STATE OF NORTH CAROLINA

COUNTY OF GRANVILLE

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
13 DHR 12504

Extending Hands Health Care Services, LLC

Petitioner,

v.

N.C. Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA),Public Consulting Group (PCG)

Respondent.

FINAL DECISION

THIS CAUSE came on for hearing before the undersigned Administrative Law Judge, Craig Croom, on February 10, 2014 in Raleigh, North Carolina.

APPEARANCES

For Petitioner: John Watson Jr., Esq.
Attorney at Law
P.O. Box 100
Oxford, NC 27565

For Respondent: Katherine M. McCraw, Esq.
Assistant Attorney General
N.C. Dept. of Justice
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ISSUE

Whether the North Carolina Department of Health and Human Services ("DHHS"), Division of Medical Assistance through its contractor Public Consulting Group (PCG) correctly determined that Petitioner Extending Hands Health Care Services, LLC had received an overpayment of $6,350.00 based upon improperly documented claims submitted to the North Carolina Medicaid program.

JURSIDICTION

As stipulated by the parties: This matter is in the appropriate form and venue. The matter was filed in a timely and appropriate fashion. All parties necessary are joined, and there is no question as to misjoinder or nonjoinder of parties.

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.G.S. § 108A-54.2 and 54.3
N.C.G.S. § 108C
N.C. State Plan for Medical Assistance
DMA Clinical Coverage Policy 3C (revised 4/1/10)
DMA Clinical Coverage Policy 3C (revised 8/1/07)
DMA Clinical Coverage Policy 3E (revised 6/1/11)

BURDEN OF PROOF

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

DOCUMENTARY EVIDENCE

Prior to the hearing, the parties stipulated as to authenticity and admissibility of the following documentary evidence. All of the following documents were accepted and admitted into evidence.

For Respondent:

1. Petitioner's Medicaid Provider Participation Agreement.
2. Screenshots of RAT-STATS processing tool for sampling.
3. Initial Records Request Letter dated 8/3/12.
4. Summary of paid amounts and pass/fail designation.
5. Screenshots of RAT-STATS processing tool for extrapolation. (illustrative purposes only)
6. RAT-STATS Stratified Variable Appraisal Audit/Review dated 10/19/12.
7. Tentative Notice of Overpayment 10/20/12.
8. Audit tool sample. (illustrative purposes only)

9. Hearing Officer's Decision dated 3/18/13.
10. Revised Provider Summary Report dated 1/31/14.
11. Summary of paid amounts and pass/fail designation.
12. RATS-STATS Stratified Variable Appraisal Audit/Review dated 1/31/14.
13. DMA Clinical Coverage Policy 3C, 3E.
14. Index of Recipient Medical Records with page numbers.
15. Copies of records submitted by Petitioner for all remaining non-compliant claims and corresponding audit tools.
16. CV for Michael Jiroutek, DrPH.
17. Illustrative diagrams prepared by Dr. Jiroutek. (illustrative purposes only)
18. Resume and credentialing information for Allison Howard.
19. Resume of Patrice Graham.
20. Sample size determination

For Petitioner:

None.

WITNESSES

Patrice Graham, Financial Analyst PCG;
Allison Howard, Registered Nurse, Clinical Nurse Reviewer, PCG;

EXPERT WITNESSES

The Court determined that Dr. Michael Jiroutek, DrPH possessed the scientific, technical and/or other specialized knowledge to assist the trier of fact to understand the evidence or to determine a fact in issue; and by virtue of the knowledge, skill, experience, training or education of Dr. Jiroutek, the Court accepted him as an expert in the field of statistics pursuant to Rule 702 of the North Carolina Rules of Evidence.

BASED UPON the Court's careful consideration of the sworn testimony of the witnesses presented at the hearing, the documentary evidence, and the entire record in this proceeding, the Undersigned Administrative Law Judge makes the following findings of fact and conclusions of law. 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.

FINDINGS OF FACT

1. At all times material to this matter, Petitioner Extending Hands Health Care Services, LLC was an enrolled provider in the North Carolina Medicaid Program. Petitioner entered into a North Carolina Medicaid Participation Agreement with the DMA to participate in this program. (Respondent's Ex. 1).

2. By entering into the Medicaid Participation Agreement, Petitioner agreed to "comply with federal and state laws, regulations and state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement." (Respondent's Ex. 1, Agreement dated 12/12/06 at 1). Petitioner agreed to maintain records for a period of five (5) years from the date of service (b) records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program…Such records are subject to audit and review by Federal and State representatives." (Respondent's Ex. 1, Agreement dated 12/12/06 at 1).

3. This matter involves an audit of Petitioner conducted by DMA, through its post-payment review contractor, Public Consulting Group (PCG). Pursuant to a contract with DMA, PCG conducted post-payment audits of Medicaid providers, including the audit of Petitioner that is the subject of the Petition.

4. The audit was conducted by review specialists for PCG. PCG's specialists examined Provider's paid Medicaid claims for the audit period, July 1, 2010 through July 31, 2011. PCG examined a random sampling of Petitioner's claims relating to Personal Care Services.

5. The audit revealed Petitioner's non-compliance with the documentation standards set forth in DMA Clinical Coverage Policy 3C Personal Care Services, DMA Clinical Coverage Policy 3C Personal Care Services and PCS-Plus, and DMA Clinical Coverage Policy 3E In-Home Care for Adults (Respondent's Ex. 13A, 13B and 13C).

6. As a result of the audit, PCG identified an overpayment to Provider of $719,455.00. By letter dated October 20, 2012 PCG notified Provider of this overpayment. (Respondent's Ex. 7).

7. The Provider requested a reconsideration review by the DHHS Hearing Office. Along with the request, the Provider sent additional documentation relating to the audited claims.

8. The reconsideration review took place on December 12, 2012. Following the review, the DHHS Hearing Office issued a Notice of Decision dated March 18, 2013. (Respondent's Ex. 9.) Petitioner was notified of the Notice of Decision via certified mail. *Id*. The Notice of Decision found and recommended an overpayment (recoupment amount) of $15,799.00. *Id* at 6.

9. DMA Clinical Coverage Policy 3C Personal Care Services, and DMA Clinical Coverage Policy 3C Personal Care Services and PCS-Plus, and DMA Clinical Coverage Policy 3E In-Home Care for Adults are properly promulgated medical coverage policies. (Respondent's Ex.

13A, 13B and 13C). These policies were in effect at the time that the services examined by the audit were rendered.

10. In certain instance, the documentation reviewed by PCG showed that Petitioner billed for, but failed to document performance of an Activity of Daily Living (ADL), such ADL being required to be performed under the Plan of Care and ordered to be provided by the treating Physician, as required by DMA Clinical Coverage Policy 3C, v. April 1, 2010-Section 7.10.2(h.1,2,3,6), p. 16. (Respondent's Ex. 13B).

11. In a certain instance, the documentation reviewed by PCG evidenced that Petitioner, billed for, but failed to document performance of, services on a specific date of service as the Recipient was in the hospital on the date of service, in violation of DMA Clinical Coverage Policy 3C; v. August 1, 2007 – Section 7.10a, p. 16; Attachment A, Section E, p.22,; and DMA Clinical Coverage Policy 3C, v. April 1, 2010-Section 4.19(e), p.5 (Respondent's Ex. 13 A and 13B).

12. PCG's audit findings are indicated in a Provider Summary. (Respondent's Ex. 10) The Provider Summary shows the case identification, the recipient name, the date of service, the paid amount, the overpaid amount, and whether each claim (date of service) is compliant or noncompliant with the applicable Clinical Coverage Policy.

13. Allison Howard, Respondent's witness, is a registered nurse and clinical reviewer with PCG who conducted the audit and reviewed the Provider's records for each date of service remaining out of compliance. Her opinions were summarized on the audit tools in Exhibit 15 and the Provider Summary, Exhibit 10. Ms. Howard identified various dates of service and their documentation requirements and explained why each date of service failed to comply with Clinical Coverage Policies.

14. Petitioner's owner, Vernita Parker, conceded that the Provider had not complied with the Clinical Coverage Policies for all dates of service remaining out of compliance which amounted to an overpayment without extrapolation of $88.50.

15. The claims for which payments were made to Petitioner, as indicated in the Provider Summary (Respondent's Ex. 10) were not in substantial compliance with the documentation requirements of DMA Policy 3C and 3E. Such payments were improper payments from the Medicaid program to the Provider.

16. Patrice Graham is a Financial Analyst with PCG. Petitioner was selected for audit by DMA.

17. The total universe (or frame size) of claim details for the audit period was 18,725. (Respondent's Ex. 6, 12 and 20)

18. The claims in the universe were stratified by paid amounts into two strata. PCG used RAT STATS to perform a sample size determination. The RAT STATS Program indicated that a valid sample for review at 95% confidence level would be 8 for strata 1 and 13 for strata 2. The sample size of 100 claims was selected per DMA guidelines to use 30 in each stratum and 100 total

claims. The sample size of 100 claims was selected at random via an excel program by matching the numbered claims in the universe of claims with the RAT STATS random number generator.

19. Dr. Michael Jiroutek, a statistical expert employed by PCG, was accepted as an expert witness in the field of statistics.

20. Dr. Jiroutek established that the computer process using excel and the RAT STATS random number generator utilized by PCG to determine the sample size of 100 claims was a statistically valid and reliable process.

21. Dr. Jiroutek established that a sample of 100 claims is sufficient to elicit an accurate extrapolation and reliable figure for overpayment based on a universe of 18,725.

22. Dr. Jiroutek established that PCG used a Stratified Random Sampling Technique in determining provider overpayments and the total overpayment for recoupment.

23. Upon completion of the audit by the clinician, the overpayment information for the sample was reviewed, and it was determined that the audit met DMA guidelines for extrapolation. The audit results were entered into the RATS-STATS statistical computer program, which then generated a statistical estimate of the overpayment for the entire universe of claims during the audit period. (Respondent's Exs. 6 and 12).

24. The revised overpayment calculated by RATS-STATS and now sought by DMA is $6,350.00. This number is shown on the RAT-STATS output as the lower limit at the 90 percent confidence level. (Respondent's Ex. 12.)

25. Dr. Jiroutek established that PCG's use of RAT STATS was a statistically valid and reliable procedure to extrapolate its audit findings and was correctly performed.

26. Dr. Jiroutek established that PCG used a Stratified Random Sampling Technique in determining provider overpayments and the total overpayment for recoupment.

27. The revised overpayment calculated by RATS-STATS and now sought by DMA is $6,350.00 and that this number is the lower limit at the 90 percent confidence level as shown on the RAT STATS appraisal report. (Respondent's Ex. 12.)

28. Dr. Jiroutek established that $6,350.00 is the "lower limit" or "lower bound" figure for the 90% confidence range. He further opined that if all of the claim details in the universe for this audit period had been examined, there is a 95% chance that the actual overpayment owed would be greater than $6,350.00. (Respondent's Ex. 12.)

29. Dr. Jiroutek established that PCG used a statistically valid and reliable procedure in selecting a random sample of claims to be audited and that PCG used a statistically valid and reliable procedure in extrapolating the audit results across the universe of claims. He was 95% sure that the $6350.00 lower limit figure was lower than the actual overpayment amount owed.

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings. 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 federal and state laws, regulations and state reimbursement plan and policies governing the services authorized under the Medicaid Program and this agreement," and to "maintain records for a period of five (5) years from the date of service.., (b) records as necessary to disclose and document fully the nature and extent of services provided and billed to the Medicaid Program…Such records are subject to audit and review by Federal and State representatives."

7. DMA Clinical Coverage Policy 3C Personal Care Services, DMA Clinical Coverage Policy 3C Personal Care Services and PCS-Plus, and DMA Clinical Coverage Policy 3E In-Home Care for Adults (Respondent's Ex. 13A, 13B and 13C), were adopted according to the procedures set forth in N.C.G.S. § 108A-54.2 and 54.3.

8. DMA Clinical Coverage Policy 3C, v. April 1, 2010-Section7.10.2 (h.1,2,3,6), p. 16 (Respondent's Ex. 13b) requires that if an ADL is stated as a need to be performed under the Plan of Care and ordered to be provided by the treating Physician, it must be implemented and documented.

9. DMA Clinical Coverage Policy 3C, v. August 1, 2007 – Section 7.10a, p. 16; Attachment A, Section E, p.22; and DMA Clinical Coverage Policy 3C, v. April 1, 2010-Section 4.19(e), p.5 requires that all tasks assigned on the Plan of Care and authorized by the Physician, be performed at the recipients residence and cannot be billed unless performed.

10. Respondent met its burden of showing by a preponderance of the evidence that DMA's identification of the improper overpayments was proper. Respondent likewise met its burden of showing by a preponderance of the evidence that DMA's subsequent action to recoup such overpayment amount was proper.

11. Petitioner failed to meet the minimum documentation standards set forth in DMA Clinical Coverage Policy No. 3C and 3E as summarized in the Provider Summary (Respondent's Ex. 10) and the Audit Tools (Respondent's Ex. 15).

12. The procedures employed by PCG to select a random sample of 100 claims from the universe of claims for the audit period were valid, proper and sound to a reasonable degree of statistical certainty.

13. The procedures employed by PCG to perform statistical extrapolation for the universe of claims, based on the audited claims, were valid, proper and sound to a reasonable degree of statistical certainty.

14. 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 to Provider in the amount of $6,350.00.

BASED UPON the foregoing Findings of Fact and Conclusions of Law, the undersigned makes the following:

DECISION

The Court hereby finds that Respondent, North Carolina Department of Health and Human Services, LLC properly determined that Petitioner, Extending Hands Health Care Services, LLC received an overpayment of $6,350.00 and properly determined that this amount should be recouped from the Petitioner. The Respondent is therefore awarded a judgment of $6350.00 against the Petitioner.

NOTICE

This is a Final Decision issued under the authority of N.C. Gen. Stat. § 150B-34.

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 the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the final decision was filed. **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 03.0102, 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 28th day of April, 2014.

IT IS SO ORDERED.

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Craig Croom
Administrative Law Judge