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| STATE OF NORTH CAROLINA | IN THE OFFICE OF ADMINISTRATIVE HEARINGS |
| COUNTY OF CRAVEN | 12 DHR 08776 |

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| CLIFFORD LEE DRUML,<br><br>Petitioner,<br><br>v.<br><br>N.C. DEPARTMENT OF HEALTH & SERVICES, DIVISION OF MEDICAL ASSISTANCE,<br><br>Respondent. | ) | **DECISION** |

THIS CAUSE came on for hearing before the undersigned Administrative Law Judge Eugene Cella on January 23, 2012 in New Bern, North Carolina.

## APPEARANCES

For Petitioner: Clifford Lee Druml
1203 Coral Reef Court
New Bern, NC 28560

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

## ISSUE

Whether the Department of Health and Human Services (DHHS) Hearing Officer correctly decided to uphold the finding of the Carolinas Center for Medical Excellence (CCME) that Druml had received an overpayment of $2,798.25 as the result of the allegedly improperly documented 41 claims for Speech/Language- Audiology Therapy Services delivered to Medicaid recipients.

## 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.*
N.C. State Plan for Medical Assistance

## EXHIBITS

Respondent's Exhibits 1 – 11 were admitted into evidence.

## WITNESSES

Clifford Lee Druml, SLP
Alicia Browning, 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, Clifford Lee Druml, 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 November 7, 2010 (Respondent's Ex. 1).

2. By entering into the Medicaid Participation Agreement, Petitioner agreed to "operate and provide services in accordance with all federal and state laws, regulations and rules, and all policies, provider manuals, implementation updates, and bulletins published by the Department, its Divisions and/or its fiscal agents in effect at the time the service is rendered, which are incorporated into this Agreement by this reference." (Respondent's Ex. 1).

3. By entering into the Medicaid Participation Agreement, Petitioner agreed to "refund or allow the Department to recoup or recover any monies received in error or in

excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents." (Respondent's Ex. 1).

4. By entering into the Medicaid Participation Agreement, Petitioner agreed to "[f]or a minimum of six (6) years from the date of service, or longer if required specifically by law or post payment audits . . . (ii) [k]eep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record-keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department." (Respondent's Ex. 1).

5. This matter involves an audit of Petitioner conducted by the Carolinas Center for Medical Excellence ("CCME") (a contractor for the Division of Medical Assistance "DMA") on or about April 2, 2012. (Respondent's Ex. 4).

6. The audit was conducted by Alicia Browning, 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 $2,798.25, which was identified as Program Integrity Case No. 2012-0555. (Respondent's Ex. 9).

7. On May 18, 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).

8. Following Petitioner's timely Request for Reconsideration, Petitioner provided additional documents to CCME, which were reviewed by Ms. Browning, who then informed the DHHS Hearing Officer of her findings. (Respondent's Ex. 10).

9. The DHHS Hearing Officer then issued a Notice of Decision on July 25, 2012, upholding the overpayment amount of $2,798.25.

10. 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).

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

12. The documentation reviewed by CCME showed that Petitioner's records failed to document the duration of the treatment rendered to the Medicaid recipient, and were not signed by the person providing the service, as required by DMA Clinical Coverage Policy 10A, 7.2 e and f. (Respondent's Ex. 2).

13. Alicia Browning, 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.

14. As part of the audit review, audit tools and a Summary of Findings were completed documenting the audit findings. (Respondent's Ex. 7, 8).

15. 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 treatment notes did not include a duration of the service rendered to the Medicaid recipient or the signature of the person providing the service, as required by DMA Clinical Coverage Policy No.: 10A 7.2 e and f. (Respondent's Ex. 2, 5).

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

17. Policy 10A states that "[e]ach provider must maintain and allow DMA to access the following documentation for each individual: . . . **e. The Duration of service (i.e. length of assessment and or treatment session in minutes); and f. The signature** 7.2 e and f. (**of the person providing each service.**" DMA Clinical Coverage Policy No.: 10A, Respondent's Ex. 2)(emphasis added).

18. Ms. Browning testified that Petitioner's documentation for services rendered to patient M.C. during the time frame of the audit (a total of 41 visits) failed to set forth the duration of the treatment services rendered to M.C. or to have the signature of the person who rendered the treatment. (Respondent's Ex. 5).

19. Upon receipt of the Tentative Notice of Appeal (Respondent's Ex. 9), Petitioner testified that he resubmitted the records in question after having signed the notes and written in a duration time. (Respondent's Ex. 6).

20. Ms. Browning testified that the resubmitted records did not change her assessment that the records were non-compliant, as Policy 10A states that "[r]eimbursement requires compliance with all Medicaid guidelines . . ." Attachment A. (Respondent's Ex. 2,).

21. Ms. Browning testified that the Policy language required that because the records lacked a record of duration and a signature at the time that they were submitted, they did not comply with the Policy and the reimbursement by Medicaid was improper.

22. Ms. Browning testified that she had personally reviewed all of the records for all 41 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 date of service, which chart was reviewed prior to the hearing. (Respondent's Ex. 8).

23. Medicaid paid a total of $2,798.25 to Petitioner for the services rendered to Medicaid recipient M.C. and which were the subject of the CCME audit.

24. The payments made to Petitioner for services delivered to the recipient identified in Ms. Browning's adverse findings chart, in which the Petitioner failed to document the duration of each treatment or to include the signature of the person providing said treatment, were improper payments. (Respondent's Ex. 2, 8 and 11).

## 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. By entering into the Medicaid Participation Agreement, Petitioner agreed to "operate and provide services in accordance with the Controlling Authority" (which includes "state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, the Department, its divisions and/or its fiscal agents in effect at the time the service is rendered").

6. By entering into the Medicaid Participation Agreement, Petitioner agreed to "refund or allow the Department to recoup or recover any monies received in error or in excess of the amount to which the Provider is entitled from the Department (an overpayment) as soon as the Provider becomes aware of said error and/or overpayment or within thirty (30) calendar days of a request for repayment by the Department, regardless of whether the error was caused by the Provider or the Department and/or its agents."

7. By entering into the Medicaid Participation Agreement, Petitioner agreed to "[f]or a minimum of six (6) years from the date of service, or longer if required specifically by Controlling Authority. . . a. (ii) [k]eep, maintain and make available complete and accurate medical and fiscal records in accordance with Department record- keeping requirements that fully justify and disclose the extent of the services or items furnished and claims submitted to the Department."

8. Clinical Coverage Policy 8A 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 "[e]ach provider must maintain and allow DMA to access the following documentation for each individual: . . . **e. The Duration of service (i.e. length of assessment and or treatment session in minutes); and f. The signature of the person providing each service.**" DMA Clinical Coverage Policy No.: 10A, 7.2 e and f. (Respondent's Ex. 2)(emphasis added).

11. 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.

12. Petitioner failed to document the duration of the services provided to the Medicaid recipient identified in the DMA audit, or to have the person providing the service sign the treatment records, as set forth in the chart presented as Respondent's Exhibit 8, which description is required by DMA Clinical Coverage Policy No. 10A 7.2 e and f.

13. Petitioner's re-submission of the records with duration times and signatures added does not bring the records into compliance, as Clinical Coverage Policy 10A clearly states that "[r]eimbursement requires compliance with all Medicaid guidelines . . ." Attachment A. (Respondent's Ex. 2,).

14. Because the Petitioner's records did not comply with Clinical Coverage Policy 10A at the time that Petitioner's bills were submitted to and paid by Medicaid, the determination that an overpayment existed, which DMA was entitled to recoup, was proper.

15. 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 $2,798.25 which shall repaid to the North Carolina Medicaid program.

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

## DECISION

The decision by Respondent DMA to recoup $2,798.25 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 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 25th day of April, 2013.

Eugene Cella
Administrative Law Judge