STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF BUNCOMBE	12 DHR 10367

ASHEVILLE SPEECH ASSOCIATES, 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 Judge Selina M. Brooks on April 10, 2013 in Waynesville, North Carolina.

APPEARANCES

For Petitioner: Curtis B. Venable
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For Respondent: Thomas J. Campbell
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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, and that Petitioner received an overpayment of $81,723.00 as the result of the allegedly improperly documented 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.*
21 N.C.A.C. 64 .0101 *et.seq.*
N.C. State Plan for Medical Assistance

EXHIBITS

Respondent's Exhibits 1 – 14 were admitted into evidence.

WITNESSES

Janet Bennett, SLP
Kristen Kershaw, SLP
Mary Mason, 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, Asheville Speech Associates, 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 January 22, 2010. (Respondent's Ex. 1).

2. By entering into the Medicaid Participation Agreement, Petitioner agreed to comply

with ". . . state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implantation updates, and bulletins published by CMS, the Department, its divisions and/or fiscal agent in effect at the time the service is rendered." (Respondent's Ex. 1).

3. By entering into the Medicaid Participation Agreement, Petitioner agreed to maintain for a period of six (6) years from the date of service "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).

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

5. The audit was conducted by Mary Mason, a review specialist for CCME and a licensed Speech-Language Pathologist. The parties stipulated that Ms. Mason qualifies as an expert in the area of speech-language pathology pursuant to Rule 702 of the North Carolina Rules of Evidence. (4/10/2013 Joint Pre-trial Order).

6. 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 $81,723.00 which was identified as Program Integrity Case No. 2012-2464. (Respondent's Ex. 9).

7. On July 5, 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, the audit was re-reviewed by Ms. Mason who found that the identified overpayment should be upheld. (Respondent's Ex. 10).

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

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

11. The documentation reviewed by CCME showed that Petitioner failed to document specific content for the patients' treatment plans and/or a description of the services provided to multiple Medicaid recipients, as required by DMA Clinical Coverage Policy 10A, 5.1 and 7.2. (Respondent's Ex. 2, 11).

12. Ms. Mason conducted the re-review of the records prior to the reconsideration review hearing.

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

14. The audit identified problems with Petitioner's documentation for Medicaid recipients for dates of service 3/1/11 through 8/31/11 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 5.1 and 7.2. (Respondent's Ex. 2, 11).

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

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. Mason testified as to her adverse findings summary which sets forth her specific findings as to each date of service and how the records 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. 11).

19. Ms. Mason testified that, as to the records which she identified as not having "specific content," the Petitioner failed to set forth a plan for treatment for the patient and that the planned activities listed by Petitioner did not constitute a specific plan for treatment.

20. In December, 2010, Respondent published the North Carolina Medicaid Bulletin to offer additional guidance to practitioners concerning the documentation requirements of Clinical Coverage Policy 10A, specifically (available online at: http://www.ncdhhs.gov/dma/bulletin/1210bulletin.htm). (Respondent's Exhibit 14).

21. 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. 14, pg. 20).

22. Ms. Mason 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. 11).

23. The North Carolina Administrative 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. 13).

24. The Medicaid Bulletin provides this explanation: "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. 14, pg. 21).

25. Ms. Mason 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. 11).

26. Not all of Petitioner's records were found to be out of compliance. Ms. Mason testified that, for example, the records for patients: J.A. DOS 6/3/11; M.B. DOS 5/26/11 and 7/28/11; A.M. DOS 5/3/11 and 6/1/11; and C.M. 4/26/11 were found to comply with the Clinical Coverage Policy. (Respondent's Ex. 11).

27. Ms. Mason testified as to how those dates of service complied with the policy. For example with regard to patient A.C., the records showed that Petitioner set forth specific forms of intervention, i.e. "facilitation of correct production of sounds using visual, tactile and kinetic cues . . .." (Respondent's Ex. 4).

28. On the record in open court, Petitioner conceded that the following claims in Respondent's Reconsideration Review decision were improperly documented:

Recipient	Date(s) of Service
Aiken	3/16
Greene	5/23
Justice	3/4
Seeger	3/10

29. Petitioner presented the testimony of Janet Bennett, SLP and Kristen Kershaw, SLP.

30. The parties stipulated that both Ms. Bennett and Ms. Kershaw qualify as experts in the area of speech-language pathology pursuant to Rule 702 of the North Carolina Rules of Evidence. (4/10/2013 Joint Pre-trial Order).

31. Both Ms. Bennett and Ms. Kershaw testified to the sufficiency of Petitioner's records and as to why they disputed Ms. Mason's findings.

32. CCME performed a statistical extrapolation to determine the overpayment amount for the entire universe of 2900 Medicaid claims (2,833 clusters) paid to Petitioner for services rendered during the audit period of 3/1/11 through 8/31/11. (Respondent's Ex. 8).

33. 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 $81,723.00.

34. Petitioner did not challenge the statistical validity of the $81,723.00 figure at the hearing of this case; rather the parties agreed on the record that, in the event that the court were to overturn CCME's findings as to any of the individual dates of service, then Respondent would have the opportunity to submit a revised calculation that could then be challenged by Petitioner at a subsequent hearing.

35. Following the entry of this Court's Amended Order, dated April 29, 2013, Respondent was directed to obtain a new statistical extrapolation figure based upon the findings set forth in the Amended Order.

36. Respondent has had CCME perform a new extrapolation based upon this Court's findings, which now sets the overpayment at $53,125.00, which figure has been provided to counsel for the Petitioner and this Court.

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 ". . . state laws and regulations, medical coverage policies of the Department, and all guidelines, policies, provider manuals, implantation updates, and bulletins published by CMS, the Department, its divisions and/or fiscal agent in effect at the time the service is rendered."

7. By entering into the Medicaid Participation Agreement, Petitioner agreed to maintain for a period of six (6) years from the date of service . . . "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).

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 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.

11. 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.

12. On the record in open court, Petitioner conceded that the following claims in Respondent's Reconsideration Review decision were improperly documented, and so those findings of the Respondent are affirmed:

Recipient	Date(s) of Service
Aiken	3/16
Greene	5/23
Justice	3/4
Seeger	3/10

13. After careful consideration of all of the documents admitted into evidence and the documents submitted in support of the claims in dispute and contained in Respondent's Exhibit 4, the Undersigned hereby determines that Respondent met its burden of proof that the following claims were improperly documented:

Recipient	Date(s) of Service
Allen	3/7, 8/11
Bell	3/8
Clendenen	4/25

Davidson	4/28
Edgerton	6/9
Garcia	4/6, 5/11, 5/18, 6/1
Greene	4/1
Hyden	4/7, 6/24, 8/29
Jackson	3/2
Jones, G	8/26
Jones, C	5/30
Pagan	6/22, 8/3
Penaaguilera	3/9, 3/22, 4/5, 8/30
Seeger	8/18
Trejovazquez	4/15, 4/21
Varnes	5/3, 7/5
Watkins	3/31
Williams	3/31, 4/19

14. As to the patients and the dates of service set forth in paragraphs 12 and 13 above, 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.

15. After careful consideration of all of the documents admitted into evidence and the documents submitted in support of the claims remaining in dispute and contained in Respondent's Exhibit 4, the Undersigned hereby determines that Respondent's Reconsideration Review decision that the following claims were improperly documented is in error:

Recipient	Date(s) of Service
Chaberski	3/14, 6/8, 6/22, 8/12, 8/31
Justice	4/7
Miller	6/24
Morris	3/7, 8/24
Murphy	3/1, 4/12, 5/10, 6/9
Onderdonk	4/18
Sanders	8/31

16. The method of statistical extrapolation used by CCME in calculating an estimated overpayment for the entire universe of Medicaid claims submitted by the Petitioner for the audit period, 3/1/2011 to 8/31/2011, was not challenged by Petitioner at the hearing of this matter, although Petitioner did reserve its right to challenge any recalculation at a subsequent hearing.

17. Respondent has had CCME perform a new extrapolation based upon this Court's findings, which now sets the overpayment at $53,125.00.

18. 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 has properly identified an improper overpayment in the amount of $53,125.00 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 amount of the recoupment from Petitioner has been adjusted in accordance with the above Findings of Fact and Conclusions of Law to the amount of **$53,125.00**, the recoupment of which is supported by the evidence and hereby is **AFFIRMED**. Petitioner shall repay the overpayment of $53,125.00 to the North Carolina Medicaid Program.

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 20th day of June, 2013.

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Selina M. Brooks
Administrative Law Judge