STATE OF NORTH CAROLINA		IN THE OFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF WAKE		14 DHR 02198
GENESIS PROJECT 1, INC.,	)	
	)	
Petitioner,	)	
	)	
v.	)	**FINAL DECISION**
	)	
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, and MECKLINK BEHAVIORAL HEALTHCARE,	)	
	)	
Respondents.	)	
_____	)	
	)	

This matter came on for hearing before Administrative Law Judge Donald W. Overby on January 29 and 30, 2015 in Raleigh, North Carolina. Petitioner Genesis Project 1, Inc. ("Genesis" or "Petitioner") was present through its agent and represented by its counsel Knicole Emmanuel and Robert Shaw; Respondent MeckLINK Behavioral Healthcare ("MeckLINK") was present through its agent and represented by its counsel Christopher W. Jones and Amanda G. Ray; and Respondent NC Department of Health and Human Services ("DHHS"), Division of Medical Assistance ("DMA") was represented by Thomas J. Campbell of the Attorney General's Office.

Appearances of Counsel

For Petitioner*: Knicole Emanuel
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N.C. Department of Justice
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ISSUE

Whether MeckLINK, acting as an agent of DHHS/DMA, erred, exceeded its authority or jurisdiction, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule by determining that Community Support Team ("CST"), Intensive In-Home ("IIH"), and certain other services assessed from ten randomly-selected paid Medicaid claims, the services for which were delivered by Petitioner from March 1, 2013, through June 1, 2013 (the "Services"), were noncompliant with rules and policies applicable to providers of Medicaid services in North Carolina, and that Petitioner therefore owed a payback for the Services in the amount of $558,746.50.

APPLICABLE STATUTES AND RULES

Title XIX of the Social Security Act
42 C.F.R. §§ 438.206 and 438.214
North Carolina General Statutes Chapter 150B, generally
N.C. Gen. Stat. § 150B-22, *et seq*.
N.C. Gen. Stat. § 108C, *et seq*.
N.C. Gen. Stat. § 108A, *et seq*.
N.C. Gen. Stat. § 122, *et seq*.
10A NCAC 27G .0104
10A NCAC 22F *et. seq*.
DMA Clinical Coverage Policy 8A
The North Carolina State Plan for Medical Assistance
Implementation Update 37
DHHS/DMA Records Management and Documentation Manual
1915(b)/(c) Medicaid Waiver for MH/DD/SA Services

EXHIBITS

For Petitioner: 2, 3, 4, 6, 10, 11, 12, 14, 15, 18, 19, 19A, 20, 23, 24, 26, 27, 28, 29, 30, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 48, 49, 50, 51, 52, 55, 56, 57, 59, 60, 61, 62, 63, 64, 65.

For Respondent MeckLINK: 1, 4, 5, 6, 7, 8, 9, 10, 13, 20, 21, 22, 23.

FINDINGS OF FACT

In finding the following facts, the undersigned has weighed all of the evidence and assessed the credibility of the witnesses. The undersigned has taken into account the appropriate factors for

judging credibility of witnesses, including but not limited to the demeanor of the witness and any interests, bias, or prejudice the witness may have. Further, the undersigned has carefully considered 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 relevant and believable evidence in the case.

After careful consideration of the sworn testimony presented at the hearing, the documents and exhibits admitted into evidence, and the entire record in this proceeding, the undersigned makes the following FINDINGS OF FACT:

1. The parties properly received notice of hearing by certified mail more than 15 days prior to the hearing.

2. Petitioner is a North Carolina corporation, which provides treatment for mental health and substance abuse services to Medicaid recipients in Charlotte, North Carolina and surrounding areas. It has been in business since 2004.

3. Respondent, The North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"), is the single State agency responsible for administering and managing North Carolina's Medicaid program. Respondent DMA is authorized to adopt rules, regulations, and policy for program operation.

4. DMA has been dismissed without prejudice from this contested case.

5. At all times relevant to the issues presented in this matter, MeckLINK was a department of Mecklenburg County government and was the state-contracted LME/MCO and/or prepaid inpatient health plan (PIHP) agent of DHHS/DMA, which was hired to, among other things, manage the provision of Medicaid funded mental health, developmental disabilities and substance abuse services in Mecklenburg County, which is MeckLINK's "catchment area." Respondent is located in MeckLINK's catchment area.

6. At all times relevant to the issues presented in this matter, MeckLINK was an agent of DHHS/DMA and has general authority to enter into contracts both with DMA and with Petitioner, to locally manage providers of Medicaid services, and to implement rules, regulations, and policies promulgated by DHHS/DMA.

7. By letter dated June 14, 2013, MeckLINK notified Petitioner in writing of an initial routine Gold Star Review to be held on July 10, 2013. The notice was sent via email and by US Postal Service. (Respondent's Ex. 4.) MeckLINK was obligated to conduct the Gold Star Review pursuant to its contract with DHHS/DMA, and MeckLINK's attendant responsibilities to manage providers of Medicaid services.

8. The time period examined in the Gold Star Review was from March 1, 2013 to June 1, 2013 (the "Audit Period"). (Tr. 28-29.) MeckLINK's correspondence to Petitioner dated June 14, 2013 specifically identified all areas of inquiry and requirements that would be assessed in the Gold Star Review, and instructed Genesis where to locate the specific template that would be used

for evaluation in the Gold Star Review (the "Gold Star Tool"). Accordingly, in advance of the Gold Star Review, Petitioner had actual notice of the information and documents that MeckLINK would review, the criteria that would be used in conducting the Gold Star Review, and the requirements that the Gold Star Review was designed to confirm. (Respondent's Exs. 4, 7; Tr. 30-31, 316.)

9. Prior to the Gold Star Review Petitioner conducted a self-audit using the Gold Star Tool. (Tr. 316.)

10. The Gold Star Review was conducted by MeckLINK at Genesis' office on July 10 and 17, 2013. (Tr. 33-34.)

11. Genesis informed MeckLINK that during the Audit Period it had one CST team and three IIH teams. (Tr. 39, 48, 52.) Thus, the Gold Star Review involved review of services provided by Genesis' three IIH teams, one CST team, as well as a sample of ten paid Medicaid claims. (Tr. 26-29.)

12. The basis for MeckLINK's findings was that

> It was determined that your agency has been providing Intensive In-Home (IIH) and Community Support Team (CST) services out of compliance with the DMA service definitions for these services, in that there was no evidence in your agency's personnel records that all members of each team had the required experience to provide Medicaid-billable IIH and CST. According to the documentation in your personnel records, at least one member of <u>each</u> IIH and CST team did not have the experience required to provide the service per the service definition staffing requirements. (Pet. Ex. 1.)

13. 10A NCAC 22F .0107 provides that all providers "shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement."

14. Thus, the burden was on Petitioner to produce records necessary for the review. The notice sent, dated June 14, 2013, instructed Genesis to have all records on site prior to the review beginning. When MeckLINK conducted the Gold Star Review at Genesis' office on July 10 and 17, Genesis did not make all of the requested personnel records available. (Tr. 31-34.)

15. Genesis submitted resumes, employment verification forms, and other documents related to its CST and IIH staff to MeckLINK, but it was extremely difficult to discern from those documents that every staff member's experience involved "the functions and tasks in those roles that would be expected in the setting of the services provided," whether the experience was with adults or children, and whether the experience was full time or part of a full time equivalent (FTE) position. Based on the documents submitted by Genesis, MeckLINK could not reasonably conclude that each member of the CST and IIH teams had the required experience with the population served at any time during the Audit Period. (Respondent's Exs. 1, 6, 20; Tr. 48-52; 73.)

16. Medicaid Clinical Coverage Policy 8A requires that Medicaid providers' IIH teams be comprised of at least three staff who each "must have a minimum of one (1) year documented experience with this population," meaning children or adolescents. (Emphasis added.) (Respondent's Ex. 1 at 36.) Each staff member on a provider's IIH team(s) must meet this requirement in order to bill Medicaid for services it provides.

17. Medicaid Clinical Coverage Policy 8A sets out the requirements that Medicaid providers' IIH teams must have including a team leader who is a licensed professional, a second member who must be a qualified professional and a third who must be a QP or AP. No member of the team can provide staffing for other services at such time as he or she is performing the IIH team services. All must possess the "knowledge, skills and abilities" to render the appropriate services to the "population and age to be served." (Respondent's Ex. 1 at 36.)

18. The documentation provided by Genesis to MeckLINK at the review showed that IIH Team 1 was comprised of Rebecca Lavoie, Jabari Adams, Susan Holtz, Ronji Hatchell, and Chandra Scott. The documentation provided by Genesis to MeckLINK at the review further showed that four of those five team members (Rebecca Lavoie (Respondent's Ex. 6E; Tr. 54-56.); Susan Holtz (Respondent's Ex. 6F; Tr. 56-58); Ronji Hatchell (Respondent's Ex. 6D; Tr. 58-60); Chandra Scott (Respondent's Ex. 6J; Tr. 61-63)) did not have the required one year of documented experience with the population served prior to providing services on that team. The experience of Jabari Adams was not challenged by MeckLINK.

19. From the documentation provided by Genesis to MeckLINK, the reviewers could not discern whether or not the experience of the team members was for adults or children, or, alternatively, if the team member provided direct services. Although Ronji Hatchell had worked for MeckLINK, the documentation provided by Petitioner did not indicate if he had provided direct services. The burden is on Petitioner to provide the information and not on the Respondent to search its own records.

20. Dr. Black offered testimony that Lavoie, Scott and Holtz had gained at least part of their experience from working with Petitioner.

21. The documentation provided by Genesis to MeckLINK at the review showed that IIH Team 2 was comprised of Andrea White, Fernando Vargas, and Lydia Covington. (Respondent's Exs. 7, 9.) The documentation provided by Genesis to MeckLINK at the review further showed that none of those team members(Fernando Vargas (Respondent's Ex. 6A; Tr. 63-64); Lydia Covington (Respondent's Ex. 6B; Tr. 64-65); Andrea White (Respondent's Ex. 6I; Tr. 65-67)) had the required one year of documented experience with the population served prior to providing services on IIH Team 2.

22. Dr. Black offered testimony that Vargas and Covington had gained at least part of their experience from working with Petitioner.

23. Dr. Black's explanation of the experience of Covington might have been sufficient to show that Covington had the requisite experience but that information was not provided to the reviewers. Additionally, even if Covington was found to have been qualified, the other team

members were not qualified, thus disqualifying the entire team.

24. The documentation provided by Genesis to MeckLINK at the review showed that IIH Team 3 was comprised of Ashley Francis, Latacia Ruff, and Benjamin Foster. (Respondent's Exs. 7, 9.) The documentation provided by Genesis to MeckLINK at the review further showed that two of those three team members (Benjamin Foster (Respondent's Ex. 6H; Tr. 67-69) and Latacia Ruff (Tr. 69-70; Respondent's Ex. 6B)) did not have the required one year of documented experience with the population served prior to providing services on IIH Team 3. The experience of Ashley Francis was not challenged by MeckLINK.

25. Dr. Black offered testimony that Ruff and Foster had gained at least part of their experience from working with Petitioner.

26. Medicaid Clinical Coverage Policy 8A requires that "[a]ll staff providing CST services shall have a minimum of one year of documented experience with the adult MHSA population." (Emphasis added). (Respondent's Ex. 1 at 56.) Each staff member on a provider's CST team(s) must meet this requirement in order to bill Medicaid for services it provides.

27. Medicaid Clinical Coverage Policy 8A sets out the requirements that Medicaid providers' CST teams must have including a team leader who is a licensed professional, a second member who must be a qualified professional and a third who must be a QP or AP or other specifically listed skilled staff member. All must possess the "knowledge, skills and abilities" to render the appropriate services to the "population and age to be served." (Respondent's Ex. 1 at 54, 56.) The third staff member may be a "certified peer support specialist" which does not require one year of experience because that person is required to have personally received either mental health or substance abuse services. There is no evidence any of the Petitioner's CST team members were certified peer support specialists.

28. The documentation presented by Genesis to MeckLINK at the review during the Gold Star Review showed that its CST team was comprised of Ryan Adamczyk, Darryl Frost, Angela Hayes, Shamira Moore, and Michelle Phillips. The documentation presented by Genesis to MeckLINK at the review further showed that CST team member Shamira Moore did not have the required one year of documented experience with the population served prior to providing services on that team. (Respondent's Ex. 16G; Tr. 48-52.)

29. Dr. Black offered testimony at the contested case hearing explaining the experience of the various members of the teams to justify their experience. The requirement is for the Petitioner Genesis to have the information available to the reviewers at the time of the audit. MeckLINK made significant efforts to try to make the teams meet the standards and to find the team members to have the requisite experience.

30. After the Gold Star Review was completed, MeckLINK concluded that Petitioner had failed to properly comply with applicable policy and staffing requirements, and on August 13, 2013, MeckLINK notified Genesis that it intended to terminate the parties' contract for provision of Medicaid services for cause. (Tr. 34-35.)

31. Also on August 13, 2013, MeckLINK notified Genesis that it owed a payback in the amount totaling $558,746.50 for the Services provided during the Audit Period that did not meet the staffing and other documentation and policy requirements, and for which MeckLINK had paid Genesis in Medicaid funds. (Tr. 36-37.)

32. On August 28, 2014, Petitioner filed a Contested Case Petition bearing case number 13 DHR 17094 which contested the termination of its contract with MeckLINK. On December 16, 2013, this Court dismissed that matter on the grounds that Petitioner had failed to exhaust its administrative remedies through the local reconsideration process with MeckLINK prior to filing its petition.

33. Genesis completed the local reconsideration process, which also resulted in a finding by MeckLINK that Genesis' contract for the provision of Medicaid services should be terminated for cause. On January 7, 2014, Genesis filed a second Contested Case Petition bearing case number 14 DHR 142, which also requested that MeckLINK be prevented from terminating its contract with Genesis.

34. On March 14, 2014, MeckLINK informed Petitioner that local reconsideration confirmed the result of the Gold Star Review, and that Petitioner owed a payback of $558,746.50 for the Services, which MeckLINK determined were improperly billed to, and paid by, MeckLINK with Medicaid funds.

35. On April 30, 2014, the parties filed a Stipulation of Dismissal of 14 DHR 142 on the basis that "Petitioner's claims have been rendered moot due to Cardinal Innovations Healthcare Solutions' assumption of the role of LME/MCO for the Mecklenburg County catchment area from MeckLINK as of April 1, 2014[.]"

36. No decision on the merits of the validity of MeckLINK's termination of its contract with Genesis or the validity of the assessed payback was reached in 13 DHR 17094 or 14 DHR 142.

37. On March 24, 2014, Petitioner filed the instant Contested Case Petition, contesting the payback for the Services that was requested by MeckLINK on March 14, 2014.

38. On January 29, 2015, the Court granted DHHS/DMA's oral motion to dismiss without prejudice, leaving MeckLINK as the sole Respondent in this matter.

CONCLUSIONS OF LAW

1. The parties are properly before the Office of Administrative Hearings.

2. Petitioner is an aggrieved person under Chapter 150B and is entitled to commence a contested case. Petitioner has satisfied all conditions precedent and all timeliness requirements for initiating this contested case.

3. MeckLINK has the burden of proof in this case pursuant to N.C. Gen. Stat. § 108C.

4. At all times relevant to this matter, MeckLINK had the authority to conduct auditing and monitoring reviews, such as the Gold Star Review, through its role as the state-contracted LME/MCO for the Mecklenburg County catchment area.

Clinical Coverage Policy 8A and Implementation Update 37

5. Petitioner is obligated to comply with: 1) Medicaid Clinical Coverage Policy 8A; 2) all directives and policies promulgated by DHHS/DMA applicable to Medicaid-reimbursable services; and 3) all other applicable federal or state laws, rules, or regulations, in effect at the time the service is rendered and concerning the provision or billing of Medicaid-reimbursable or State-funded services.

6. Medicaid Clinical Coverage Policy 8A requires that "[a]ll staff providing CST services shall have a minimum of one year of documented experience with the adult MHSA population." (Emphasis added). (Respondent's Ex. 1 at 56.) Each staff member on a provider's CST team(s) must meet this requirement in order to bill Medicaid for services it provides.

7. Medicaid Clinical Coverage Policy 8A requires that Medicaid providers' IIH teams be comprised of at least three staff who each "must have a minimum of one (1) year documented experience with this population," meaning children or adolescents. (Emphasis added.) (Respondent's Ex. 1 at 36.) Each staff member on a provider's IIH team(s) must meet this requirement in order to bill Medicaid for services it provides.

8. Medicaid Clinical Coverage Policy 8 very specifically requires certain people with certain experience and training for the positions on both the CST and IIH teams; for example, both require a Licensed Professional as team leader. The definitions and requirements for each such position required in Policy 8 are set forth in 10A NCAC 27G .0104.

9. Genesis acknowledges that it was obligated to follow Clinical Coverage Policy 8A in the provision of the Services. (Tr. 262-63.)

10. Implementation Update 37 issued by DHHS/DMA on December 3, 2007, provides guidance as to how providers should determine staff members' experience with the population served for purposes of meeting the staffing requirements of Medicaid Clinical Coverage Policy 8A and 10A NCAC 27G .0104. (Emphasis added) Implementation Update 37 "outlines the DHHS interpretation of th[e] concept" of "experience with the population served." (Respondent's Ex. 22.)

11. Pursuant to Implementation Update 37, the one year of required experience with the population served must involve actually providing mental health, substance abuse, or developmental disability services to the specific population the staff member will be serving in his or her potential employment with a provider. Experience in position(s) that merely involve some

unspecified interaction or involvement with the target population is insufficient to meet this requirement. (Respondent's Ex. 22; Tr. 41-42.)

12. Provider organizations were copied on Implementation Update 37 when it was issued in December 2007, and it was otherwise available and accessible by them. Providers are required to keep up with and be informed about implementation updates. Although Petitioner has been billing Medicaid since 2005, Dr. Black said that she was unfamiliar with Update 37 and had not seen it until the matters in this contested case. If nothing else she should have been familiar with the Update when it was issued.

13. Genesis contends that Update 37 has no applicability to the matters herein. Genesis is correct in that the Update 37 is not a properly promulgated "rule." Whether or not Update 37 meets the definition of "medical coverage policy" as defined in N. C. Gen. Stat. 108A-54.2 is of no consequence because it is beyond question that Update 37 is at the very least guidance. Further, as discussed below, the plain language of Clinical Coverage Policy 8A is instructive of what is expected of Providers. Implementation Update 37 was applicable to providers of Medicaid services in North Carolina at all times relevant to the instant matter, and was in effect during the Audit Period. (Respondent's Ex. 22; Tr. 43-44, 97-98, 134-35.)

14. While Update 37 was in effect and was relevant during the audit period, the real guidance is from the plain English of the words "documented experience" in Clinical Coverage Policy 8A.

15. Merriam-Webster defines "experience" thusly: "1) direct observation of or participation in events as a basis of knowledge; the fact or state of having . . . gained knowledge through direct observation or participation; 2) practical knowledge, skill, or practice derived from direct observation of or participation in events or in a particular activity; 4) something personally encountered, undergone, or lived through." (Merriam-Webster at merriam-webster.com/dictionary/experience).

16. Obviously, "experience" is something you get from having gone through an event. Experience is gained as you go through the event. Since the requirement is for documented (i.e. written) experience with certain groups of individuals, it very obviously is requiring that "experience" prior to being engaged with Petitioner Genesis. One does not get hired and then get the experience—the experience is a prerequisite. While it is conceivable that someone could "work" as an intern and gain experience, that person could <u>not</u> of necessity be a part of a team. That "experience" would have to be gained prior to being part of a team.

17. Genesis' contention that Update 37's requirement that the positions be "full time equivalent (FTE)" is not found in Coverage Policy 8A is just plain wrong. Medicaid Clinical Coverage Policy 8A, page 36 in reference to IIH staffing requirements states: "This service model is delivered by an IIH team comprised of one full-time equivalent (FTE) team leader and at least two additional full-time equivalent positions."

18. Similarly, Medicaid Clinical Coverage Policy 8A, page 54 in reference to CST staffing requirements states: "CST shall be composed of three full-time staff positions as follows: A. One

full-time equivalent (FTE) team leader who is a Licensed Professional. . . B. One FTE QP . . . C. One FTE who is a QP, AP, Paraprofessional, or Certified Peer Support Specialist . . . ."

19. Genesis acknowledges that it was obligated to follow the Records Management and Documentation Manual promulgated by DHHS/DMA (also known as "APSM-45.2"). APSM-45.2 was applicable to providers of Medicaid services at all times relevant to the instant matter, was distributed to provider organizations, and was in effect during the Audit Period. Genesis acknowledges that the requirements of APSM-45.2 are mandatory. (Respondent's Ex. 20; Tr. 257-59.)

20. APSM-45.2 requires that providers of Medicaid services must maintain records of all the required educational credentials and other applicable qualifications of their staff, and that those records must be made available in the event of an audit by the LME/MCO or the State. (Respondent's Ex. 20, App. A; Tr. 257-59.)

21. An essential aspect of the North Carolina Medicaid program is that Medicaid providers comply with APSM-45.2, the applicable Clinical Coverage Policies, administrative rules, and DHHS/DMA policies. Such compliance is necessary in order for the State to effectively implement Medicaid services, to ensure that auditors and LME/MCOs may complete the tasks that they have contracted with the State to perform; and to prevent misuse or misallocation of taxpayer funds.

22. 10A NCAC 22F .0107 provides that all providers "shall keep and maintain all Medicaid financial, medical, or other records necessary to fully disclose the nature and extent of services furnished to Medicaid recipients and claimed for reimbursement."

23. Thus in post payment reviews, the burden is on the provider to produce certain documentation to validate that the provider has indeed complied with state and federal requirements. While the ultimate burden of proof is on Respondent in the contested case hearing, provider cannot rest on its laurels in at least the initial phases of the post payment reviews and must produce the information to substantiate with particularity the work experience each team member had prior to joining the team.

24. The burden is on the Provider to produce the requisite information to verify the documented experience with the population served. The plain English language of this provision is that not only is the Provider required to have written documentation of the experience prior to joining the team, that experience has to be specific to the population served. To merely identify that someone worked at a facility or business that provided services that might fit the requirement is NOT sufficient. It must be shown that the individual actually did the direct work serving the particular population, whether it is IIH or CST services.

25. This is not "best practices" requirements—this is the plain language of Clinical Coverage Policy 8A. The records should be clear as to the prior experience and that it was to the population to be served. It is not up to the reviewers to try to figure it all out or to guess or speculate—it is up to the provider to produce the required information to substantiate.

26. Genesis' oral testimony and attempted explanation of its staff's experience, without written documentation of the same, is insufficient to meet the mandatory and unambiguous documentation requirement(s) of APSM-45.2 and Clinical Coverage Policy 8A. (Respondent's Exs. 20; 1 at 36, 56.)

Recoupment

27. A significant part of the issue in this contested case is whether MeckLINK should be allowed to recoup money from Petitioner when services have been rendered by Petitioner and there is no issue of the quality of the services, but the recoupment is based on MeckLINK's contention that the documentation of staff qualifications to provide the services has not been sufficiently produced by Genesis.

28. The North Carolina Administrative Code requires proper documentation. 10A NCAC 22F .0107

29. The Code has two provisions which are entitled "Recoupment": 10A N.C.A.C. § 22F .0601 and 10A N.C.A.C. § 22F .0706.

30. 10A N.C.A.C. § 22F .0706 speaks to recoupment of overpayments and how the money will be distributed.

31. The Code states at 10A N.C.A.C. § 22F .0601 that "the Medicaid agency will seek full restitution of any and all improper payments made to providers by the Medicaid program." The phrase "improper payments" is not defined in the Code. However, in reading *in pari materia* other sections, one may discern its meaning and intent.

32. 10A N.C.A.C. § 22F .0103 also similarly states that the Division shall institute methods and procedures to, among other things, "recoup improperly paid claims."

33. The Administrative Code states at 10A N.C.A.C. § 22F .0103 that "[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."

34. There has been no assertion or allegation in this proceeding that Petitioner was in any way responsible for fraud as defined in N.C.G.S. § 108A-63, i.e., there is no allegation or assertion of 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.

35. There is no allegation or assertion of overutilization or that Petitioner provided medically unnecessary or medically inappropriate services.

36. 10A N.C.A.C. § 22F .0301 defines provider abuse as including, among other things, "[b]illing for care and services that are provided by an unauthorized or unlicensed person."

Services provided by someone who lacks the proper credentials or who does not meet minimum requirements to provide the service would be an "unauthorized or unlicensed person."

37. 10A N.C.A.C. § 22F .0103 also lists measures and procedures to be taken whenever a provider has violated any of the listed missteps or misdeeds. Among the items listed that the Respondent shall institute are methods and procedures to "establish remedial measures including but not limited to monitoring programs, referral for provider peer review those cases involving questions of professional practice, and analyze and evaluate data and information to establish facts and conclusions concerning provider and recipient practices" as well as recoup improperly paid claims.

38. In section 10A N.C.A.C. § 22F .0501 (captioned "general") it is stated that the Division will safeguard against providers' practices that provide medically unnecessary and medically inappropriate health care and services, and to ensure that quality of care rendered recipients meets acceptable standards.

39. In section 10A N.C.A.C. § 22F .0602, the Code addresses "administrative sanctions and remedial measures" for program abusers that the reviewers may consider. Among those sanctions and remedial measures are warning letters, suspension or termination as a provider, probation with close monitoring, or "flagging" a provider for manual review.

40. 10A N.C.A.C. § 22F .0602 does not provide for any monetary assessment among the remedial measures listed because that is incorporated into the previous section, 10A N.C.A.C. § 22F .0601, which is set forth in paragraph 31 above. The provisions of 10A N.C.A.C. § 22F .0602 are discretionary ("may") and the provisions of 10A N.C.A.C. § 22F .0601 are mandatory ("will").

41. Petitioner Genesis contends that this case is similar to the case of *At Home Personal Care Services, Inc. v. N.C. Department of Health & Human Services, Division of Medical Assistance*, No. 11 DHR 08755, 26 N.C. Reg. 1607 (N.C.O.A.H. Apr. 16, 2012), a case decided by the Undersigned. The matters in this contested case hearing are significantly different in that the issues are not just about record-keeping as in *At Home Personal Care*, but actually meet the definition of "abuse."

42. MeckLINK did not commit error by failing to utilize the administrative or remedial remedies in 10A N.C.A.C. § 22F .0602.

Gold Star Review

43. During the Gold Star Review, Genesis failed to produce documentation sufficient to demonstrate that it had three staff members on each IIH team with one year of full time or full time equivalent experience with the population served, as required by Clinical Coverage Policy 8A. Based on the documents submitted by Genesis, MeckLINK could not reasonably conclude that

each member of the IIH teams had the required experience with the population served at any time during the Audit Period. (Respondent's Exs. 1, 6, 20; Tr. 48-52; 73.)

44. During the Gold Star Review, Genesis did produce documentation sufficient to demonstrate that four members of its CST team had one year of full time or full time equivalent experience with the population served. There was not sufficient documentation to show that Shamira Moore had the requisite experience. A team is only required to have three members. Teams that were properly comprised of three members that did not include Shamira Moore would be entitled to have been compensated.

45. Clinical Coverage Policy 8A provides that IIH and CST services are team-delivered services. Specifically, Clinical Coverage Policy 8A provides that a CST team works "though a team approach to assist adults in achieving rehabilitative and recovery goals" and "maintain[s] contact and intervenes as one organizational unit." (Respondent's Ex. 1 at 52.) It further provides that an IIH team "is a team approach designed to address the identified needs of children and adolescents[,]" and that IIH staff "maintain contact and intervene as one organizational unit." (Respondent's Ex. 1 at 34.)

46. Accordingly, CST and IIH services are considered to be provided not by one staff member or individual staff members, but by the team as a whole. A team is comprised of three members as set forth in Clinical Coverage Policy 8A. If any member of the three member team is noncompliant with a requirement in Clinical Coverage Policy 8A, then the services billed by the team are noncompliant. (Tr. 31-35.)

47. Because Genesis failed to present sufficient documentation to MeckLINK showing that it had fully qualified IIH teams during the Audit Period, all IIH services provided during the Audit Period were noncompliant. All CST services provided during the Audit Period which included Shamira Moore were noncompliant.

48. During the reconsideration review as provided in 10A N.C.A.C. § 22F .0402, Genesis was given an opportunity to clarify and supplement the information provided during the review, but failed to do so satisfactorily. During the reconsideration review, possible administrative measures and restitution could have been considered.

49. Genesis also failed to provide appropriate documentation for ten paid claims that MeckLINK examined during the Gold Star Review, which were part of the Services (and which Genesis was informed would be evaluated in the Gold Star Review). These paid claims were noncompliant because, among other things, services billed to Medicaid were not signed within seven days of the date of service rendered as required by APSM-45.2; services that were not a billable function of IIH or CST teams were improperly billed to Medicaid; and services that were allegedly provided over the phone and not face-to-face were improperly billed to Medicaid. (Respondent's Ex. 7; Tr. 76-79.)

50. An auditor, such as MeckLINK during the Gold Star Review, does not have discretion to simply assume that providers' staff have the required experience with the population served if that experience is not clearly documented in the providers' records as required by APSM-45.

51. With the exception of CST services that may have been provided by a team without Shamira Moore, the services rendered during the Audit Period were noncompliant with Clinical Coverage Policy 8A, Implementation Update 37, and APSM-45.2.

52. Genesis billed MeckLINK for Medicaid reimbursement for the services and was paid for the services through Medicaid funds.

53. MeckLINK has established by a preponderance of the evidence that the services delivered to Medicaid recipients by Genesis to the degree set forth herein and paid by MeckLINK through Medicaid funds were in fact not appropriately billed to Medicaid due to their noncompliance with Clinical Coverage Policy 8A, Implementation Update 37, and APSM-45.2.

54. There is no evidence that all CST teams' services were noncompliant when there were possibly teams that could have been properly constructed so as to exclude Shamira Moore. MeckLINK committed error by finding that all CST teams were noncompliant. Otherwise MeckLINK has established by a preponderance of the evidence that at no time relative to the Gold Star Review or in its determination of the Services' noncompliance did it exceed its authority or jurisdiction, fail to use proper procedure, act arbitrarily or capriciously, or fail to act as required by law or rule.

55. MeckLINK has established by a preponderance of the evidence that all IIH services rendered were out of compliance during the audit period and that payback for those services is owed. Credit should be given to Genesis for services rendered by CST teams properly comprise of three team members that did not include Shamira Moore and were otherwise properly composed. Any CST team that included Shamira Moore was out of compliance and therefore payback for those services during the audit period is owed.

56. The calculated amount of payback as $558,746.50 for the out-of-compliance services delivered may be incorrect. MeckLINK is required to calculate the amount owed by Genesis as payback for all IIH services during the audit period. MeckLINK is required to determine the amount of payback owed by Genesis for CST services rendered during the audit period that included Shamira Moore or were improperly constituted.

57. The undersigned finds and concludes that MeckLINK committed error by finding that all CST teams were noncompliant. The undersigned finds and concludes that MeckLINK did not otherwise err, exceed its authority or jurisdiction, fail to use proper procedure, act arbitrarily or capriciously, or fail to act as required by law in connection with its Gold Star monitoring review conducted on July 10 and 17, 2013, that the services were noncompliant as set forth herein with rules and policies required for the services to be billable to Medicaid; that the services were improperly billed to Medicaid; that MeckLINK's assessment of a payback for the services was proper; and that Petitioner owes MeckLINK a repayment of Medicaid funds in the amount of $558,746.50 for the services, less any amount to be determined for CST services performed by properly constituted three member CST teams.

DECISION AND ORDER

Based upon the foregoing findings of fact and conclusions of law, it is hereby ORDERED that MeckLINK shall determine within 30 days of this ORDER the amount of payback Genesis owes for all of the IIH services performed for the audit period. Within 60 days of Petitioner's receipt from MeckLINK of the amount of the overpayment due for IIH services, Petitioner shall remit to MeckLINK payment in full the amount determined to be owed for IIH services that were inappropriately billed during the audit period.

It is further ORDERED that Genesis shall have 30 days from the date of this ORDER to submit to MeckLINK documentation to show properly constituted CST teams during the audit period that do not include Shamira Moore as having been a team member. Genesis is to submit the amount it was reimbursed in Medicaid funds for the services of those identified CST teams. MeckLINK shall have 15 days to verify those teams through the records produced by Genesis. The parties shall have an additional 15 days to work through any discrepancies in determining a final amount of payback. Once MeckLINK makes the final determination of the amount of payback for CST services, Genesis shall be given credit against the total payback amount of $558,746.50 for the services provided by the properly constituted CST teams. Within 60 days of receipt of the final amount due, Petitioner shall remit to MeckLINK payment in full the amount determined to be owed for CST services that were inappropriately billed during the audit period.

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 17th day of June, 2015

Donald W. Overby
Administrative Law Judge