STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF WAKE	12 DHR 09832

VICKI LUCAS-CROWDER,	)	
	)	
Petitioner,	)	
	)	
v.	)	**DECISION**
	)	
DIVISION OF MEDICAL ASSISTANCE,	)	
	)	
Respondent.	)	

THIS CAUSE came on for hearing before the undersigned Administrative Law Judge Eugene J. Cella on February 27, 2013 in Raleigh, North Carolina.

APPEARANCES

For Petitioner: Vicki-Lucas Crowder
5321 Passenger Place
Raleigh, NC 27603

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 September 28, 2012 decision of the DHHS Hearing Officer to uphold a DMA recoupment of $1,569.75 was correct?

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 2-12 were admitted into evidence.

WITNESSES

Vicki Lucas-Crowder, 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, Vicki Lucas-Crowder, 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.

2. This matter involves an audit of Petitioner conducted by the Carolinas Center for Medical Excellence ("CCME") on or about July 2, 2012. (Respondent's Ex. 4).

3. 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 $1,569.75, which was identified as Program Integrity Case No. 2012-2518. (Respondent's Ex. 8).

4. On August 2, 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. 8).

5. Following Petitioner's timely Request for Reconsideration, the audit was re-reviewed by Ms. Browning, who found that the identified overpayment should be upheld. (Respondent's Ex. 9).

6. 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).

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

8. 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.

9. As part of the audit review, audit tools and a Summary of Findings were completed documenting the audit findings. (Respondent's Ex. 6, 7).

10. 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 original plans of care submitted by the Petitioner did not include the specific content of the treatment plan and the subsequent undated treatment plans did not document that they were in place prior to the time that the services were rendered, as required by DMA Clinical Coverage Policy No.: 10A 5.1, 7.2b and Attachment A to the Policy (Respondent's Ex. 2, 7).

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

12. 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.

13. 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.

14. 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).

15. Policy 10A states that "[r]eimbursement requires compliance with all Medicaid guidelines, including appropriate referrals for recipients enrolled in Medicaid

managed care programs." DMA Clinical Coverage Policy No. 10A, Attachment A (Respondent's Ex. 2).

16. Policy 10A states that "[p]roviders must comply with all applicable federal, state, and local laws and regulations . . ." DMA Clinical Coverage Policy No. 10A, 7.1. (Respondent's Ex. 2).

17. Ms. Browning testified as to the 23 dates of service for Medicaid recipient J.C. which were found to be non-compliant because the records had originally failed to adequately set forth the specific content of treatment in the plan of care for said recipient. (Respondent's Ex. 5A).

18. Ms. Browning also testified that Petitioner resubmitted the treatment plans which did include specific content of treatment, but that the plans remained non-compliant as they were undated and therefore could not be confirmed to be in place prior to the time that services were rendered to patient J.C.. (Respondent's Ex. 5B).

19. 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 12).

20. The Medicaid Bulletin explains that written plans of care must contain the date of the plan of care, including the month, date and year. (Respondent's Ex. 12, pg. 20).

21. The NC Code requires speech language pathologists to document, among other things, "[t]he date services were provided." 21 NCAC 64 .0209(a)(3). (Respondent's Ex. 11).

22. Ms. Browning testified that she had personally reviewed all of the records for all 23 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 J.C. for each date of service. (Respondent's Ex. 7).

23. All 23 of the claims submitted by the Petitioner were found to be non-compliant. (Respondent's Ex. 7).

24. 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 $1,569.75.

25. Petitioner did not challenge the $1,569.75 figure at the hearing of this case, but rather challenged the merits of the CCME findings as to the dates of service being non-compliant with Clinical Coverage Policy 10A.

26. The payments made to Petitioner for services delivered to J.C. as identified in Ms. Browning's adverse findings chart, in which the Petitioner failed to include a date on the revised plans of care that Petitioner submitted, were improper payments. (Respondent's Ex. 2, 5B).

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

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

7. 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.

8. 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.

9. 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.

10. Policy 10A states that "[r]eimbursement requires compliance with all Medicaid guidelines, including appropriate referrals for recipients enrolled in Medicaid managed care programs." DMA Clinical Coverage Policy No. 10A, Attachment A.

11. The court finds that Ms. Browning's testimony as to the deficiencies in Petitioner's records in view of Clinical Coverage Policy 10A was credible. This decision has

considered Ms. Browning's testimony and knowledge and accorded appropriate weight to her opinions.

12. 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.

13. Petitioner originally submitted treatment plans for patient J.C. which failed to set forth specific content as to planned treatment as required by DMA Clinical Coverage Policy No. 10A 5.1.

14. The re-submitted plans of treatment for patient J.C., while setting forth the Effective Plan of Care Dates, were still not compliant with Clinical Coverage Policy 10A as the plans themselves are undated and therefore do not confirm that they were in place prior to the services rendered to patient J.C..

15. Without a valid treatment plan in place prior to rendering services to patient J.C. as require by Clinical Coverage Policy 10A, the 23 dates of service for patient J.C. in the audit period were properly disallowed and the overpayment of $1,569.75 was properly identified.

16. 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 $1,569.75 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 $1,569.75 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 _____ day of _____, 2013.

_____

Eugene J. Cella
Administrative Law Judge