STATE OF NORTH CAROLINA

COUNTY OF CUMBERLAND

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
13 DHR 10228

SHERYL A. LYONS, Petitioner, v. NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	)	**FINAL DECISION**

On January 14, 2014, Administrative Law Judge Melissa Owens Lassiter heard this contested case in Fayetteville, North Carolina pursuant to Petitioner's petition for a contested case hearing filed with the Office of Administrative Hearings on March 6, 2013. In such petition, Petitioner appealed Respondent's January 15, 2013 decision to recoupment of $98,333.00 in Medicaid payments paid to Petitioner for providing personal care services to Medicaid recipients.

On January 8, 2014, the undersigned granted partial Summary Judgment for Respondent as Respondent complied with N.C. Gen. Stat. § 108C-5(j) in credentialing PCG's auditors prior to extrapolation. The undersigned granted partial Summary Judgment for Petitioner as Respondent violated N.C. Gen. Stat. § 108C-5(i) by failing to give Petitioner proper notice prior to extrapolation of the results. The undersigned ruled that Respondent could not recoup the extrapolated amount from Petitioner based on the Summary Judgment ruling.

APPEARANCES

For Petitioner: Joy Rhyne Webb
Merritt, Webb, Wilson & Caruso, PLLC
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For Respondent: Brenda Eaddy
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ISSUE

Whether Respondent is entitled to recoup $3555.24 in alleged Medicaid overpayments for personal care services rendered by Petitioner to Medicaid recipients?

APPLICABLE LAW

N.C. Gen. Stat. Chapter 150B, Article 3
N.C. Gen. Stat. Chapter 108C, Articles 1, 2, and 3
10A NCAC 22F.

BURDEN OF PROOF

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

EXHIBITS

For Petitioner: 1-3 & 7

For Respondent: 1, 4, 8-10, 12, 13, 16, 17, 19 & 21

WITNESSES

For Petitioner: Sheryl Lyons

For Respondent: Mary Jane Plowman
Sheryl Lyons

FINDINGS OF FACT

1. Petitioner Sheryl Lyons is the President and owner of The Janice Mae Hawkins Foundation, Inc., d/b/a S & S Associates Home Health Care Agency ("S & S Associates." S & S Associates provides care to North Carolina Medicaid recipients pursuant to a Medicaid Participation Agreement with Respondent's Division of Medical Assistance. S & S Associates provides personal care services (PCS) to its clients, including Medicaid recipients, in their homes. Beneficiary eligibility and provider responsibilities for payment for PCS are located in Medicaid Clinical Coverage Policy 3C.

2. Respondent's Division of Medical Assistance (hereinafter referred to as "DMA") operates the North Carolina Medicaid program, including conducting post-payment reviews of Medicaid services under 42 CFR §§ 544 *et.seq.* and 10A NCAC 22F.

3. In a PCS post-payment review audit, Respondent reviews the provider's records and documentation to determine whether the provider requested payment for services rendered pursuant to the duties, obligations, and responsibilities contained in Clinical Coverage Policy 3C.

4. By letter dated September 15, 2011, Respondent notified Petitioner that S & S Associates was the subject of a post-payment review audit by DMA's agent, PCG. Respondent audited PCS claims of Medicaid services provided by Petitioner for dates between January 1, 2009 and June 30, 2010 (the "Audit Period"). Respondent reviewed a random sample of 101 PCS claims during the Audit Period submitted by Petitioner. (Pet Exh 1)

5. By follow-up letter dated September 11, 2012, Respondent notified Petitioner that it had not received the requested records from S & S Associates, and requested S & S Associates provide such records to PCG so that it could conduct the post-payment review audit. (Pet Exh 2)

6. Petitioner received a Tentative Notice of Overpayment ("TNO"), dated October 5, 2012, informing Petitioner that PCG had tentatively identified the total amount of improperly paid claims in the sample to be $3,555.24, and that PCG had extrapolated those results to determine that the total Medicaid overpayment amount that S & S Associates had received was $125,365.00. The overpayment was based on PCG's review of 101 claims paid to S & S Associates.

7. By letter dated October 12, 2012, Petitioner requested a reconsideration of the TNO overpayment amounts. On December 3, 2012, Respondent's Hearing Officer Alison Weatherman conducted a reconsideration review hearing.

8. On January 15, 2013, Respondent's Hearing Officer issued a Notice of Decision, upholding PCG's recommendations, but modifying the total Medicaid recoupment amount from $125,365.00 to $98,333.00. (Resp Exh 12)

9. Petitioner did not submit any revised claims or new documentation to Respondent after the Hearing Officer's Reconsideration Review Decision.

10. Before all OAH hearings, Respondent reviews its findings and updates them to reflect currently existing policy and procedure. If during that review, claims that were at one time deemed to be out-of-compliance, now pass review due to existing policy, Respondent credits the overpayment amount for that claim to Petitioner, and no longer considers that claim in error.

11. Mary Jane Plowman is a Registered Nurse and the appeal team lead at PCG who performed the audit in this case for DMA. Ms. Plowman reviewed this case before the OAH hearing to make sure she agreed with the Notice of Decision by Alison Weatherman, and to determine if any new guidance may have been provided by DMA that would change the results of the decision.

12. Following her review of this case, Plowman prepared a Revised Summary Report, dated December 18, 2013. (Resp Exh 13) Plowman identified the following types of errors in her report:

a. Ordered tasks not being performed by Nurse Aides;
b. Invalid PACT forms due to Assessments not being completed timely;
c. No PACT form submitted for review;

d. Providing PCS to beneficiaries who do not qualify for the service;
e. Providing PCS without a physician's order;
f. Invalid PACT forms due to not obtaining the physician's signature in a timely manner;
g. Providing PCS tasks not ordered by the physician;
h. Providing PCS on days not ordered by the physician; and,
i. Plan of Care not matching the assessed needs of the beneficiary.

13. At hearing, Respondent acknowledged that it did not provide the Revised Summary Report to Petitioner before this contested case hearing. Ms. Plowman opined that if the provider submitted documentation, following the Notice of Decision, which refuted the reason for seeking recoupment, then she could reverse the recoupment decision on that item, and could also find new reasons in her subsequent audit to find recoupment due. In such cases, the provider would not be provided an opportunity to rebut any new alleged reasons for the claimed recoupment.

14. On the Notice of Decision, Respondent found 5/11/09, 5/22/09, 6/16/09, 7/23/09 and 2/23/10 Dates of Service for recipient Sonya Barkley out of compliance because the PACT form dated 4/26/2010 did not cover the Dates of Service.

15. However, on November 21, 2012, Petitioner sent a PACT form dated 4/21/09 to Hearing Officer Weatherman, which covered the Dates of Service at issue, and such a 4/21/09 PACT form was included in the documents of Respondent's Exhibit 19. Once the 4/21/09 PACT form was located, Respondent's reason for finding a recoupment of these claims, no longer existed. (Resp Exh 9, 10)

16. Respondent sought recoupment for services rendered to Sonya Barkley for two additional reasons. First, the RN, Sheryl Lyons, scored ambulation and feeding as 0/0 on the PACT form, but assigned 60 minutes to the plan of care for those services. Second, while Petitioner scored dressing as 3/2 and checked dressing as a need, she failed to list any actual dressing duties on the plan of care.

17. Plowman further explained that when the RN assessment does not address a need, and yet it is provided, then there is a complete recoupment for that Date of Service. Ms. Plowman claimed this was the case regarding Sonya Barkley, even if there were other services provided that had been correctly identified and performed for the particular date in question.

18. Clinical Coverage Policy 3C Section 7.7 states "Medicaid payment for in-home aide services is limited to the tasks identified on the plan of care." Plowman did not cite a section in the Clinical Coverage Policy 3C supporting her position that when the RN assessment does not address a need, and yet Petitioner provides for that need, then Respondent is entitled to a complete recoupment for the Date of Service.

19. Plowman noted that not all items on the Plan of Care for Sonya Barkley were performed on 6/16/09, 7/23/09, and 2/23/10. However, she acknowledged, that S & S Associates did not bill for the full amount of hours listed on the Plan of Care for Sonya Barkley.

20. Neither did Plowman identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Sonya Barkley.

21. At hearing, Plowman changed the alleged recoupments for client Frances Davis to a full pass, and stated that no overpayments were due from S & S Associates for the Dates of Service for Frances Davis of 3/14/09, 3/17/09, 5/5/09, and 6/24/09.

22. For client Denise Elliott, Respondent sought recoupment for Dates of Service 7/3/09, 7/28/09, 10/12/09, and 10/22/09 because Petitioner billed for services provided on those Dates of Services, even though Petitioner failed to check off that any activities of daily living tasks were performed for those Dates of Service. Plowman asserted that she could only look to the Date of Service selected for the audit, and could not look at the rest of the days in that week to see if all tasks on the Plan of Care for the week were completed. She did not look at the weekly ratio of activities of daily living (ADLs) tasks performed in relation to the number of incidental activities of daily living tasks (IADLs) performed.

23. Ms. Plowman acknowledged that Attachment F in Clinical Coverage Policy 3C requires that services provided must be directly related to the condition of the client, but did not provide any reference for how this makes all services rendered on the dates in question subject to recoupment.

24. DMA's Frequently Asked Questions, dated 7/31/2007, included the following question:

> On a particular day documented on the POC, can IADL time exceed ADL time? Answer: Yes, so long as ADL time exceeds IADL time on a weekly basis. See *Policy #5.7.*

(Pet Exh 7, p. 2)

25. Plowman opined that because client Denise Elliott's prior PACT form was dated October 30, 2008, she needed a new PACT form completed by October 30, 2009. Plowman claimed that because a new PACT form was not signed within 60 days of the assessment, the payments made for services rendered on 11/17/09, 12/3/09, 12/16/09, 12/24/09 and 1/21/10 should be recouped. However, DMA's Frequently Asked Questions dated 7/31/2007, stated:

> [i]f you have a verbal order to start the services after the assessment you can certainly start. If your PACT is not signed within 60 days, you are at risk of noncompliance from day 61 till the day it is signed.

(Pet Exh 7, p. 3) The only Date of Service for client Diane Elliott that was after day 60 was the 1/21/10 date.

26. Ms. Plowman did not identify an exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Denise Elliott.

27. Plowman noted that no PACT form covered the Dates of Service for client Kenesha Evrard for 10/14/09, 10/28/09, and 12/11/09. However, the information provided by Petitioner in Respondent's Exhibit 9 showed that Kenesha Evrard's physician had ordered personal care services for her.

28. Ms. Plowman did not identify an exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Kenesha Evrard.

29. Ms. Plowman explained that documentation for client Louise Hicks lacked two unmet activities of daily living for which she required assistance, and did not meet the criteria for personal care services for Dates of Service 8/17/09, 8/19/09, 8/31/09, 9/24/09, 12/7/09, 1/8/10, 1/18/10, 2/5/10, and 3/5/10. However, Louise Hicks' physician signed the PACT form indicating that Hicks needed PCS services. Petitioner provided evidence (Respondent's Exhibit 10) that Louise Hicks did have two unmet activities of daily living for which she required assistance, but RN Sheryl Lyons had incorrectly completed the PACT form due to her inexperience with completing PACT forms.

30. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Louise Hicks.

31. Respondent sought recoupment for Date of Service 12/18/09 for client Easter Hill, because there were no activities of daily living checked on the nurse aide log for that Date of Service. Ms. Plowman did not look to see if the ADL time exceeded the IADL time for the week.

32. Respondent sought recoupment for client Easter Hill's Date of Service 2/11/10, because there was no PACT form in place authorizing services within 60 days from the order initiating services. However, there was a PACT form dated 1/5/10 that was signed by Ms. Hill's physician on 4/23/10. Ms. Hill's doctor issued a verbal order. According to the above-cited DMA's Frequently Answered Questions, verbal orders were allowed. Since the 2/11/10 Date of Service was within the first 60 days of the verbal order, Petitioner is entitled to payment for that Date of Service.

33. Plowman did not offer any testimony supporting the reasons Respondent based its recoupment action for services rendered to client Easter Hill on Dates of Service 2/6/09, 3/4/09, and 4/21/09. In the Notice of Decision, Hearing Officer Weatherman upheld recoupment for those Dates of Service, as "plan of care does not match RN assessment." (Resp Exh 12, p 5)

34. Plowman did not identify an exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Easter Hill.

35. Ms. Plowman opined that Petitioner had not checked, on the aide log for client Annie Humphrey, that tasks #19, #23, and #24 were performed on Dates of Service of 2/20/09 and 4/16/09, and that a 6-unit recoupment for each Date of Service was appropriate. However,

Ms. Plowman did not consider that the aide did not bill for the fully allotted time on the Plan of Care for these Dates of Service.

36. Neither did Ms. Plowman identify an exact monetary amount of recoupment Respondent was seeking from Petitioner for services provided for client Annie Humphrey.

37. Plowman explained that recoupment was proper for client Lisa Martinez for Dates of Service on 2/24/09, 3/18/09, 4/22/09, 5/26/09, 6/15/09, 6/24/09, 7/8/09, 8/21/09, 10/5/09, 10/12/09, 12/23/09, 1/18/10, 1/22/10, 2/2/10, 2/25/10, 4/8/10, and 5/7/10, because the PACT forms submitted, dated 9/5/08 and 9/4/09, were both incomplete and missing pages.

38. Yet, Ms. Plowman's explanation why recoupment was proper for Martinez is a different reason than the reason Hearing Officer Weatherman upheld recoupment for services provided to Martinez. Weatherman upheld recoupment for client Martinez because the doctor's signature on the PACT order was more than 60 days from the date of order for assessment.

39. Ms. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Lisa Martinez.

40. Plowman opined that for client DaShonna McDougald, Dates of Service on 10/19/09 and 11/13/09, task #19 was allocated 30 minutes on the plan, but task #19 was not identified as a client need on the PACT form, and the aide log did not show that task #19 was performed for the client. However, this reason was not the reason for the alleged overpayment in Notice of Decision by Hearing Officer Weatherman. Additionally, there was no evidence presented that Petitioner was paid for 2 units of time (30 minutes) for Task #19. The documentation showed that Petitioner was allowed to bill for 12 units of services (or 3 hours, 45 minutes) provided to this client, yet Petitioner only billed Respondent for 45 minutes of services.

41. Ms. Plowman did not identify an exact amount of recoupment Respondent was seeking from Petitioner for services provided for client DaShonna McDougald.

42. Ms. Plowman claimed Respondent was entitled to recoup 6 units of services for client Estelle McMillan for 8/12/09 Date of Service, because tasks #22, #23, and #24 were not documented on the aide log. Documentation showed the nurse aide did not work for the full amount of approved time on 8/12/09. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Estelle McMillan.

43. Plowman explained that Respondent sought recoupment for client Eurina McPherson, on Date of Service 11/8/09, because that day was a Sunday and services were not authorized for this client on the weekends. She also noted that the services provided on 3/27/10 and 5/15/10 were on Saturdays, and the services provided on 6/6/10 was on a Sunday.

44. Section 7.10 of Clinical Care Policy 3C provides that if the PCS In-Home Aide Service Log does not reflect the plan of care, the reason for this discrepancy must be documented in the recipient's record. However, Section 7.10 of Clinical Care Policy 3C does not state that

failure to so document this discrepancy will result in recoupment of all amounts paid for the services provided.

45. At no time, however, did the services provided by S & S Associates Home Health Care Agency exceed the weekly totals approved by Eurina McPherson's physician.

46. The reason Plowman gave for seeking recoupment does not match the reason Hearing Officer Weatherman gave in the Notice of Decision. Weatherman upheld recoupment for each date of service listed for client McPherson, because the "plan of care does not match RN assessment." The plan of care and PACT form support Weatherman's findings, but there was no testimony presented at hearing regarding that finding.

47. Plowman further explained that Petitioner's aide Elaine Lyons provided services for client Eurina McPherson on 2/26/10 and 3/17/10, but Petitioner failed to provide credentials for aide Lyons. However, this was not the reason given for the alleged overpayment in Notice of Decision by Hearing Officer Alison Weatherman.

48. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Eurina McPherson.

49. Plowman opined that for client Skylar Moultrie-Lewis, Dates of Service on 4/14/09, 5/6/09, 5/12/09, 6/14/09, 7/13/09, 7/31/09, 8/4/09, 8/16/09, 9/3/09, 11/18/09, 1/31/10, 5/18/10, 5/11/10, 5/26/10, 6/13/10, and 6/28/10, Task #20 was not completed in the aide log, so 2 units recoupment was appropriate. However, the aide did not work for the full number of allotted hours on any of these days, so there was no evidence presented by Respondent that time to complete Task #20 was actually billed on any of these Dates of Service.

50. Plowman also noted for recoupment was proper for client Skylar Moultrie-Lewis, as each Date of Service 6/14/09, 08/16/09, 1/31/10 and 6/13/10, was on a Sunday, and the client was only authorized to receive personal care services Monday through Friday.

51. At no time, however, did the services provided by S & S Associates Home Health Care Agency exceed the weekly totals approved by Skylar Moultrie-Lewis' physician.

52. Plowman also indicated that a new PACT form was prepared for client Skylar Moultrie-Lewis on 1/1/10, but was not signed by her physician until 4/26/10. However, Sheryl Lyons noted on the PACT form that she had received a doctor's verbal order for services for this client on 1/1/10. The client's doctor signed a Medical Order form on 3/11/10, and signed the PACT on 4/26/10.

53. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Skylar Moultrie-Lewis.

54. For patient Amos Shaw, Plowman explained that there was nothing checked on Task #25 and Task #27 on the PACT form, but 1 unit of time was allotted to each of these tasks on the plan of care. Therefore, Plowman claimed that two units should have been recouped for

each of these tasks for the 4-9-09 and 9-25-09 Dates of Service. However, on 4-9-09, the aide log shows that multiple items under Tasks #25 and #27 were performed for patient Amos Smith. The aide log for 9-25-09 also shows multiple items under Tasks #25 and #27 were performed. Amos Smith's physician certified that he needed PCS services for both of these tasks.

55. Plowman also asserted that Task #19 was not completed for the 4-9-09 and 9-25-09 Dates of Service for patient Amos Smith. However, the aide logs showed that assisting with toilet and bed/sponge bath were checked, which would involve transferring the patient, for the 4-9-09 Date of Service. For the 9-25-09 Date of Service for Amos Smith, turn/position was checked on the aide log, which is an item under Task #19. In addition, bed/sponge bath was checked as was PT/Exercises for the 9-25-09 Date of Service.

56. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Amos Smith.

57. Plowman explained that no recoupment was due for patient Jenna Smith from S & S Associates Home Health Care Agency for the 12-2-09 Date of Service.

58. Plowman opined that for client Earnest Williams, Dates of Service 11/3/09, 11/10/09, and 5/2/10, he lacked two unmet activities of daily living for which he required assistance, and did not meet the criteria for personal care services. Plowman admitted that Earnest Williams' physician had signed the PACT form, and indicated that he needed PCS services.

59. Ms. Plowman did not identify the exact amount of recoupment Respondent was seeking from Petitioner for services provided for client Earnest Williams.

60. Plowman admitted that the standard for whether recoupment is due from a Medicaid Provider is not zero error, but that substantial compliance with the laws, regulations and policies is what is required.

61. Respondent did not present testimony of the exact monetary amounts of recoupment it alleged was due from S & S Home Health Care Agency.

62. After the hearing, Respondent filed a Motion for Reconsideration of Partial Summary Judgment based on the grounds that the undersigned had ruled differently on the same extrapolation issue in another Medicaid case. Petitioner filed a response objecting to such reconsideration.

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings as the Office of Administrative Hearings has jurisdiction over the parties and the subject matter pursuant to Chapters 108C and 150B of the North Carolina General Statutes. To the extent, 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 is the single State agency responsible for administering North Carolina's program of Medical Assistance ("the Medicaid program"). N.C. Gen. Stat. §§ 108-25(b), 108A-54. Respondent's Program Integrity unit and its authorized agents, Public Consulting Group (PCG), conduct post-payment reviews of paid Medicaid claims to identify program abuse and overpayments in accordance with 42 USC § 1396a, 42 CFR 455 & 456, and 10A NCAC 22F.

3. N.C. Gen. Stat. §108C-12 requires this tribunal to issue a final agency decision within 180 days of the date of filing of the contested case petition. "The time to make a final decision shall be extended in the event of delays caused or requested by the Department."

4. Because Respondent requested continuances in these cases, and did not object to Petitioner's request for continuances in order to address discovery issues, the time for making the final agency decision was extended both as a result of and at the request of the Agency. Under N.C. Gen. Stat. § 108C-12 this final decision is timely.

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

6. Respondent's Motion for Reconsideration is hereby Denied.

7. 10 NCAC 22F .0103 states in part:

> The 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.

8. 10 NCAC 22F .0402 provides that:

> Upon notification of a tentative decision, the provider will be offered, in writing, by certified mail, the opportunity for a reconsideration of the tentative decision and the reasons thereof.

9. In this case, there are no allegations that Petitioner committed any fraud.

10. Petitioner was not given an opportunity prior to the hearing in this case to refute many of the reasons given by Respondent to justify recoupment, as Respondent changed its purported reasons once Petitioner presented evidence to refute the reasons outlined in the Tentative Notice of Overpayment. Respondent's failure to provide Petitioner with an opportunity to address the alleged reasons it contends Petitioner was overpaid was in violation of 10 NCAC 22F .0402.

11. Respondent failed to meet its burden of proof to establish that Petitioner did not substantially comply with applicable laws, rules, and policies.

12. Respondent failed to meet its burden of proving that full recoupment was due from Petitioner for a Date of Service when the RN assessment did not address a need that was provided.

13. Respondent failed to meet its burden of proving that full recoupment was due from Petitioner for a Date of Service when the IADL time exceeded ADL time for that specific date.

14. Respondent failed to meet its burden of proving that full recoupment was due from Petitioner for services it provided under a physician's order that was entered 60 days after the PACT form was completed.

15. Respondent failed to meet its burden of proving that full recoupment was due from Petitioner for services it provided if the aide log was different from the Plan of Care, and the reason for the discrepancy was not documented.

16. Respondent failed to establish the amount of recoupment it sought. Respondent has failed to meet its burden of proving that Petitioner was overpaid in the amount of $3,555.24.

17. 10A NCAC 22F .0302(c) states that, when conducting an audit of a Medicaid provider:

> The Division shall review the findings, conclusions, and recommendations and make a tentative decision for disposition of the case from among the following administrative actions:
>
> (1) To place provider on probation with terms and conditions for continued participation in the program.
> (2) To recover in full any improper provider payments.
> (3) To negotiate a financial settlement with the provider.
> (4) To impose remedial measures to include a monitoring program of the provider's Medicaid practice terminating with a "follow-up" review to ensure corrective measures have been introduced.
> (5) To issue a warning letter notifying the provider that he must not continue his aberrant practices or her will be subject to further division actions.
> (6) To recommend suspension or termination.

18. Respondent provided no testimony or evidence to show that either PCG, as Respondent's agent, or Respondent DMA reviewed PCG's findings and made a determination regarding whether recoupment would be the appropriate administrative action.

19. Respondent acted contrary to rule and failed to use proper procedure by not providing evidence or testimony that it reviewed the tentative findings to determine the

appropriate administrative action that should have been taken as required by 10A NCAC 22F .0302.

20. Respondent has substantially prejudiced Petitioner's rights by attempting to recoup funds from Petitioner for reasons it had not disclosed prior to the hearing, denied Petitioner the opportunity to effectively refute such reasoning, violated 10 NCAC 22F .0402, and denied Petitioner its full due process rights.

FINAL DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the undersigned hereby **REVERSES** Respondent's decision to recoup $3,555.24 from Petitioner.

NOTICE

Under the provisions of N.C. Gen. Stat. §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 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 26 N.C. Admin. Code 03.012, and the Rule of Civil Procedure, N.C. Gen. Stat. §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 the 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 Hearing at the time the appeal is initiated in order to ensure the timely filing of the record.

This 12th day of May, 2014.

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Melissa Owens Lassiter
Administrative Law Judge