent issued Clinical Coverage Policy 10A to direct the provision of "outpatient specialized therapies," (therapeutic physical, occupational, speech, respiratory and audiologic services) and the billing for such services for Medicaid recipients.

17. The relevant portion of Clinical Coverage Policy 10A (Section 5.1 Treatment Services) requires:

> (c) The written plan for services must include defined goals for each therapeutic discipline.
>
> (d) Each plan must include a specific content, frequency, and length of visit of service for each therapeutic discipline.

18. Respondent proffered no binding definition for "specific content."

19. The relevant portion of Clinical Coverage Policy 10A (Section 7.2 Documenting Services) requires that "[e]ach provider must maintain and allow [Respondent's Division of Medical Assistance] to access the following documentation for each individual:

> (d) Description of services (intervention and outcome/client response) performed and dates of service.

20. Respondent proffered no binding definition for "intervention." Stedman's Medical Dictionary (2002) defines the word as "interference so as to modify a process or situation." Merriam-Webster Dictionary defines the word as "the act or fact or a method of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)."

21. In December, 2010, Respondent offered to providers its non-binding interpretation and guidance to practitioners concerning the documentation requirements of Clinical Coverage Policy 10A in an issuance entitled the North Carolina Medicaid Bulletin (available online at: http://www.ncdhhs.gov/dma/bulletin/1210bulletin.htm). The issuance is non-binding as directed by N.C. Gen. Stat. §150B-18 as it was not promulgated pursuant to the requirements of N.C. Gen. Stat. Chapter 150B, Article 2A.

22. Both speech therapy witnesses, Ms. Casey and Ms. Browning were accepted as experts concerning speech therapy. Ms. Browning testified as to her knowledge concerning Respondent's documentation requirements. This decision has considered Ms. Browning testimony and knowledge and accorded appropriate weight to her opinions.

23. The Court gives weight to Ms. Casey's credibility as a result of her acknowledgement of error in 34 dates of services. Furthermore, this decision has considered Ms. Casey's testimony and knowledge and accorded appropriate weight to her opinions.

24. Ms. Browning testified that Respondent's documentation requirements call for the speech therapist' Plan of Care to provide elaboration as to the specific treatments planned for the patient and that simple references to the patient's goals would not satisfy Respondent's requirements for documenting "specific content … of services."

25. The records of Petitioner's Plans of Care contain various descriptions of defined goals and contents. Examples include, *inter alia*: plans' focus upon various phonological process such as "final consonant deletion," "syllable deletion," "syllable reduction," "prevocalic voicing," "cluster reduction," "gliding," "deaffrication," "vocalization," "fronting," and "stopping."

26. With the exception of the Plans of Care conceded by the Petitioner as being in error, each of the records of Petitioner's Plans of Care for speech therapy services contain such descriptions of defined goals and contents for each the remaining patients' Plans of Care.

27. The therapist's "measurement, testing, evaluation, prediction, counseling, treating, instruction, habilitation, or rehabilitation" of such phonological processes fall within the definition of the "practice of speech and language pathology" as defined by N.C. Gen. Stat. §90-293(3).

28. As a result, Petitioner substantially complied with the requirements of Respondent's Clinical Coverage Policy 10A, Section 5.1 by maintaining documentation of each patients' Plan of Care that contain defined goals and specific content.

29. The records of Petitioner's delivery of speech therapy services contain various descriptions of the interventions provided to patients. Examples include, *inter alia*:

- The therapist targeted the phonological process of "final consonant deletion."
- The therapist targeted the phonological process of "final syllable deletion."
- The therapist targeted the phonological process of "deaffrication and fronting."
- The therapist targeted the phonological process of "syllable reduction."
- The therapist provided the intervention of "minimal pairs."
- The therapist targeted the phonological process of "cluster reduction."
- The therapist targeted the phonological process of "gliding."
- The therapist provided an intervention by targeting the phoneme /l/ at the word and sentence level.
- The therapist provided an intervention by targeting the phoneme /th/ and /l/ at the word and sentence level.
- The therapist targeted the phonological process of "stopping."
- The therapist focused the patient's efforts at specific levels, such as at the "syllable and word level" or "word, sentence and conversation level" as required by the patient.
- The therapist targeted a specific process at different positions within words, such as "initial," "medial," or "final."

30. The therapist's "measurement, testing, evaluation, prediction, counseling, treating, instruction, habilitation, or rehabilitation" of such phonological processes fall within the definition of the "practice of speech and language pathology" as defined by N.C. Gen. Stat. §90-293(3).

31. The records of Petitioner's delivery of speech therapy services contain various notations as to the patient's responses to the interventions. Some dates of services recorded the responses by the use of "+" (plus sign for successful patient response) or "-" (minus sign for unsuccessful patient response). Other dates of service recorded the responses by the use of "hash marks" such as "////" for successful responses or "-----" for unsuccessful responses by the patient. Other dates of service recorded the responses by the use of "+"(plus sign for successful patient response) or "0" (zero sign for unsuccessful patient response).

32. Ms. Browning testified that Respondent's documentation requirements call for the speech therapist to provide elaboration as to the specific treatments provided to patients and that simple references to "cuing" would not be sufficient.

33. With the exception of the dates of service conceded by the Petitioner as being in error, each of the records of Petitioner's delivery of speech therapy services contain descriptions of the services provided to patients for each the remaining disputed date of service.

34. With the exception of the dates of service conceded by the Petitioner as being in error, each of the records of Petitioner's delivery of speech therapy services contain a record of the patient's responses to utilized interventions for each the remaining disputed date of service.

35. With the exception of the dates of service conceded by the Petitioner as being in error, each of the records of Petitioner's delivery of speech therapy services for each of the remaining disputed dates of service document "the act or fact or a method of interfering with the outcome or course especially of a condition or process (as to prevent harm or improve functioning)."

36. As a result, Petitioner substantially complied with the requirements of Respondent's Clinical Coverage Policy 10A, Section 7.2 by maintaining documentation of the "description of services (intervention and outcome/client response) performed…."

37. Petitioner's "records of professional services" for each disputed date of service include the "the nature of the service provided" required by 21 N.C.A.C. 64 .0209(a) and .0303(4).

38. With the exception of the dates of service conceded by the Petitioner as being in error, Respondent has failed to demonstrate how Petitioner "failed to substantially comply with the requirements of State or federal law or regulation" as required by N.C. Gen. Stat. §108C-5(i).

39. Respondent has demonstrated error on the part of Petitioner for the following patients, dates of service, units of service and amounts:

Patient's Last Name	First Name	Date of Service	Unit of Service	Amount
A	CA	4/18/2011	1	68.25
A	CA	5/9/2011	1	68.25
A	CA	5/23/2011	1	68.25
A	CA	5/25/2011	1	68.25
B	KHAM	4/5/2011	1	68.25
B	KHAM	4/25/2011	1	68.25
B	KHAM	5/16/2011	1	68.25
B	KHAM	7/20/2011	1	68.25
B	KHAM	8/9/2011	1	68.25
B	KHAM	8/10/2011	1	68.25
D	CA	4/11/2011	1	68.25
D	CA	5/12/2011	1	68.25
F	NO	4/25/2011	1	68.25
F	NO	5/4/2011	1	68.25
F	NO	5/25/2011	1	68.25
H	TE	5/12/2011	1	68.25
H	TE	8/16/2011	1	68.25
K	MI	8/2/2011	1	68.25
K	MI	8/4/2011	1	68.25
K	MI	8/9/2011	1	68.25
N	CA	4/7/2011	1	68.25
R-S	BR	4/4/2011	1	68.25
R-S	BR	7/5/2011	1	68.25
R-S	BR	7/29/2011	1	68.25
R-S	BR	8/9/2011	1	68.25
S	AM	8/4/2011	1	68.25

Patient's Last Name	First Name	Date of Service	Unit of Service	Amount
S	AM	8/22/2011	1	68.25
S	AM	8/29/2011	1	68.25
S	JE	4/20/2011	1	68.25
S	JE	5/4/2011	1	68.25
V-V	MI	7/8/2011	1	68.25
V-V	SA	3/3/2011	1	68.25
V-V	SA	7/29/2011	1	68.25
V-V	SA	8/24/2011	1	68.25

40. Respondent has demonstrated a total error arising from the 34 dates of services (alternatively referred to as claim details) listed above in the amount of $2,320.50

41. For all other dates of service (alternatively referred to as claim details) arising from Respondent's PI #2012-0511, Respondent has failed to carry its burden to prove that the Department of Health and Human Services (DHHS) Hearing Officer correctly decided to uphold the decision of the Division of Medical Assistance (DMA) to review Speech/Language-Audiology Therapy Services provided to Medicaid recipients by Petitioner and that Petitioner received an overpayment of $60,196.50 as a result of improperly documenting claims for Speech/Language-Audiology Therapy Services delivered to Medicaid recipients.

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned makes the following:

DECISION

Petitioner received an overpayment in the amount of $2,320.50 for the following patients, dates of service, units of service and amounts:

Patient's Last Name	First Name	Date of Service	Unit of Service	Overpaid Amount
A	CA	4/18/2011	1	68.25
A	CA	5/9/2011	1	68.25
A	CA	5/23/2011	1	68.25
A	CA	5/25/2011	1	68.25
B	KHAM	4/5/2011	1	68.25
B	KHAM	4/25/2011	1	68.25
B	KHAM	5/16/2011	1	68.25
B	KHAM	7/20/2011	1	68.25
B	KHAM	8/9/2011	1	68.25
B	KHAM	8/10/2011	1	68.25
D	CA	4/11/2011	1	68.25
D	CA	5/12/2011	1	68.25
F	NO	4/25/2011	1	68.25

Patient's Last Name	First Name	Date of Service	Unit of Service	Overpaid Amount
F	NO	5/4/2011	1	68.25
F	NO	5/25/2011	1	68.25
H	TE	5/12/2011	1	68.25
H	TE	8/16/2011	1	68.25
K	MI	8/2/2011	1	68.25
K	MI	8/4/2011	1	68.25
K	MI	8/9/2011	1	68.25
N	CA	4/7/2011	1	68.25
R-S	BR	4/4/2011	1	68.25
R-S	BR	7/5/2011	1	68.25
R-S	BR	7/29/2011	1	68.25
R-S	BR	8/9/2011	1	68.25
S	AM	8/4/2011	1	68.25
S	AM	8/22/2011	1	68.25
S	AM	8/29/2011	1	68.25
S	JE	4/20/2011	1	68.25
S	JE	5/4/2011	1	68.25
V-V	MI	7/8/2011	1	68.25
V-V	SA	3/3/2011	1	68.25
V-V	SA	7/29/2011	1	68.25
V-V	SA	8/24/2011	1	68.25

Respondent was in error in concluding that all other dates of services (alternatively referred to as claim details) arising from Respondent's PI #2012-0511 did not satisfy the requirements of Respondent's Clinical Coverage Policy 10A (effective December 1, 2009).

The amount of the recoupment shall be adjusted in accordance with these findings of fact and conclusions of law.

NOTICE

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 Wake County or in the Superior Court of the county in which the party resides. **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 03.012, 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 24th day of April, 2013.

_____

Eugene Cella
Administrative Law Judge