STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
13 DHR 15135

JABEZ HOME INFUSION COMPANY SERVICES, Petitioner, v. N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Respondent.	)	**FINAL DECISION**

THIS CAUSE came on for hearing before the undersigned Administrative Law Judge, Craig Croom, on May 1-2, 2014 in Raleigh, North Carolina.

APPEARANCES

For Petitioner: Robert Leandro, Esq.
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For Respondent: Michael T. Wood, Esq.
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ISSUE

Whether the North Carolina Department of Health and Human Services correctly determined that Petitioner received an overpayment from Medicaid in the amount of $245,470.63, based on an audit of paid Medicaid claims relating to Home Infusion Therapy ("HIT")?

JURISDICTION

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.*
N.C. State Plan for Medical Assistance

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. Clinical Coverage Policy 3H-1 (rev. 8/1/2007)
2. Medicaid Bulletin Feb. 2008
3. DMA Vendor Introductory Letter to Jabez (10/2/2012)
4. PCG letter to Jabez (10/2/2012)
6. Tentative Notice of Overpayment (12/19/2012) with findings chart
9. Appeal Provider Summary Report (4/29/2013)
10. Notice of Decision (5/8/2013) ($245,470.63)
11. Provider Administrative Participation Agreement
12. C. Landtroop demonstrative
13. AdvanceMed spreadsheet (01312012) (Jabez) (excerpts only)
14. CD with full Exel version of Ex. 13

For Petitioner:

1. Clinical Coverage Policy 3H-1 (Effective January 1, 2007)
4. State Medicaid Plan Excerpt – Home Infusion
5. State Medicaid Plan Excerpt – North Carolina Policy for Dually Eligible Recipients.
7. Example of Jabez Nursing Order Form with Contractor
8. Jabez Nursing Contract with 3HC.
9. Jabez Nursing Contract with Tar Heel Home Health
10. HCPCS Codes documenting Durable Medical Equipment Covered by Home Health Program
12. Excerpt Medicare Claims Processing Manual - Home Health Agency Billing
13. ARRP Public Policy Institute - Insight on the Issue Excerpt
14. Excerpt of North Carolina Report on Number of Dual Eligible Recipients – May 2013 from the North Carolina Department of Health and Human Services Website
15. DMA's Response to Petitioner's First Set of Interrogatories and First Request for Production of Documents
16. 30(b)(6) Deposition Transcript
17. Curriculum Vitae of Deanne B. Birch
25. Medicare claims manual
26. Policy 3C

WITNESSES

Linda Marsh, Manager of Special Projects and Quality Control, Program Integrity, DMA
Chad Landtroop, Chief Statistician, Advance Med Corporation
James T. Cowart, President, Jabez Home Infusion
Deanne Birch, President, HICAP Inc. Consulting
Sabrena Lea, Acting Assistant Director for Facility Home and Community Based Services, Clinical Policy, DMA

STIPULATIONS

Prior to hearing, the parties stipulated and agreed to the following issues, which are not disputed.

1. DMA Clinical Coverage Policy 3H-1 (rev. 8/1/2007) was in effect at the time that the services were rendered. This policy is authentic and admissible as an exhibit in this case.

2. At all times relevant to this audit and dispute, Petitioner submitted claims to Medicaid for Home Infusion Therapy (HIT) services for recipients who were dually-eligible under both Medicare and Medicaid. Dually-eligible recipients are eligible to receive both Medicaid benefits and Medicare-covered home health nursing services on the same date(s) of service.

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. Petitioner Jabez Home Infusion Company ("Petitioner") was a provider of Home Infusion Treatment ("HIT") Services and is located in Greenville North Carolina. (Cowart, T. Vol. 1, p. 251). Petitioner provided HIT services to patients in 42 counties until March 2014. (*Id*.).

2. Petitioner was founded in 2002 to provide HIT Services to patients that other home infusion companies would not accept, including Medicaid and dually-eligible patients. (*Id*. at pp. 249-50). James Cowart is the owner and operator of Petitioner. Mr. Cowart has nearly three decades of experience providing HIT services in North Carolina. (*Id*.).

3. Petitioner is licensed as a home care agency by the North Carolina Department of Health and Human Services, Division of Health Service Regulations, Acute and Home Care Licensure Section. (Cowart, T. Vol. 1, p. 273; Pet. Ex. 1, p. 8).

4. Respondent the North Carolina Department of Health and Human Services (the "Department" or "Agency") oversees the Division of Medical Assistance ("DMA"). DMA is the state agency responsible for administering North Carolina's program of medical assistance ("the Medicaid Program"). N.C. Gen. Stat. Chapter 108A, Article 2, Part 6. The Department also oversees the Department Hearing Office, which reviewed the post-payment review of the Department's post-payment review contractor, the Public Consulting Group ("PCG").

5. Petitioner was required to suspend these services in March 2014 pursuant to a Temporary Restraining Order (TRO) entered by the Board of Pharmacy, relating to questions about Jabez's clean room. Tr. 358-359. At that time, all of Jabez's patients were transferred over to other home infusion agencies. Tr. 359.

6. Petitioner's President Mr. Cowart provided pharmacy services to Jabez prior to November 2013, when he surrendered his pharmacy license for cause. Tr. 360-362. At the time of the hearing, Mr. Cowart did not have a pharmacy license. *Id*.

7. Home infusion therapy ("HIT") involves administering medication intravenously to patients in their homes. Tr. 255-256. The HIT services at issue in this audit all concern HIT of intravenous antibiotics. Tr. 259. HIT therapy involves multiple components, including nursing, supplies, pharmacy oversight, and the drug. Tr. 48, 119.

8. HIT provides a clinical benefit to patients because it reduces the number of viral and other infections that the individual would be exposed to if they were required to receive infusion therapy services in a hospital or nursing home setting. (Cowart, T. Vol. 1, pp. 255-56).

9. HIT is also significantly less costly than infusion services provided in a hospital or nursing home setting. (Cowart, T. Vol. 1, pp. 256-258).

10. HIT must be ordered by a physician. (Cowart, T. Vol. 1, p. 261; Respondent's Ex. 1, p. 7, § 5.4). A pharmacist must compound the drugs used for HIT in a clean and sterile environment. (Cowart, T. Vol. 1, pp. 261-268). HIT providers provide all necessary supplies and durable medical equipment needed to administer the intravenous ("IV") drugs. (Cowart, T. Vol. 1, p. 261).

11. A specially trained registered nurse ("RN") delivers the drugs and supplies and teaches the patient how to administer the IV drugs. (Marsh, T. Vol. 1, p. 128; Cowart. T. Vol. 1, p. 254). Petitioner employs one nurse to assist with this process and also contracts with home health agencies to use their nurses to provide HIT. (Cowart, T. Vol. 1, pp. 266-267; Petitioner Exs. 8-9). Petitioner pays home health agencies directly for the time contracted nurses spend providing HIT. (Id. at 267; Petitioner's Exs. 7-9).

12. A HIT pharmacist reviews lab test to determine if the proper dosage is being provided to the patient. (Cowart, T. Vol. 1, pp. 261-62).

13. Antibiotic HIT services are not covered by the Medicare. All services in this audit are antibiotic HIT services. Petitioner billed Medicare and received a rejection and remark code. This remark code, PR-204, indicates that the services were medically necessary but not covered by Medicare. (Cowart, Vol. 2, pp. 299-301; Birch, T. Vol. 2, pp 412-413; Petitioner Ex. 25).

14. At all times material to this matter, Petitioner was an enrolled provider in the North Carolina Medicaid Program. Petitioner entered into a Provider Administrative Participation Agreement with DHHS to participate in this program. (Respondent's Ex. 11; Tr. 311-312).

15. By entering into the Medicaid Participation Agreement, Petitioner agreed to "operate and provider services in accordance with all federal and state laws, regulations and rules, and all policies, provider manuals, implementation updates, and bulletins published by the Department, its Divisions and/or its fiscal agent in effect at the time the service is rendered …." (Respondent's Ex. 11 at ¶ 3).

16. Medicaid is the payor of last resort. Tr. 185, 298, 408. Where there are other sources of insurance coverage, including Medicare, those sources must be billed first, before Medicaid may be billed. Tr. 185, 258.

17. DMA Clinical Coverage Policy 3H-1 (original effective date of January 1, 1998, revised date August 1, 2007) was in effect and applicable to the services and dates of service that

were audited. (Respondent's Ex. 1; Stip. 1). Policy 3H-1 relates to coverage by the North Carolina Medicaid program relating to Home Infusion Therapy ("HIT"). The HIT program covers self-administered infusion therapy and enteral supplies provided to a Medicaid recipient residing in a private residence or an adult care home. Resp. Ex. 1, § 1.0.

18. Before Policy 3H-1 was promulgated, it went through a formal review process. Tr. 81, 83. The policy was drafted by a clinical policy committee with a view to best practices, changes in Medicare, changes in Medicaid, and other considerations. Tr. 83. It was reviewed by a physician group. Tr. 83-84. It was put out for comment from the public and any of the professional associations with an interest in the subject matter. Tr. 84. This lengthy process can take a year. *Id*. Only after all of these steps were completed did Policy 3H-1 become final. Tr. 84.

19. Section 4.1 of Policy 3H-1 states the following, as relevant to the parties' dispute:

> 4.1 General Criteria
>
> HIT services are **not covered** when:
>
> d. the recipient is receiving Medicare-covered home health nursing services.

Resp. Ex. 1, § 4.1 (emphasis added).

20. DMA published a Medicaid Bulletin in February 2008. (Resp. Ex. 2; Tr. 85). That bulletin addressed the circumstances in which Medicaid would cover HIT services provided to dually-eligible recipients. It states the following:

> **[W]hen the recipient is dually eligible under Medicare and Medicare** and the home health services are being billed to Medicare, **the HIT provider cannot bill Medicaid for reimbursement for the provision of a home drug infusion therapy.** Medicare reimbursement for home health services is under a prospective service fee that is all inclusive. Billing the HIT drug therapy per diem would be considered a duplication of services and therefore not reimbursable by Medicaid. The home health agency should include all medical care needs of the recipient within the episode of care in accordance with Medicare reimbursement guidelines.

Resp. Ex. 2, at 12 (emphasis added). The bulletin was published to advise the provider community of these important policy limitations regarding dual-eligible recipients. Tr. 86-87. Petitioner's representative agreed that this bulletin was published to address Policy 3H-1 requirements. Tr. 355.

Medicare's Prospective Payment System

21. This dispute centers on the potential overlaps and differences in coverage under Medicare and Medicaid. A dual-eligible recipient is one who qualifies for benefits under both Medicare (which is a federal program) and Medicaid (which is a federal-state program).

22. Under a previous version of Medicare, which predates the issues in this case, Medicare had a fee-for-services system. Tr. 432. This meant that Medicare providers would bill the federal program, and be paid, for each individual medical service provided to the patient. This former fee-for-services model was replaced prior to the audit in this case. Tr. 432.

23. At all times relevant to this dispute, Medicare had in place the Prospective Payment System ("PPS"). Tr. 32, 432. The PPS applied to Medicare recipients who had an open episode of home health care. The PPS provided for a flat-fee payment from Medicare to the home health agency for a given recipient for a 60-day period of time. Tr. 32, 43, 332-333, 432. In exchange for receiving the PPS, the home health agency was responsible "to take care of that patient for whatever needs are provided during that period of time." Tr., 32-33. This includes all nursing care. Tr. 433. Petitioner's expert agreed that the Medicare PPS covers all necessary nursing services for the 60-day period. Tr. 433.

24. The PPS is "all-inclusive." Tr. 42, 43. This means that the PPS payment constitutes payment in full from Medicare for any and all costs associated with that patient for that 60-day period. Tr. 43. The PPS is payment in full for all services that are medically necessary, including nursing, physical therapy, occupational therapy, home health care aides, as well as all supplies and any other type of therapy that can be provided in the home. Tr., 33, 43, 130-31.

25. Under Medicare PPS, the home health agency that receives the 60-day payment is obligated to care for the in-home patient for the 60-day period. Tr. 148-150. By accepting the patient, and agreeing to accept the PPS payment, the agency has agreed that it will receive payment in full for the patient – even if its actual expenses exceed the PPS payment. In this respect, the PPS shifts the risk to the home care agency. Tr. 43, 44. This is true where the agency must incur expenses to provide HIT services to one of the patients for which it receives the PPS payment. Tr. 148-150.

26. The amount of money paid to the home care agency under the 60-day PPS was determined by OASIS. OASIS is the intake and assessment document that is used at the onset of the home care episode. Tr. 33. The home health agency completes the OASIS document by inputting information about the patient's condition and medical needs. Tr. 33. The OASIS document specifically asks about the patient's need for intravenous care. Tr. 33. If this question is answered in the affirmative, then the PPS payment is increased accordingly. In other words, the PPS payment is increased based on a patient's need for an IV. Tr. 34.

27. In contrast to the PPS under Medicare (which pays a flat fee for all care needed during a 60-day period), billings to Medicaid are per diem for each recipient and date of service. Tr. 266.

28. The issue here is whether "the recipient is receiving Medicare-covered home health nursing services." Resp. Ex. 1, Policy 3H-1, sec. 4.1.d. If so, then Medicaid does not cover HIT services. *Id*.

29. As shown next, the undisputed evidence showed that all recipients in this audit were receiving "Medicare-covered home health nursing services" (Policy 3H-1, sec. 4.1.d) at the time that Petitioner billed Medicaid for HIT services.

Identification of Duplicative Payments from the Medicare-Medicaid Data

30. In late 2010 or early 2011, representatives of DMA Program Integrity's Medicare-Medicaid Data Match team participated in discussions. The discussions focused on areas where there were overlaps between services covered by Medicare and Medicaid. Program overlaps are a concern to federal and state governments, as there can be duplication of payments for these recipients. Tr. 35-37.

31. The Data Match team engaged Advance Med Corporation ("Advance Med") to analyze the data. Tr. 40, 206-208. Advance Med was a federal contractor with expertise comparing federal Medicare data with state Medicaid data, and in identifying overlaps. Tr. 40-41, 202. DMA Program Integrity has worked with Advance Med for multiple years, and believed that Advance Med performed accurate work. Tr. 41.

32. Advance Med has expertise in analyzing data from federal Medicaid and state Medicaid systems. Mr. Chad E. Landtroop, Chief Statistician, testified that Advance Med regularly analyzes federal and state data to investigate and identify fraud, waste, abuse and duplication in the Medicare and Medicaid programs. Tr. 202-204. Advance Med regularly matches data for dual-eligible beneficiaries to look for overlap or duplication of payments. Tr. 204.

33. Advance Med's mission was to determine whether Medicare beneficiaries under an open home health episode (billing Medicare pursuant to the flat-fee PPS) were also billing North Carolina Medicare for home infusion therapy. Tr. 42, 208 ("We identify dually eligible beneficiaries or recipients who have an open home health episode on the Medicare side and are within that episode receiving Medicaid infusion therapy services"). Such overlapping payments are duplicative – meaning that both Medicare and Medicaid are being billed, and both programs are paying, to provide the same care for the same recipient on the same date of service. The goal was to determine whether Medicaid providers in North Carolina were billing claims to Medicaid in violation of Policy 3H-1. Tr. 46.

34. Advance Med returned a data run (spreadsheets) to Program Integrity. Tr. 45-46. Program Integrity examined this data and found "a significant number of overlaps." Tr. 45. To be as conservative as possible, Program Integrity requested that Advance Med make certain refinements to the data analysis. Tr. 47, 213. This included removing the cost of the drug from the data (because drug costs are covered by Medicare Part D, Tr. 291); it also included eliminating the first and last date of the open home health episode. Tr. 47-48, 213-214. This refinement was done to be as conservative and narrow as possible. Tr. 49-50, 215.

35. Advance Med thereafter refined the data and returned a revised data run (spreadsheets) to Program Integrity in January 2012. Tr. 50, 213, 216; Resp. Ex. 13 (printed excerpts); Resp. Ex. 14 (CD with full version of spreadsheets). The revised data run showed overlap between the federal Medicare data (i.e., Medicare recipients under an open home health episode, receiving the PPS) and the state Medicaid data (claims billed to North Carolina for HIT services). Tr. 50-51. The comparison showed "significant amounts of overlap for both nursing visits and supplies." As Program Integrity representative Ms. Marsh explained, "[i]n some instances, there were nursing visits that were billed both the same day to Medicare and to Medicaid." Tr. 51. These are duplicative and overlapping charges for the same recipient and same date of service. Tr. 51.

36. In other words, the data showed that both Medicare and Medicaid were paying for the same nursing services and HIT services, for the same patients, for the same dates of service.

37. The data run showed that Petitioner had billed and received $245,470.63 in overpayments from Medicaid. (Resp. Ex. 13, at p. 1). DMA made the decision to seek recoupment of these funds from Petitioner. Tr. 192. The data run alone was sufficient to show a potential violation by Petitioner of Policy 3H-1 requirements. Tr. 192.

The Audit Letters

38. On October 2, 2012, DMA prepared and mailed a Vendor Introductory Letter to Petitioner. (Resp. Ex. 3; Tr. 56-57, 273-74). That letter notified Petitioner that DMA had initiated a post-payment review of claims submitted to Medicaid. Resp. Ex. 3 at 1. The letter notified Petitioner that DMA had contracted with Public Consulting Group ("PCG") to conduct post-payment reviews. *Id*. The letter was sent via certified mail. *Id.*

39. PCG is a contractor to Respondent. Tr. 55. DMA asked PCG to prepare and mail letters to certain Medicaid providers that had been identified in the Advance Med data run. Tr. 55. Program Integrity did not ask PCG to analyze the Medicare-Medicaid data, as that already had been done by Advance Med. Tr. 55. PCG's role was limited to sending notices. Tr. 55.

40. Also on October 2, 2012, PCG prepared and mailed a letter to Petitioner. (Resp. Ex. 4). The PCG letter was mailed at the same time as the DMA Vendor Introductory letter, also via certified mail. *Id*.; Tr. 57, 273-74. The PCG letter cited Policy 3H-1 and the reimbursement requirements for HIT. *Id*. (The PCG letter included a typographical error and referenced 4.2.d, which does not exist, rather than the applicable section, 4.1.d.) The PCG letter noted that Petitioner had submitted claims to Medicaid between 2008 and 2010 for HIT services provided to dually-eligible recipients. *Id*. These recipients also were receiving Medicare-covered home health nursing services on the same claimed date(s) of service. *Id*. PCG's letter identified twelve examples of claims that appeared to be billed in Medicaid in violation of Policy 3H-1, section 4.2.d. *Id*. The PCG letter stated, "If your agency demonstrates that these claims do not represent a violation of the specific policy stated above, no further action will be taken." *Id*., at 1. As Ms. Marsh explained, Respondent was giving Petitioner a chance to explain why this billing would not be a violation of Policy 3H-1. Tr. 59.

The Tentative Notice of Overpayment

41. On December 19, 2012, PCG prepared and sent a Tentative Notice of Overpayment ("TNO") to Petitioner. (Resp. Ex. 6; Tr. 62). The TNO stated that PCG had completed a review of Petitioner's Medicaid-paid claims for dates of service between 1/1/2008 to 10/31/2011. *Id*. The data showed that Petitioner's claims related to HIT services provided to dually-eligible recipients who were also receiving Medicare-covered home health nursing services on the same dates of service. *Id*. The TNO notified Petitioner that this was a violation of Policy 3H-1. *Id*. PCG notified Petitioner that it had received an overpayment of $245,470.63 as a result of this violation. *Id*.; Tr. 65. The TNO notified Petitioner of its due process rights to appeal the tentative decision. *Id*., at 1-3. The TNO was sent via certified mail. *Id*., at 1; Tr. 63.

42. Attached to the TNO was a multiple-page table. (Resp. Ex. 6, attachment). The table of findings summarized Petitioner's claims related to HIT services provided to dually-eligible recipients on the same dates of service. *Id*.; Tr. 63-64. For each claim, the table identified the recipient name, Medicaid identification number, date of service, payment billed and payment paid. Under findings, for each claim the table stated, "Recipient receiving Medicare-covered home health nursing services." *Id*., findings/remarks column.

43. Petitioner received the TNO and table of findings on December 26, 2012. (Resp. Ex. 6, green card).

The Hearing Officer's Decision

44. After receiving the TNO, Petitioner requested a reconsideration review with the Hearing Office of DHHS. (Resp. Ex. 7, Tr. 274). The reconsideration review took place on February 6, 2013. (Resp. Ex. 10). Petitioner submitted documentation and argument during and after the review. *Id*.; Tr. 274.

45. Program Integrity reviewed the documents provided by Jabez as part of the reconsideration review proceeding. Tr. 60-61. The Jabez records confirmed that all recipients on the table of findings were receiving Medicare-covered home health nursing services, at the same time that Medicaid was billed. Tr. 61.

46. On May 8, 2013, the Hearing Office issued its Notice of Decision. (Resp. Ex. 10). The Hearing Officer upheld the TNO. *Id*., at 3; Tr. 66, 275. The Hearing Officer found that the information "supports PCG's determination that the provider submitted claims for HIT services when the recipients were receiving Medicare-covered home health nursing services." The Hearing Officer recognizes that Policy 3H-1 "states that HIT services are not covered when the recipient is receiving Medicare-covered home health nursing services." *Id*., at 3. Accordingly, the Hearing Officer upheld the recoupment amount of $245,470.63. *Id*., at 3.

47. Following receipt of the Hearing Officer's Notice of Decision, Petitioner filed a Petition in this Court. Tr. 275. This matter came on for hearing on May 1 and 2, 2014.

Respondent's Recalculated Overpayment

48. Prior to the hearing, Respondent re-examined the data compiled by Advance Med. Tr. 66, 221-223. Respondent determined that one recipient included in the initial data run was receiving occupational therapy, billed to Medicaid, rather than nursing services. Tr. 66-67, 221-223. This recipient, arguably, did not have an open episode of home health care under Medicare, and, arguably, should have been excluded from the audit. Respondent decided to remove this claim, pertaining to recipient KN, from the audit. That reduced the claimed overpayment by $419.60 to a modified amount of $245,051.03. (Resp. Ex. 13; Tr. 66-69, 72-75, 221-223).

49. With this modification, Advance Med's data run captured only recipients who had (1) received "Medicare-covered home health nursing services" (Policy 3H-1, sec. 4.1.d); and also (2) received nursing care and HIT services paid by Medicaid. Tr. 238.

50. At the time of the hearing, Respondent had calculated and was claiming that Petitioner received an overpayment from Medicaid in the amount of $245,051.03. Tr. 75, 223.

Jabez's Duty to Verify Insurance Coverage

51. Before providing Medicaid services to recipients, Petitioner had a responsibility to check and verify whether the recipient was eligible for Medicare. Resp. Ex. 1, sec. 5.5, sec. 7.2; Tr. 76-79, 142-43. Petitioner's representative and expert witness agreed that Jabez had an affirmative duty to check insurance coverage under Medicare. Tr. 326, 435. Both witnesses agreed that it is important to know a patient's insurance coverage. Tr. 436.

52. Mr. Cowart admitted that Jabez was able to determine a patent's insurance coverage. Tr. 320. Jabez could verify Medicare coverage. Tr. 320. Jabez would know that a patient had an open home health episode under Medicare if the patient said so, or if the nursing subcontractor said so. Tr. 321. Petitioner's expert testified that software packages were available to verify whether a patient had an open home health episode. Tr. 442, 444. In addition, some of Jabez's nursing subcontractors had ways to verify an open home health episode. Tr. 323.

53. Despite its obligation to check insurance coverage, and despite Policy 3H-1, section 4.1.d, Jabez did not check whether its patients were "receiving Medicare-covered home health nursing services." (Resp. Ex. 1, Policy 3H-1, sec. 4.1.d). Tr. 320.

Jabez's Subcontracts with Nursing Companies

54. In order to provide services to its patients, Jabez entered into subcontracts with third party nursing companies. These companies provided the nursing services necessary to the HIT services. Tr. 267-268; Pet. Ex. 8-9 (contracts between Jabez and Gentiva, 3HC).

55. None of the subcontractors ever informed Jabez that the patients had open home health episodes under Medicare. Tr. 269, 329. Neither Gentiva nor 3HC informed Mr. Cowart that these subcontractors billed and collected a PPS payment from Medicare for taking care of the patient, while at the same time collecting per diem payments from Jabez (which Jabez billed

to Medicaid). Tr. 269, 337. These payments were duplicative – both Medicare, under the PPS, and Medicaid, separately (as billed by Jabez), paid for nursing services and HIT services on the same dates to the same patients.

56. Petitioner's expert Ms. Birch testified that the subcontractors "should have informed" Jabez if a patient had an open home health episode. Tr. 437; *see also* Tr. 438 ("If the patient was, in fact, qualified for homebound 60-day episode, then they [the home health agency] should have informed Jabez.").

57. For each of the recipients in the audit, Mr. Cowart admitted that both Medicare and Medicaid paid for the same nursing services, for the same recipients, for the same dates of service. Tr. 337. He admitted that subcontractors to Jabez were receiving a PPS payment from Medicare for skilled nursing services (and other medically-necessary services) at the same time that Jabez was billing Medicaid for these same nursing services. Tr. 337.

58. Mr. Cowart testified that he was not concerned about these duplicative payments. Tr. 329. To date, he has never asked Gentiva or 3HC why his subcontractors failed to inform Jabez of the patients' open home health episodes under Medicare. Tr. 340.

Jabez's Interpretation of Policy 3H-1, section 4.1.d

59. Petitioner's representative agreed that he was obligated to comply with the requirements of Policy 3H-1. Tr. 311-312. He testified that did not understand section 4.1.d, regarding dual-eligible recipients, at the time that he billed claims to Medicaid. Tr. 313-314. Mr. Cowart agreed and conceded that Jabez did not comply with section 4.1.d when it billed claims to Medicaid. Tr. 316.

60. Instead of following section 4.1.d, Petitioner's representative chose to rely only upon section 7.2.6 of Policy 3H-1. Tr. 313-316. Mr. Cowart admitted, though, that section 7.2.6 does not address the issue of dual-eligible recipients. Tr. 318. He also admitted that section 7.2.6 only addresses medications covered under Medicaid part D – which is not the same as having Medicare-covered home health nursing services. Tr. 318. Even so, Jabez chose to rely on section 7.2.6 and ignore section 4.1.d of Policy 3H-1.

61. There was no dispute that all recipients in the audit were dual eligible for both Medicare and Medicaid. Tr. 72. At all times relevant to this audit and dispute, Petitioner submitted claims to Medicaid for Home Infusion Therapy (HIT) services for recipients who were dually-eligible under both Medicare and Medicaid. Dually-eligible recipients are eligible to receive both Medicaid benefits and Medicare-covered home health nursing services on the same date(s) of service. (Stip. 1, Pre-Hearing Order).

62. There was no dispute that all recipients in this audit were receiving Medicare-covered home health nursing services, and, during the same time period, Petitioner billed HIT services to Medicaid.

63. Policy 3H-1, section 4.1.d, is clear and unambiguous on its face. It plainly provides that North Carolina Medicaid will not pay for HIT services where "the recipient is receiving Medicare-covered home health nursing services." (Resp. Ex. 1, sec. 4.1.d).

64. Petitioner's claims billed to Medicaid, as summarized in the TNO (Respondent's Ex. 6, findings chart) and on the data run spreadsheet (Respondent's Ex. 14), were in violation of Policy 3H-1, section 4.1.d.

65. Respondent has met its burden of showing that the total overpayment from Medicaid to Petitioner was $245,051.13. Tr. 75, 223. This amount equals the overpayment identified in the TNO (Resp. Ex. 6, $245,470.63) minus the one claim that Respondent removed from the audit prior to hearing (recipient KN, $419.60). Tr. 66-69, 72-75, 221-223.

66. Petitioner argued that Policy 3H-1, sec. 4.1.d, discriminates against dually-eligible recipients. However, there is no evidence showing this to be true. In fact, the record shows that every recipient in this audit did receive all medically necessary HIT services. Petitioner has not identified any recipient who has been discriminated against (*i.e.*, did not receive medically necessary HIT services) as a result of Policy 3H-1, section 4.1.d.

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.

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

3. Petitioner and DMA entering into a valid Medicaid Participation Agreement. Respondent's Ex. 11. By entering into the Medicaid Participation Agreement, Petitioner agreed to "operate and provider services in accordance with all federal and state laws, regulations and rules, and all policies, provider manuals, implementation updates, and bulletins published by the Department, its Divisions and/or its fiscal agent in effect at the time the service is rendered …." (Respondent's Ex. 11 at ¶ 3).

4. Respondent is responsible for administering and managing the State Medicaid plan and program. Pursuant to N.C. Gen. Stat. 108A-54, Respondent is authorized to adopt the rules and regulations for program operation. Pursuant to 10A N.C.A.C. 22F .0103(b)(5), Respondent "shall institute methods and procedures to recoup improperly paid claims."

5. Under 10A NCAC 22F .0601(a), DMA "will seek full restitution of any and all improper payments made to providers by the Medicaid Program."

6. DMA Clinical Coverage Policy 3H-1 (original effective date of January 1, 1998, revised date August 1, 2007) was in effect and applicable to the services and dates of service that were audited. (Respondent's Ex. 1). Policy 3H-1 was adopted according to the procedures set forth in N.C.G.S. § 108A-54.2 and § 54.3. At all times relevant to the audit, Petitioner was obligated to follow the requirements set forth in Policy 3H-1.

7. Respondent met its burden of showing by a preponderance of the evidence that Petitioner's claims billed to Medicaid relating to HIT services were in violation of Policy 3H-1,

sec. 4.1.d. The evidence showed that all such claims were for recipients who were receiving Medicare-covered home health nursing services during the same time that Petitioner billed Medicaid.

8. The evidence does not show that Policy 3H-1, section 4.1.d discriminates against the dual-eligible population, or that it is a violation of federal law, or the State Medicaid Plan, or state law.

9. Under N.C. Gen. Stat. § 108C-7 and § 150B-23(a), 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 determined that Petitioner received an overpayment of $245,051.03 from the North Carolina Medicaid program.

10. Respondent did not deprive Petitioner of property; did not order Petitioner to pay a fine or civil penalty; and did not substantially prejudice Petitioner's rights. Further, Respondent did not exceed its authority or jurisdiction; did not act erroneously; did not fail to use proper procedure; did not act arbitrarily or capriciously; and did not fail to act as required by law or rule.

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

DECISION

The Court hereby AFFIRMS the Notice of Decision of the North Carolina Department of Health and Human Services ("DHHS") Hearing Office, issued on May 8, 2013 (Resp. Ex. 10), except that the Court finds that the Petitioner received an overpayment from Medicaid in the amount of $245,051.13.

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 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.

IT IS SO ORDERED.

Dated this the 3rd day of September, 2014.

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Craig Croom
Administrative Law Judge