STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF PITT	12 DHR 10447

THERAPEUTIC LIFE CENTER, INC., Petitioner, v. N.C. DEPARTMENT OF HEALTH AND SERVICES, DIVISION OF MEDICAL ASSISTANCE, Respondent.	)	**FINAL DECISION**

On March 21, 2013, Administrative Law Judge Melissa Owens Lassiter heard this contested case in Greenville, North Carolina. On November 19, 2012, Petitioner filed a contested case petition with the Office of Administrative Hearings, appealing Respondent's October 12, 2012 decision to recoup $1947.00 in Medicaid payments to Petitioner for providing outpatient specialized therapy services to Medicaid recipients. On June 17, 2013, Chief Administrative Law Judge Julian Mann III extended the deadline for filing a Decision in this case to July 15, 2013.

APPEARANCES

For Petitioner: Pamela Klinger
Therapeutic Life Center, Inc.
102 Eastbrook Drive, Ste. B & C
Greenville, NC 27858

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

ISSUE

Whether Respondent is entitled to recoup $1947.00 in Medicaid payments from Petitioner for failing to comply with Medicaid laws and policies in documenting the outpatient specialized therapy services that Petitioner provided 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

BURDEN OF PROOF

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

EXHIBITS ADMITTED INTO EVIDENCE

For Petitioner: None

For Respondent: 1 – 19

WITNESSES

For Petitioner: Pamela Klinger

For Respondent: Roseann K. Sparano, Occupational Therapist, CCME
Cheri Hall, Physical Therapist & Review Specialist, CCME
Dr. John Feaganes, CCME

FINDINGS OF FACT

Background Facts

1. At all times material to this matter, Petitioner was an enrolled provider of Outpatient Specialized Therapy Services, i.e. occupational and physical therapies, to Medicaid recipients in the North Carolina Medicaid Program.

2. Petitioner entered into a North Carolina Medicaid Participation Agreement with the Division of Medical Assistance ("DMA") to participate in Medicaid program, and 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.

(Medicaid Participation Agreement, 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. Pursuant to 42 CFR 455 42 CFR 456, and 10A NCAC 22F, the Program Integrity Section of Respondent's Division of Medical Assistance ("DMA") is required to conduct post-payment reviews of Medicaid paid claims. Respondent's DMA contracted with The Carolinas Center for Medical Excellence ("CCME") to conduct post-payment reviews when

Medicaid recipients have received certain outpatient therapies, such as physical therapy, occupational therapy, respiratory therapy, audiology, and speech language pathology services.

5. On March 1, 2012, Roseann K. Sparano and Cheri Hall, CCME review specialists, conducted an audit, and examined a random sampling of Petitioner's paid Medicaid claims, relating to outpatient specialized therapies, for the audit period March 1, 2011 through August 31, 2011. (Respondent's Ex. 3)Because Petitioner provided both occupational and physical therapy services, Ms. Sparano, a licensed occupational therapist, and Ms. Hall, a licensed physical therapist, reviewed the records involving their particular areas of expertise.

6. Sparano and Hall determined that Petitioner "failed to substantially comply with Medicaid Clinical Coverage Policy 10A, Outpatient Specialized Therapies" ("Medicaid Policy 10A") by:

- 2 of 101 records revealed noncompliance with the therapy order requirements of Medicaid Policy 10A – sections 5.1 e, f, and g, and 7.1, 7.2c.
- 2 of 101 records revealed claims billed that exceeded the limitations of the therapy order in violation of Medicaid Policy 10A – section 5.1 e.
- 16 of 101 records provided reveal noncompliance with therapy plan requirements in violation of Medicaid Policy 10A- sections 5.1 b, c, d, and f, and 7.1, 7.2b.
- 17 of 101 records provided revealed claims billed exceeded the limitations of the written plan in violation of Medicaid Policy 10A-section 5.1 b, c, and d.
- 30 of 101 records provided lacked service documentation per policy requirements for dates of service billed in violation of Medicaid Policy 10A-sections 3.1, 6, 7.1, 7.2 d, e, and f, Attachment A

As a result of the audit, CCME initially identified an overpayment of $40,674.00 in Medicaid funds to Petitioner. (Respondent's Ex. 8)

7. On June 7, 2012, CCME notified Petitioner of the audit results via certified mail, and requested that Petitioner send a check for the overpayment within thirty (30) days, or file a Request for Reconsideration within fifteen (15) days. (Respondent's Ex. 8).

8. After Petitioner's timely Request for Reconsideration, Petitioner submitted additional documentation to CCME. Ms. Sparano and Ms. Hall reviewed Petitioner's documentation, and found that the identified overpayment should be modified to $25,490.00. (Respondent's Ex. 10).

9. After conducting a Reconsideration Review on September 17, 2012, Respondent's Hearing Officer issued a decision on October 12, 2012, modifying the overpayment amount to $1,947.00. (Respondent's Ex. 12)

10. The Hearing Officer reversed 11 of 14 CCME's recoupments for occupational therapy claims submitted by Petitioner for Medicaid reimbursement, and found no overpayment for 1 additional occupational therapy claim. The Hearing Officer upheld 2 of those 14 recoupments for occupational therapy services provided to Medicaid recipients J.H. and Y.S.

a. Regarding recipient J.H., the Hearing Officer found there was no documentation showing an order authorizing or covering J.H.'s 3/4/11 therapy session.

b. Regarding recipient Y.S., the Hearing Officer found there was no documentation, i.e. a service note for services on 7/25/11, but none for 7/26/11. She found the billing

administrator made a clerical error by entering 7/26/11 instead of 7/25/11 into the Medicaid billing system. However, she noted that while she did not question this was a clerical error, she "does not have the authority to pass this issue," and thus, upheld recoupment, because "policy requires a service note for each date of service billed for." (Respondent's Ex. 12)

c. The Hearing Officer reversed 2 of 6 recoupments, and upheld 4 of those 6 recoupments for physical therapy services Petitioner billed Medicaid for reimbursement.

1. Regarding recipients S.W, E.W., and M.D., the Hearing Officer uphold recoupment, because Petitioner's service documentation for the dates of service did not contain the provider's signature.

2. Regarding recipient P.D., the Hearing Officer uphold recoupment because Petitioner's documentation failed to satisfy the "specific content" requirement of Policy 10A sec. 5.1b, c, and d.

11. DMA issued Clinical Coverage Policy No. 10A, titled Outpatient Specialized Therapies, with an original effective date of October 1, 2002, and revised such policy December 1, 2009. Such policy was in effect when Petitioner rendered the services that Respondent examined during the subject audit. (Respondent's Ex. 2).

Adjudicated Facts

12. Medicaid Clinical Coverage Policy 10A contains documentation requirements for providing Outpatient Specialized Therapies. (Respondent's Ex. 2). Policy 10A states that the records must include the "signature of the person providing each service." (DMA Clinical Coverage Policy No. 10A, 7.2f, Respondent's Ex. 2)

13. Policy 10A states, "[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, Respondent's Ex. 2)

14. Policy 10A states that:

> There 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, Respondent's Ex. 2, Emphasis added)

15. Medicaid Policy 10A further states, "Each 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).

16. The audit identified problems with Petitioner's documentation for Medicaid recipients for dates of service 3/1/11 through 8/31/11. Generally, they identified documentation errors such as plans of care did not include the specific content of the treatment plan, treatment notes were unsigned, there was no doctor's order regarding the treatment, and there were no treatment notes provided for the date billed, all of which are required by DMA Clinical Coverage Policy No.: 10A (Respondent's Ex. 2, 19).

17. Ms. Sparano specifically determined that there was no valid physician's order in place for date of service ("DOS") 3/4/11 for Medicaid recipient J.H. The only physician's order in the file was dated 9/13/10, and called for occupational therapy ("OT") one time per week for a period of 12 weeks. Sparano opined that the doctor's order had expired by the 3/4/11 date of service. (Respondent's Ex. 4C, 19).

18. Ms. Sparano found that there was no treatment note at all submitted for Medicaid recipient Y.S. for the 7/26/11 DOS. Petitioner billed Medicaid, and received payment from Medicaid, for that 7/26/11 DOS. (Respondent's Ex. 4D, 19).

19. Ms. Hall determined that there were no signatures of the person(s) providing the service in the treatment notes for Medicaid recipients M.D. (DOS 3/22/11), E.W. (DOS 3/15/11 and 4/26/11)(Respondent's Exs. 4A, 4E, 19), and S.W. (DOS 3/8/11 and 3/15/11) (Respondent's Exs. 5, 7A, 8). In these cases, Hall explained that the therapist who provided a service must document and sign every date of service. (See 21 NCAC 48C .0102l) There was no signature for the dates of services for these recipients. She opined that there was no way to determine which therapist provided the individual date of service if there was no therapist signature after each date of service, even though the therapist's signature was at the bottom of the page underneath a list of several dates of service for recipient M.D.

20. Ms. Hall also found that there was no specific content as to treatment in the plan of care for patient P.D. for DOS 6/30/11, as required by Clinical Coverage Policy 10A, 5.1. (Respondent's Ex. 2, 4B, 19)

21. 21 NCAC 48C .0102(l) requires the physical therapist to document every evaluation and intervention/treatment including, among other things, (1) "[a]authentication (signature and designation) by the physical therapist who performed the service." (Respondent's Ex. 15)

22. Ms. Sparano and Ms. Hall used the audit tools, or questions, in Respondent's Exhibit No. 6, and personally reviewed all records for 101 dates of service in the audit sample in their respective areas of expertise. They created a Summary of Findings chart regarding the documentation errors in Petitioner's records as to each patient and date of service. (Respondent's Exs. 6, 19)

23. After Sparano and Hall completed their audit of Petitioner's claims, CCME's Dr. John Feaganes reviewed the overpayment information for the sample, and determined that it met DMA guidelines for extrapolation. Dr. Feaganes performed a statistical extrapolation to determine the overpayment amount by entering the information into the RATS-STATS statistical computer program. RATS-STATS generated a statistical estimate of the overpayment for the entire universe of Medicaid claims paid to Petitioner for services rendered during the audit period of 3/1/11 through 8/31/11. (Respondent's Ex. 7, 11, 13).

24. At hearing, the undersigned qualified Dr. Feaganes as an expert in statistics. Dr. Feaganes explained that Respondent randomly selected Petitioner for audit from a list of similar providers supplied by DMA, and that a computer randomly selected the sample of 101 claim details for individual dates of service. He opined that a sample of 101 claim details is sufficient to elicit an accurate extrapolation figure for overpayment. To produce a more accurate figure, all of the procedures performed on one patient on one date of service were grouped into clusters based upon the date of service.

25. Feaganes noted that the total universe (or sampling frame size) of claim details submitted by the Petitioner for services rendered during the audit period of 3/1/2011 to 8/31/2011 was 1,928 claim details, grouped into 1,791 clusters. The sample of 101 claim details worked out to be 85 clusters, given that multiple patients had more than one procedure performed on a given date of service.

26. Dr. Feaganes performed three successive calculations of the overpayment for: (1) the Tentative Notice of Overpayment; (2) after CCME's review of the additional records sent in by Petitioner, and (3) following the Hearing Officer's decision. (Respondents Exs. 7, 11, 13)

27. RATS-STATS calculated the final recoupment amount of $1947.00 based on the Hearing Officer's decision. (Respondent's Ex. 13C) Dr. Feaganes opined that $1,947.00 is the "lower limit" or "lower bound" figure for the 90% confidence range. In other words, if Respondent reviewed all of Petitioner's claim details in the universe over the entire audit period, there would be a 5% chance that the resulting overpayment would be less than $1,947.00. On the other hand, if Respondent reviewed all of Petitioner's claim details in the universe over the entire audit period, there would be a 95% chance that the overpayment would actually exceed $1,947.00.

28. Feaganes expounded that by using the lower limit or lower bound figure, between the provider and Respondent, that figure actually favors the provider. Dr. Feaganes opined that this was a statistically valid procedure, and that the $1,947.00 lower limit figure was accurate within a reasonable degree of statistical certainty.

29. Respondent sought recoupment for Medicaid recipient J.H.'s 3/4/11 DOS for a $44.32 overpayment amount, because "no valid physician's order was in place for that date of service," and "no plan of care covering services billed on 3/4/11." (Respondent's Ex. 12, p 3)

30. A preponderance of the evidence showed that the doctor who ordered the therapy services for J.H. signed the plan of care on 9/13/10. (Respondent's Ex. 4C)

a. DMA Clinical Coverage Policy 10A, section 5.1f provides that a plan of care is valid for 6 months after the date of the physician signature. Under that policy, the 9/13/10 order was valid for 6 months until 3/13/11. The Progress Update signed by the physician included a request by the therapist to extend services for an additional 12 weeks. Reading the signed Progress Update in its entirety, the doctor's signature approved all aspects of the update including the 12 week extension of services.

b. In Respondent's 10/12/12 Notice of Decision, the Hearing Officer wrote:

> December 2010 Bulletin shows that the proposed dates the Provider chose to put on the Order do not determine when the order is valid. Rather, the date the order was signed determines the beginning and ending of the dates the Order is valid. . . .

As previously stated, I find that the proposed effective dates to have NO relevance to the actual period the order is valid.

(10/12/12 Notice of the Decision, p 4, Respondent's Ex. 12)

c. In addition, CCME granted prior authorization extensions for J.H.'s plan of care through 3/14/11. DMA Clinical Coverage Policy 10B, section 5.4 "Amount of Service"

states “The amount of service is determined by the prior approval process.” Based on that policy and CCME’s prior authorization extension, J.H.’s 3/4/11 DOS was covered by a valid doctor’s order.

d. Given that the physician’s 9/13/10 order was valid for 6 months per Policy 10A, sec. 5.1f, the Hearing Officer’s determination regarding the signature date, the progress update signed by the physician which included an extension for 12 additional weeks of therapy, and CCME’s extension of J.H.’s plan of care, the preponderance of the evidence established that J.H.’s 3/4/11 DOS was valid and covered by the doctor’s signed order on 9/13/10.

31. DMA Clinical Coverage Policy 10A, section 5.1d provides that “each plan [of care] must include a specific content, frequency, and length of visits of services for each therapeutic discipline.

a. At hearing, Petitioner explained that in the Progress Update, J.H.’s therapist described the frequency of J.H.’s visits would be “1x/week for 12 weeks, Units per visit 4.” She also described the goals, baseline, and progress of the therapy. JH was treated 1x a week for 12 non-consecutive weeks and then discharged.

b. Petitioner explained that J.H.’s therapist thought the doctor’s order was valid for six months, and requested an additional 12 weeks of visits due to J.H.’s inconsistent attendance at his therapy sessions. (See 9/13/10 Progress Note, Respondent’s Ex. 4C) The therapist wrote, “[a]dditional units are requested to work toward more functionality for J and improve the use of his hand for everyday activities.” (Respondent’s Ex. 4C) J.H.’s physician signed the Progress Update, including a request for additional 12 weeks of visits, on 9/13/10. Petitioner further explained that J.H. remained under CCME authorization through 3/13/11. (Petitioner’s testimony)

32. Respondent sought recoupment for $98.36 for recipient Y.S.’s date of service 7/26/11, because there was “no service documentation for services billed on 7/26/11.” (Respondent’s Ex. 12, p 7) A preponderance of the evidence established that Petitioner’s billing administrator made a clerical or typographical error when she keyed in 7/26/11, instead of 7/25/11, as the date of therapy services for recipient Y.S which Petitioner requested Medicaid reimbursement.

a. However, Petitioner’s documentation, i.e. service note, showed that Petitioner conducted therapy services with Y.S. on 7/25/11, not 7/26/11. Y.S.’s invoice for that service note was also dated 7/25/11. Petitioner’s therapist’s invoice for Y.S. for July 2011 also indicated that Petitioner saw Y.S. on July 8, 13, 19, 25.

b. Respondent’s $98.36 recoupment for date of service 7/26/11 was the same amount of reimbursement Petitioner would have received had it correctly billed Respondent for the 7/25/11 date of service. Petitioner did not receive more Medicaid reimbursement than it was entitled, and was not overpaid. (Petitioner’s testimony)

c. In the Notice of Decision, Respondent’s Hearing Officer acknowledged that Petitioner made a clerical error, but explained that she lacked the “authority to pass this issue because the policy does require a service note for each date of service billed.” (Respondent’s Ex. 12)

33. Respondent sought recoupment for Medicaid recipients M.D.'s DOS 3/22/11 (recoupment amount of $98.36), E.W.'s DOS 3/15/11 and 4/25/11 (recoupment amount for each session $96.38), and S.W.'s DOS 4/26/11 (recoupment amount $97.24). Respondent found that "service document does not contain provider's signature" for these DOS.

a. At hearing, Petitioner explained that for each recipient, Petitioner listed several DOS on one page to accommodate financial costs of copying notes for the Child Developmental Service Agency (NC-CDSA) as state budget cuts had disallowed faxing of notes.

b. She noted that while the therapist failed to initial each individual DOS on those pages, all the service documents in question, for each recipient, contained a typed and written signature, along with professional status, by the physical therapist, at the bottom of the page below the lists of dates of service. (Respondent's Exs. 4A, 4E, 5) Respondent reviewed other DOS for that therapist for 5/19, 6/28, 7/14, 7/14, 8/8, 8/25, and 8/25, and approved those DOS. The therapist's usual practice was to initial each DOS, but she just missed initialing the DOS at issue.

34. Respondent sought recoupment for recipient P.D.'s DOS 6/30/11 (recoupment amount of $17.08), because there was no specific content in the plan of care. Petitioner admitted at hearing that she was not contesting Respondent's decision to recoup $17.08 for this DOS. Yet, Petitioner contended that, assuming Respondent erred in upholding recoupment on all other DOS discussed above, the total recoupment amount would only be $17.08. She asserted that applying N.C. Gen. Stat. § 108C-8 to this case, Respondent was not entitled to pursue recoupment of only $17.08.

CONCLUSIONS OF LAW

1. All parties properly are before the Office of Administrative Hearings. This tribunal has jurisdiction of the parties and of the subject matter at issue. To the extent that the Findings of Fact contain Conclusions of Law, or that the Conclusions of Law are Findings of Fact, they should be so considered without regard to the given labels.

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

3. The North Carolina Administrative Code has two provisions titled "Recoupment:" 10A NCAC 22F .0706 and 10A NCAC 22F .0601. 10A NCAC 22F .0706 discusses how the money will be distributed in recoupment of overpayments. 10A NCAC 22F .0601 states "the Medicaid agency will seek full restitution of any and all improper payments made to providers by the Medicaid program." (Emphasis added) However, since the term "improper payments" is not defined in the Code, one may read such term *in pari materi* with other sections to discern the meaning and intent of that term.

4. 10A NCAC 22F .0103 provides:

> [t]he Division shall develop, implement and maintain methods and procedures for preventing, detecting, investigating, reviewing, hearing, referring, reporting, and disposing of cases involving fraud, abuse, error, overutilization or the use of medically unnecessary or medically inappropriate services.

5. In this case, documentation errors are the only misdeeds applicable to this contested case. Respondent has not asserted or alleged that Petitioner was responsible for fraud as defined in N.C. Gen. Stat. § 108A-63, i.e. there is no allegation or assertion that 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. Neither has Respondent made allegations against Petitioner of abuse, overutilization, or using medically unnecessary or inappropriate services.

6. Under 10A NCAC 22F .0103(b)(5), DMA "shall institute methods and procedures to recoup improperly paid claims." 10A NCAC 22F .0606 allows Respondent to use a Disproportionate Stratified Random Sampling Technique in establishing provider overpayments and to determine the total overpayment for recoupment.

7. The North Carolina Administrative Code requires Medicaid providers support reimbursement claims with proper documentation. Petitioner signed 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 and bulletins, which would command proper documentation.

8. 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.

9. 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) . . . , regardless of whether the error was caused by the Provider or the Department and/or its agents.

10. Medicaid Clinical Coverage Policy 10A contains documentation requirements for providing Outpatient Specialized Therapies, which include occupational therapy and physical therapy. Policy 10A states that the records must include the "signature of the person providing each service." DMA Clinical Coverage Policy No. 10A, 7.2f.

11. Policy 10A states, "[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.

12. Policy 10A also states that:

> There 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 Policy 10A, section 5.1f, Respondent's Ex. 12)

13. Policy 10A provides that "[e]ach plan must include a specific content, frequency, and length of visits of services for each therapeutic discipline." (DMA Policy No.: 10A, section 5.1d, Respondent's Ex. 12).

14. Regarding the recoupment for Medicaid recipient J.H., DOS 3/4/11, Respondent failed to prove by a preponderance of the evidence that there was no valid physician's order in place for that date of service. The physician signed the order and Progress Update note for J.H.'s therapy services on 9/13/10. While the Progress Note called for occupational therapy one time per week for a period of 12 weeks, the order was valid for six months according to Policy 10A, Section 5.1f. Additionally, since the Progress Note that the J.H.'s doctor signed included the therapist's request for 12 additional weeks of visits, the doctor's signature on such note constituted approval of that additional treatment period, and therefore, covered treatment provided to J.H. on 3/4/11.

15. Respondent failed to prove by a preponderance of the evidence that there was no plan of care covering J.H.'s DOS for 3/4/11. In the 9/13/10 Progress Update, J.H.'s therapist explicitly described why 12 weeks of additional therapy was requested for J.H. Reading the Progress Update in its entirety, it is clear that the additional therapy would be a continuation of therapy services J.H. had already been authorized to receive, and had received.

16. Regarding recoupment for Medicaid recipient Y.S. DOS 7/26/11, the preponderance of the evidence proved that Petitioner made a typographical error in billing for services to Y.S. on 7/26/11, and that Petitioner actually rendered services to Y.S. on 7/25/11. N.C. Gen. Stat. § 108C-5(o) clearly provides, "The Department shall permit limited correction of clerical, typographical, scrivener's, and computer errors by the provider prior to final determination of any audit." Under N.C. Gen. Stat. § 108C-5(o), Respondent erred in seeking recoupment based on a typographical error.

17. Policy 10A, section 7.2f requires, "the signature of the person providing each service." (Respondent's Ex. 2) Regarding recoupment for Medicaid recipients M.D.'s DOS 3/22/11 (recoupment of $98.36), E.W.'s DOS 3/15/11 and 4/25/11 (recoupment for each session $96.38), and S.W.'s DOS 4/26/11 (recoupment of $97.24), Respondent failed to prove by a preponderance of evidence that each recipient's "service document does not contain provider's signature" in violation of Policy 10A, section 7.2. To the contrary, the evidence showed that for each recipient, the signature of the therapist providing services appeared at the bottom of a page containing a list of DOS for that recipient. Policy 10A did not specify the format a provider must use in meeting the Policy 10A, section 7.2 requirements, and did not require that the "person providing the service" actually initial each DOS as part of the signature requirement.

18. At hearing, Petitioner admitted there was no specific content of treatment in the plan of care for recipient P.D. (DOS 6/30/11). Respondent proved by a preponderance of evidence that Petitioner failed to comply with Policy 10A, section 5.1, and that it was entitled to recoup $17.08 for that provision of services.

19. N.C. Gen. Stat. § 108C-8 provides:

> The Department shall not pursue recovery of Medicaid or Health Choice overpayments owed to the State for any total amount less than one hundred fifty dollars ($150.00) unless directed to do so by the Centers for Medicare and Medicaid Services or unless such recovery would be cost-effective and in the best interest of the State of North Carolina and Medicaid recipients.

20. CCME's initial Tentative Notice of Overpayment to Petitioner could be construed to be a direction to Respondent to recover $17.08 in Medicaid overpayments to Petitioner. However, applying N.C. Gen. Stat. § 108C-8 to this case, and the findings in this decision, Respondent failed to prove that it would be cost-effective, and would be in the best interest of the State of North Carolina and Medicaid recipients for Respondent to pursue $17.08 in Medicaid overpayment from Petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned finds that Respondent's decision to recoup $1,947.00 from Petitioner is **REVERSED**.

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 8th day of July 2013.

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Melissa Owens Lassiter
Administrative Law Judge