STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF WAKE	12 DHR 08395

KATHERINE FREE, Petitioner, v. N.C. DEPARTMENT OF HEALTH AND SERVICES, DIVISION OF MEDICAL ASSISTANCE, Respondent.	)	**FINAL DECISION**

THIS CAUSE came on for hearing before the undersigned Administrative Law Selina M. Brooks on January 31, 2013 in Raleigh, North Carolina.

APPEARANCES

For Petitioner: Katherine Free
1337 Konnarock Rd. Apt. 6
Kingsport, TN 37664

For Respondent: Thomas J. Campbell
Assistant Attorney General
N.C. Dept. of Justice
9001 Mail Service Center
Raleigh, North Carolina 27699-9001

ISSUE

Whether the July 18, 2012 decision of the DHHS Hearing Officer to uphold a DMA recoupment of $11,124.75 for Petitioner's alleged failure to provide documentation for services rendered should be upheld or reversed?

APPLICABLE STATUTES AND RULES

42 U.S.C. §§ 1396a - 1396v
42 C.F.R. Parts 455 and 456
N.C. Gen. Stat. § 150B-22 *et seq.*
10A N.C.A.C. 22F *et seq.*
21 N.C.A.C. 64 .0101 *et.seq.*
N.C. State Plan for Medical Assistance

EXHIBITS

Respondent's Exhibits 1 – 5, 7, 11-14, 16 and 17 were admitted into evidence.

WITNESSES

Katherine Free, SLP
Cheryl Wessel, SLP, CCME

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 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 believable evidence in the case. From the sworn testimony of witnesses, the Undersigned makes the following:

FINDINGS OF FACT

1. At all times material to this matter, Petitioner, Katherine Free, was an enrolled provider of Outpatient Specialized Therapy Services in the North Carolina Medicaid Program and entered into a North Carolina Medicaid Participation Agreement with the Division of Medical Assistance ("DMA") to participate in this program. Petitioner signed the Medicaid Participation Agreement on May 1, 2005 (Respondent's Ex. 1).

2. By entering into the Medicaid Participation Agreement, Petitioner agreed to "comply with all federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement (including, but not limited to, Medicaid provider manuals and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent)." (Respondent's Ex. 1).

3. By entering into the Medicaid Participation Agreement, Petitioner agreed to "[m]aintain for a period of five (5) years from the date of service; . . . (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program."(Respondent's Ex. 1).

4. This matter involves an audit of Petitioner conducted by the Carolinas Center for Medical Excellence ("CCME") on or about February 1, 2012. (Respondent's Ex. 3).

5. The audit was conducted by Cheryl Wessel, a review specialist for CCME and a licensed Speech-Language Pathologist. The audit revealed non-compliance with

Clinical Coverage Policy 10A Outpatient Specialized Therapies. (Respondent's Ex. 2). As a result of the audit, CCME identified an overpayment of $11,124.75, which was identified as Program Integrity Case No. 2012-0493. (Respondent's Ex. 11).

6. On March 28, 2012 CCME notified Petitioner of the audit results via certified mail and requested that Petitioner send in a check for the overpayment within thirty (30) days or file a Request for Reconsideration within fifteen (15) days. (Respondent's Ex. 9).

7. Following Petitioner's timely Request for Reconsideration, additional documents were submitted by the Petitioner and the audit was re-reviewed by Ms. Wessel, who found that the identified overpayment should upheld. (Respondent's Ex. 13).

8. DMA Clinical Coverage Policy No.: 10A, Revised December 1, 2009, Outpatient Specialized Therapies, a properly promulgated medical coverage policy, was in effect at the time that the services examined by the audit were rendered. (Respondent's Ex. 2).

9. It is undisputed that Petitioner is a Speech-Language Pathologist providing Outpatient Specialized Therapies to Medicaid recipients.

10. Cheryl Wessel, a review specialist for CCME and a licensed Speech-Language Pathologist, testified on behalf of Respondent that she conducted the initial and subsequent audit of Petitioner's records.

11. As part of the audit review, audit tools and a Summary of Findings were completed documenting the audit findings. (Respondent's Ex. 5, 16).

12. The audit identified problems with Petitioner's documentation for Medicaid recipients for dates of service 3/1/11 through 8/31/11, specifically because the plans of care did not include the specific content of the treatment plan and/or the treatment notes did not include a description of services rendered to the Medicaid recipient, as required by DMA Clinical Coverage Policy No.: 10A 5.1d and 7.2d. (Respondent's Ex. 2, 7).

13. Medicaid Clinical Coverage Policy 10A contains documentation requirements for providing Outpatient Specialized Therapies. (Respondent's Ex. 2).

14. Policy 10A states that "[a] verbal or written order must be obtained for services prior to the start of the services. Backdating is not allowed." DMA Clinical Coverage Policy No.: 10A, 5.1e.

15. Policy 10A states that "[t]here will be no payment for services rendered more than 6 months after the most recent physician order signature date and before the following renewal/revision signature date. The signature date must be the date the physician

signs the order. Backdating is not allowed." DMA Clinical Coverage Policy No.: 10A, 5.1f.

16. Policy 10A states that "[e]ach plan must include a **specific content**, frequency, and length of visits of services for each therapeutic discipline." DMA Clinical Coverage Policy No.: 10A, 5.1d. (Respondent's Ex. 2)(emphasis added).

17. Policy 10A states that "[e]ach provider must maintain and allow DMA to access the following documentation for each individual: . . . d. **Description of services** (**intervention** and outcome/client response) performed and dates of service." DMA Clinical Coverage Policy No.: 10A, 7.2d. (Respondent's Ex. 2)(emphasis added).

18. Ms. Wessel testified as to the dates of service for each Medicaid recipient which were found to be non-compliant because the records failed to adequately set forth the specific content of treatment in the plan of care and/or a description of the treatment services rendered to said recipients. (Respondent's Ex. 7).

19. Ms. Wessel also testified that with regard to patient T.M. for dates of service 3/2/11 through 6/9/11, the doctor's order was signed on 7/6/11, which was after those dates of service and which rendered those dates of service to be non-compliant. (Respondent's Ex. 4d, 7).

20. Although another doctor's order was submitted for patient T.M. which indicated that a verbal order was received from the doctor on 1/6/11, the doctor did not sign the order until 3/9/12, which again was after the dates of service at issue. (Respondent's Ex. 12).

21. In December, 2010, Respondent published a bulletin to offer additional guidance to practitioners concerning the documentation requirements of Clinical Coverage Policy 10A, specifically the North Carolina Medicaid Bulletin (available online at: http://www.ncdhhs.gov/dma/bulletin/1210bulletin.htm). (Respondent's Exhibit 17).

22. The Medicaid Bulletin explains that "Specific Content of Services: Refers to the therapy-specific intervention(s) including planned modalities, therapeutic techniques, and/or treatment approaches requiring the skill of a licensed therapist and which target achievement of the stated goals (i.e. what the therapist plans to do to elicit patient responses). (Respondent's Ex. 19, pg. 17).

23. Ms. Wessel also testified that, as to the records which she identified as having "no description of services," the Petitioner failed to document what specific services were provided to the patient on each given date of service. (Ex. 7).

24. The North Carolina Code requires speech language pathologists to document, among other things, "[t]he nature of the service provided." 21 NCAC 64 .0209(a)(2). (Respondent's Ex. 16).

25. The Medicaid Bulletin explains "Description of Services (intervention and outcome/client response): This is the intervention(s) provided by the therapist in combination with the client's response to the provided intervention(s). Interventions which are documented and described sufficiently would convey the abilities, unique body of knowledge and services that can only be provided by a licensed therapist. . ." (Respondent's Ex. 17, pg. 21).

26. Ms. Wessel testified that she had personally reviewed all of the records for all 100 dates of service in the audit sample, and that she had created a chart which accurately reflected all of her findings regarding the documentation errors in Petitioner's records as to each patient and date of service. (Respondent's Ex. 7).

27. All 100 of the claims submitted by the Petitioner were found to be non-compliant. (Respondent's Ex. 7).

28. CCME performed a statistical extrapolation to determine the overpayment amount for the entire universe of 163 Medicaid claims paid to Petitioner for services rendered during the audit period of 3/1/11 through 8/31/11. (Respondent's Ex. 10).

29. DMA is seeking recoupment for the non-compliant Medicaid claims paid to Petitioner for services rendered during the audit period of 3/1/11 through 8/31/11, which was calculated through statistical extrapolation to be $11,125.00.

30. Given the 100% error rate and that only $11,124.75 was actually paid by Respondent to the Petitioner, that is the amount of the overpayment that Respondent is seeking.

31. Petitioner did not challenge the statistical validity of the $11,124.75 figure at the hearing of this case, and did not object to that figure being admitted as the correct amount of the overpayment at issue.

32. The payments made to Petitioner for services delivered to the recipients identified in Ms. Wessel's adverse findings chart, in which the Petitioner failed to document a specific content in the treatment plan and/or a description of the treatment services rendered to the recipients, and in the case of patient T.M., failed to have an appropriate doctor's order in place prior to rendering treatment, were improper payments. (Respondent's Ex. 2).

33. Petitioner testified that at the reconsideration hearing that she remained unclear about how to improve her documentation. She asked the Hearing Officer and Respondent how to improve her documentation. Her question was not answered and she was told to enroll in training.

34. Ms. Wessel testified that at the time of the reconsideration hearing that she was a new employee, did not know what she could advise Petitioner and, therefore, did not answer her question.

CONCLUSIONS OF LAW

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

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

3. Under 10A NCAC 22F .0103(b)(5), DMA "shall institute methods and procedures to recoup improperly paid claims."

4. Under 10A NCAC 22F .0601(a), DMA "will seek full restitution of any and all improper payments made to providers by the Medicaid Program."

5. 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.

6. By entering into the Medicaid Participation Agreement, Petitioner agreed to "comply with all federal and state laws, regulations, state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement (including, but not limited to, Medicaid provider manuals and Medicaid bulletins published by the Division of Medical Assistance and/or its fiscal agent)." (Respondent's Ex. 1).

7. By entering into the Medicaid Participation Agreement, Petitioner agreed to "[m]aintain for a period of five (5) years from the date of service; . . . (b) other records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program."(Respondent's Ex. 1).

8. Clinical Coverage Policy 10A was adopted according to the procedures set forth in N.C.G.S. § 108A-54.2 (2009).

9. Medicaid Clinical Coverage Policy 10A contains documentation requirements for providing Outpatient Specialized Therapies.]

10. Policy 10A states that "[a] verbal or written order must be obtained for services prior to the start of the services. Backdating is not allowed." DMA Clinical Coverage Policy No.: 10A, 5.1e.

11. Policy 10A states that "[t]here will be no payment for services rendered more than 6 months after the most recent physician order signature date and before the following renewal/revision signature date. The signature date must be the date the physician signs the order. Backdating is not allowed." DMA Clinical Coverage Policy No.: 10A, 5.1f.

12. Policy 10A states that "[e]ach plan must include a specific content, frequency, and length of visits of services for each therapeutic discipline." DMA Clinical Coverage Policy No.: 10A, 5.1d.

13. Medicaid Clinical Coverage Policy 10A states that "[e]ach provider must maintain and allow DMA to access the following documentation for each individual: . . . d. Description of services (intervention and outcome/client response) performed and dates of service." DMA Clinical Coverage Policy No.: 10A, 7.2d.

14. The court finds that Ms. Wessel's testimony as to the deficiencies in Petitioner's records in view of Clinical Coverage Policy 10A was credible. This decision has considered Ms. Wessel's testimony and knowledge and accorded appropriate weight to her opinions.

15. Respondent met its burden of showing by a preponderance of the evidence that DMA's identification of the improper overpayment and any subsequent action to recoup such overpayment was proper.

16. Petitioner failed to sufficiently document specific content as to planned treatment and/or a description of the services provided to the Medicaid recipients, as set forth in detail in the chart presented as Respondent's Exhibit 7, which content and description are required by DMA Clinical Coverage Policy No. 10A 5.1 d and 7.2d.

17. With regard to claims for patient T.M. for dates of service 3/2/11 through 6/9/11, the doctor's order was signed on 7/6/11, which was after those dates of service and which rendered those dates of service to be non-compliant pursuant to DMA Clinical Coverage Policy 10A 5.1e and f.

18. The method used by CCME in calculating the overpayment for the entire universe of Medicaid claims submitted by the Petitioner for the audit period, 3/1/2011 to 8/31/2011, is valid and proper, and was not challenged by Petitioner at the hearing of this matter.

19. Under N.C. Gen. Stat. § 150B-34, based upon the preponderance of the evidence and "giving due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency," Respondent properly identified an improper overpayment in the amount of $11,124.75 which shall repaid to the North Carolina Medicaid program.

20. Respondent's failure to explain to Petitioner at the reconsideration hearing as to how to improve her documentation does not overcome the errors in Petitioner's documentation.

21. Respondent's failure to explain to Petitioner at the reconsideration hearing as to how to improve her documentation does, however, reflect negatively upon Respondent's performance of its duty to deal fairly and openly with the citizens of this State.

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the undersigned makes the following:

DECISION

The decision by Respondent DMA to recoup $11,124.75 from Petitioner is supported by the evidence and hereby is **AFFIRMED**.

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 lA-I, 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. § l50B-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 12th day of April, 2013.

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Selina M. Brooks
Administrative Law Judge