STATE OF NORTH CAROLINA

COUNTY OF MCDOWELL

IN THE OFFICE OF ADMINISTRATIVE HEARINGS
15 DHR 01519

STRATEGIC INTERVENTIONS, INC.,

Petitioner,

v.

SMOKY MOUNTAIN CENTER AREA AUTHORITY LME/MCO,

Respondent.

FINAL DECISION GRANTING SMOKY MOUNTAIN CENTER AREA AUTHORITY LME/MCO's MOTION FOR SUMMARY JUDGMENT

THIS CAUSE came before the undersigned Selina M. Brooks, Administrative Law Judge, upon Respondent Smoky Mountain Center Area Authority LME/MCO's ("Smoky") Motion for Summary Judgment (the "Motion") filed May 8, 2015.

Having considered Smoky's Motion, Strategic Interventions, Inc.'s ("Petitioner") Brief in Opposition to Respondent's Motion for Summary Judgment and In Support of Petitioner's Motion for Attorneys' Fees ("Petitioner's Motion"), the affidavits and supporting documentation filed by Petitioner and Smoky, the briefing of the parties and other matters of record and having heard the arguments of counsel at a hearing conducted on July 27, 2015 in High Point, North Carolina, the Undersigned enters this decision granting Smoky's Motion for Summary Judgment:

SUMMARY OF UNDISPUTED FACTS

1. Smoky is an area authority and local management entity/managed care organization ("LME/MCO"), governed by an area board pursuant to N.C. Gen. Stat. § 122C-117(b). Pursuant to a contract with the North Carolina Department of Health and Human Services, Division of Medical Assistance ("DMA"), Smoky operates the 1915(b)/(c) Medicaid Waiver within its twenty-three (23) county catchment area.

2. The 1915(b)/(c) Medicaid Waiver is a Medicaid managed care program approved by the federal Centers for Medicare and Medicaid Services ("CMS") which waives certain provisions of North Carolina's traditional fee-for-service Medical Assistance Program, also known as the "NC Medicaid Program."

3. Smoky does not itself provide behavioral healthcare services to eligible enrollees, but rather is "responsible for the management and oversight of the public system of mental health,

developmental disabilities, and substance abuse services at the community level." N.C. Gen. Stat. § 122C-115.4(a).

4. In the operation of the 1915(b)/(c) Medicaid Waiver managed care program and pursuant to its contract with DMA, Smoky is charged with selecting and maintaining its own closed network of providers to serve the behavioral healthcare needs of eligible consumers in Smoky's catchment area. By the authority of its contract with DMA, Smoky is also charged with conducting program integrity activities and routine monitoring of providers in its closed provider network, including monitoring all fraud and abuse investigations and conducting post-payment reviews of providers in accordance with 42 C.F.R. § 456.1, *et seq.* *See also* 42 C.F.R. § 455.1, *et seq.* The Code at 42 C.F.R. § 438.608 further requires that: "The MCO or PIHP must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse."

5. Program integrity activities are conducted by a specific team at Smoky made up of individuals who have received training on identifying potential fraud and abuse and provider overpayments. Routine monitoring is conducted by a separate team at Smoky and utilizes a specific monitoring tool mandated by DMA. The two functions are distinct activities under the DMA contract and provider contracts.

6. Smoky's Program Integrity Unit does not undertake routine monitoring or Gold Star Reviews of its providers. Instead, the Program Integrity Unit conducts targeted reviews which are often based upon reports received from third-parties involving fraud and/or abuse on the part of the provider in question. This function is a specific requirement of Smoky's contract with DMA.

7. Petitioner Strategic Interventions, Inc. ("Petitioner") is a provider of behavioral healthcare services operating throughout central and western North Carolina. Among other services, Strategic provides Assertive Community Treatment Team ("ACTT") services to its consumers.

8. At all times relevant to the issues presented in this matter, Petitioner delivered behavioral healthcare services to Smoky enrollees.

9. Effective July 1, 2012, Petitioner entered into a one-year Procurement Contract for the Provision of Services with Smoky (the "2012 Provider Contract"). The 2012 Provider Contract included the provision of ACTT services. (Resp't. Ex. 1)

10. Effective July 1, 2013, Petitioner entered into another Procurement Contract for the Provision of Services with Smoky (the "2013 Provider Contract"). The 2013 Provider Contract also included the provision of ACTT services. (Resp't. Ex. 2)

11. Both the 2012 and 2013 Provider Contracts required Petitioner to comply with DMA Clinical Coverage Policy No. 8A and all relevant service definitions. (*See* Resp't. Exs. 1 and 2)

12. The 2012 Contract specifically required that "SERVICES are to be provided consistent with the requirements of the SMC Operations Manual, the Innovations Manual, the General Conditions of the Agency Procurement Contract, in its most recent and subsequent versions, and all…**Service Definitions**." (Resp't. Ex. 1) (emphasis added)

13. The 2013 Contract required providers to be governed by certain "Controlling Authority," which is defined to include "Medical or clinical coverage policies promulgated by the Department [of Health and Human Services] in accordance with N.C.G.S. § 108A-52.2." (Resp't. Ex. 2)

14. By letter dated March 22, 2013, Smoky provided notice by personal service of its intention to conduct a post-payment review. This letter specifically identified certain consumer records and dates of service involving ACTT services which would be the subject of the post-payment review. (Duggins Aff., Ex. 7)

15. Smoky's Program Integrity Unit conducted a post-payment review of certain Medicaid reimbursements made by Smoky to the Petitioner for ACTT services provided by Petitioner for dates of service from 7/1/2012 to 12/31/2013. The preliminary results of the post-payment review identified potential provider abuse in several areas.

16. By letter dated January 16, 2014, Smoky requested additional records from Petitioner. Based on this letter, ACTT services would be reviewed based on "adherence to requirements as outlined in applicable clinical coverage policies and provider participation agreements…and documentation of staff qualifications and credentials." (Duggins Aff., Ex. 8)

17. By letter dated October 22, 2014, Smoky sent a Notice of Overpayment to Petitioner in the amount of $242,247.12, with a detailed spreadsheet identifying the reason(s) each claim was found to have been improperly paid. The results of the post-payment review revealed program abuse involving Petitioner's Marion, Morganton and Yadkinville ACT Teams. (Kumar Aff., Ex. 5)

18. Petitioner timely requested a Reconsideration Review of Smoky's Notice of Overpayment on November 20, 2014, at which time it provided a letter from Donna Duggins, Petitioner's Director of Operations, along with additional documentation in support of its attempt to rebut the preliminary results of Smoky's review. (Resp't. Ex. 6)

19. On December 18, 2014, representatives from Petitioner, including its President, Director of Operations, and Quality Management Director, met with Smoky's independent Program Integrity Reconsideration Panel, the members of which had no prior involvement with Smoky's investigation into ACTT services provided by Petitioner which led to the Notice of Overpayment. Petitioner was invited to submit any and all additional documentation to the Reconsideration Panel that it believed supported its position that it did not owe Smoky a payback for the overpayments.

20. As a result of the additional documentation submitted by Petitioner and information presented by Petitioner at the December 18, 2014 meeting, the independent Reconsideration Panel

overturned Smoky's Notice of Overpayment as to several of the claims. However, the additional information submitted by Petitioner either failed to rebut, or in some circumstances confirmed, certain overpayments.

21. By letter dated December 29, 2014, Smoky informed Petitioner of the results of its independent reconsideration process and issued its final Notice of Decision in the amount of $104,449.68, which amount Smoky determined was improperly billed to, and paid by, Smoky with Medicaid funds. (Resp't. Ex. 3)

22. Based on documentation identified during the post-payment review and provided by Petitioner during reconsideration, Smoky determined that Petitioner's Marion ACT Team did not employ the required number of nurses during August 2012. (Resp't. Ex. 3)

a. Pursuant to the 2011 DMA Clinical Coverage Policy No. 8A, ACT Team sizing depends upon the number of consumers being served by that Team. For example, "Mid-size teams serving 51-75 recipients shall employ a minimum of 8 to 10 FTE multidisciplinary clinical staff person…" (Resp't. Ex. 4 at 70)

b. Petitioner's Marion ACT Team was comprised of fifty-five (55) consumers during August 2012, and therefore, was considered mid-size under the 2011 Clinical Coverage Policy. (Resp't. Ex. 5)

c. The 2011 DMA Clinical Coverage Policy No. 8A requires that mid-size ACT Teams must employ a *minimum* of "2 FTE registered nurses (RNs)." (Resp't. Ex. 4 at 70)

d. The documentation produced by Petitioner during the Reconsideration Review showed that it staffed the Marion ACT Team with only 1.0 FTE RN during August 2012. (Resp't. Ex. 6)

e. Petitioner does not dispute that it employed only 1.0 FTE RN during August 2012 for its Marion ACT Team or that the 2011 DMA Clinical Coverage Policy No. 8A "required 2 FTE nurses." (Petitioner's Motion at 24)

23. Based on documentation identified during the post-payment review and provided by Petitioner during reconsideration, Smoky determined that Petitioner's Marion ACT Team did not employ the required number of nurses during August 2013. The documentation produced by Petitioner during the Reconsideration Review showed it only staffed the Marion ACT Team with 2.0 FTE nurses during August 2013. (Resp't. Ex. 6)

a. Pursuant to the 2013 DMA Clinical Coverage Policy No. 8A, "Large [ACT] Teams" are defined as serving 75-120 beneficiaries and require 3.0 FTE RN staffing. (Resp't. Ex. 7 at 70)

b. Petitioner's Marion ACT Team was comprised of eighty-two (82) consumers during August 2013, and at no point during 2013 did the Marion ACT Team drop below seventy-nine (79) consumers. (Resp't. Ex. 8)

c. Petitioner's Marion ACT Team was considered a large Team in August 2013.

d. The documentation produced by Petitioner during the Reconsideration Review showed that it staffed the Marion ACT Team with only 2.0 FTE RN during August 2013. (Resp't. Ex. 6)

e. Petitioner does not dispute that it employed only 2.0 FTE registered nurses on its Marion ACT Team for the month of August 2013, "though due to team size 3.0 FTE nurses were required." (Petitioner's Motion at 24)

24. Based on documentation identified during the post-payment review and provided by Petitioner during reconsideration, Smoky determined that Petitioner's Morganton ACT Team did not have a properly licensed Team Leader from August 1, 2013 through September 29, 2013. (Resp't. Ex. 3)

a. The 2013 DMA Clinical Coverage Policy No. 8A requires that each ACT Team shall have exactly one Team Leader. (Resp't. Ex. 7 at 71, 73) Moreover, the Team Leader must be a mental health professional holding any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Pediatric Nurse Practitioner, Clinical Nurse Specialist certified as an advanced practice psychiatric nurse specialist. (Resp't. Ex. 7 at 73)

b. Petitioner's Morganton ACT Team Leader was formerly Ms. Nina Hightower. Ms. Hightower was licensed as a Licensed Clinical Social Worker (LCSW). However, Ms. Hightower left Petitioner's employ on or about August 22, 2013. (Resp't. Ex. 6) Following the departure of Ms. Hightower, Ms. Marybeth Hermann was staffed as the "interim Team Lead" for the Morganton ACT Team. (Resp't. Ex. 6)

c. Ms. Hermann did not receive her license as a Licensed Professional Counselor Associate until September 30, 2013. (Resp't. Ex. 11)

d. At the time of her appointment to "interim Team Lead" until September 29, 2013, Ms. Hermann was not a licensed mental health professional. There is no evidence to suggest that Ms. Hermann was properly licensed to serve as an ACT "Team Lead" under the 2013 DMA Clinical Coverage Policy No. 8A until September 30, 2013.

e. The documentation submitted by Petitioner during Reconsideration demonstrated that no one other than Ms. Hermann served as "Team Lead" for the Morganton ACT Team from August 22, 2013 through September 29, 2013. (Resp't. Ex. 6)

f. Smoky only sought payback for Petitioner's failure to properly staff its Morganton ACT Team Leader position from September 1, 2013 through September 29, 2013. (Resp't. Ex. 3)

g. Petitioner does not dispute that Ms. Hermann lacked the proper license to serve as an ACT Team Leader until September 30, 2013. (Petitioners' Motion at 25)

25. Based on documentation identified during the post-payment review and provided by Petitioner during reconsideration, Smoky determined that Petitioner's Yadkinville ACT Team did not have a properly licensed Team Leader for August 2013 and from October through December 2013. (Resp't. Ex. 3)

a. Again, the 2013 DMA Clinical Coverage Policy No. 8A requires that each ACT Team shall have exactly one Team Leader. (Resp't. Ex. 7 at 71, 73)

b. At all times relevant, Ms. Janell Jordan served as Petitioner's Yadkinville ACT Team Leader.

c. Ms. Jordan received her licensed as a Licensed Professional Counselor Associate on May 30, 2014. (Resp't. Ex. 14)

d. Petitioner does not dispute that Ms. Jordan lacked the proper license to serve as an ACT Team Leader in August and October through December 2013. (Petitioners' Motion at 25-26)

26. On March 2, 2015, Petitioner filed the instant Contested Case Petition, contesting the overpayment identified in Smoky's notice of December 29, 2014.

CONCLUSIONS OF LAW

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

2. To the extent that the findings of facts contain conclusions of law, or that the conclusions of law are findings of fact, they should be so considered without regard to the given labels. *Bonnie Ann F. v. Calallen Indep. Sch. Dist.*, 835 F. Supp. 340 (1993).

3. Petitioner is an aggrieved person under Chapter 150B of the North Carolina General Statutes and is entitled to commence a contested case. Petitioner has satisfied all conditions precedent and all timeliness requirements for initiating this contested case.

4. Petitioner bears the burden of proof in this case pursuant to N.C. Gen. Stat. § 108C-12.

5. The burden of proof which a petitioner must meet in order to prevail in a contested case is set forth in N.C. Gen. Stat. § 150B-23(a).

6. Applying N.C. Gen. Stat. § 150B-23(a) the Court of Appeals has explained the petitioner's burden of proof as follows:

> The subject matter of a contested case hearing by the ALJ is an agency decision. Under N.C. Gen. Stat. § 150B-23(a), the ALJ is to determine whether the petitioner has met its burden in showing that the agency substantially prejudiced petitioner's rights, and that the agency also acted outside its authority, acted erroneously, acted arbitrarily and capriciously, used an improper procedure, or failed to act as required by law or rule.

Britthaven, Inc. v. N.C. Dep't of Human Res., 118 N.C. App. 379, 382, 455 S.E.2d 455, 459, *rev. denied*, 341 N.C. 418, 461 S.E.2d 754 (1995) (emphasis omitted).

7. Administrative Law Judges may rule on all prehearing motions authorized under the North Carolina rules of Civil Procedure, including motions for summary judgment. *See* N.C. Gen. Stat. §§ 150B-33(b)(3a), 34(3); 26 N.C.A.C. 3.0105(1) and (6).

8. Summary judgment is appropriate where there is no genuine issue of material fact and the movant is entitled to judgment as a matter of law. N.C. R. Civ. P. 56(c); *see also Patmore v. Town of Chapel Hill NC*, ___ N.C. App. ___, 757 S.E.2d 302, 304 (2014), *disc. rev. denied*, 367 N.C. 519, 758 S.E.2d 874 (2014)).

9. Here, there are no genuine issues of material fact, and Smoky is entitled to judgment as a matter of law.

10. A court need not make findings as to every fact that arises from the evidence and need only find those facts that are material to the settlement of the dispute. *See Flanders v. Gabriel*, 110 N.C. App. 438, 449, 429 S.E.2d 611, 612 (1993).

11. At all times relevant to this matter, Smoky had the authority to conduct audits, post-payment reviews, program integrity and other monitoring activities, including unannounced audits, through its role as the state-contracted LME/MCO for its catchment area. Routine, scheduled audits are distinct from targeted audits that are prompted by an allegation of fraud or abuse.

12. Smoky has the authority to conduct unannounced audits as needed. Pursuant to N.C. Gen. Stat. § 108C-5 governing payment suspensions and audits of providers, "[n]othing in this Chapter shall be construed to prevent the Department from conducting unannounced or targeted audits of providers." N.C. Gen. Stat. § 108C-5(s).

13. The "Department" is defined to include LME/MCOs like Smoky: the "North Carolina Department of Health and Human Services, its legally authorized agents, contractors, or

vendors, who acting within the scope of their authorized activities, assess, authorize, manage, review, audit, monitor. . . the North Carolina State Plan of Medical Assistance." N.C. Gen. Stat. § 108C-2(3).

14. Reviews of allegations of fraud and/or abuse by a provider are handled in accordance with the requirements of federal regulations, the contracts between providers and LME/MCOs, and Smoky's contract with DMA to operate the 1915(b)/(c) Medicaid Waiver.

15. Following an investigation by the LME/MCO into an allegation of fraud or abuse, contracted providers such as Petitioner are required to remit any and all improper payments identified by the LME/MCO.

16. Federal Medicaid regulations define "abuse" to mean:

> Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

42 C.F.R. § 455.2.

17. North Carolina has further defined Medicaid provider abuse to include:

> Any incidents, services, or practices inconsistent with accepted fiscal or medical practices which cause financial loss to the Medicaid program or its beneficiaries, or which are not reasonable or which are not necessary including, for example, the following:
>
> (1) Overutilization of medical and health care and services.
> (2) Separate billing for care and services that are:
> (a) part of an all-inclusive procedure,
> (b) included in the daily per-diem rate.
> (3) Billing for care and services that are provided by an unauthorized or unlicensed person.
> (4) Failure to provide and maintain within accepted medical standards for the community:
> (a) proper quality of care,
> (b) appropriate care and services, or
> (c) medically necessary care and services.
> (5) Breach of the terms and conditions of participation agreements, or a failure to comply with requirements of certification, or failure to comply with the provisions of the claim form.
>
> The foregoing examples do not restrict the meaning of the general definition.

10A N.C.A.C. 22F.0301.

18. In conducting post payment review audits pursuant to an allegation of fraud or abuse, no specific monitoring tool is mandated by federal or state law, rule or regulation or the contract between Smoky and DMA to operate the 1915(b)/(c) Waiver.

19. Further, the 2012 and 2013 Provider Contracts make clear the distinction between targeted or fraud investigatory audits and other types of audits: "At a minimum of once every two (2) years, the CONTRACTOR [Petitioner] will participate in an audit of paid claims conducted by LME/PIHP. . . . Audits shall be arranged with the CONTRACTOR in advance, *except when the LME/PIHP has received a credible allegation of fraud*." *See, e.g.,* 2013 Provider Contract, Resp. Ex. 2, Article II, Section 4(i).

20. Smoky's Program Integrity Department conducted an investigation and review of Petitioner upon receipt of a credible report of fraud or abuse utilizing appropriate procedures as outlined above. Smoky was under no obligation to provide Petitioner with advance notice of its targeted investigation audit, nor was it required to use the Gold Star Monitoring or any other specified tool when conducting such a review. Moreover, the Gold Star Monitoring Tool is not applicable to the review of ACT Team services.

21. The 2012 Provider Contract required Petitioner to document all services provided in compliance with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services ("DMH/DD/SAS") Records Management and Documentation Manual as well as applicable DMA Clinical Coverage Policies. The 2013 Provider Contract further required Petitioner to maintain necessary records and accounts related to the Contract, including medical, personnel and financial records, "to assure a proper accounting of all funds." (*See* Article II, Section 4 of Resp't Ex. 2) Further, all Medicaid providers are required to "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." 10A N.C.A.C. 27F.0107. Thus, the burden was on Petitioner to provide records necessary for review.

22. Petitioner is required to comply with: 1) DMA Clinical Coverage Policy No. 8A and corresponding service definitions; 2) all directives and policies promulgated by DHHS and its Divisions 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. (*See* Resp't Ex. 2)

23. DMA Clinical Coverage Policy No. 8A, including its service definitions, meets the definition of "medical coverage policy" as defined and authorized by N.C. Gen. Stat. § 108A-54.2.

24. As discussed below, the plain language of DMA Clinical Coverage Policy No. 8A and all attached service definitions detail what is required of Petitioner as a provider in Smoky's catchment area.

25. DMA promulgated, and at various times has revised, Clinical Coverage Policy No. 8A setting forth the requirements for the eligibility and provision of Medicaid behavioral health care services, including ACTT services.

26. According to the plain terms of the 2012 Provider Contract, Petitioner agreed to comply, *inter alia*, with the Clinical Coverage Policies promulgated by DMA. These Clinical Coverage Policies are promulgated by DMA and set forth the requirements for eligibility, staffing and the provision of Medicaid behavioral healthcare services, including ACTT services. The "General Conditions" section of the 2012 Contract specifically holds that Petitioner "shall comply with all applicable . . . State laws/rules/regulations; and (b) implement services in accordance with applicable laws/rules/regulations." (Resp't. Ex. 1)

27. According to the plain terms of the 2013 Provider Contract, Petitioner agreed to comply, *inter alia*, with the Clinical Coverage Policies promulgated by DMA. The 2013 Contract required Petitioner "to operate and provide services in accordance with Controlling Authority," which is defined in the Contract to specifically include "Medical or clinical coverage policies promulgated by the Department [of Health and Human Services] in accordance with N.C.G.S. § 108A-54.2" (Resp't. Ex. 2)

28. During the 2012 Contract, the provision of ACTT services was governed by DMA Clinical Coverage Policy No. 8A, revised effective August 1, 2011 (the "2011 DMA Clinical Coverage Policy No. 8A").

29. Beginning in August 2013, under the 2013 Contract, the provision of ACTT services was governed by DMA Clinical Coverage Policy No. 8A, revised effective August 1, 2013 (the "2013 DMA Clinical Coverage Policy No. 8A").

30. Clinical Coverage Policy No. 8A requires that ACT teams consist of "a community-based group of medical, behavioral health, and rehabilitation professionals who use a team approach to work together to meet the needs of beneficiaries with severe and persistent mental illness." (Resp't. Ex. 7 at 68)

31. Accordingly, ACTT services are considered to be provided by not one staff member or individual staff members, but by the team as a whole. If the team, or any member of the team, is noncompliant with a requirement of DMA Clinical Coverage Policy No. 8A, then the services billed by the team are noncompliant.

32. National Program Standards for ACT Teams do not serve as a replacement for the requirements of DMA Clinical Coverage Policy No. 8A and the corresponding ACTT service definition. By its own terms, the National Program Standards for ACT Teams "is written to provide an **archetype** for departmental of [sic] mental health to use in writing and promulgating their own [ACT] program standards. These standards can be customized to address a particular client group and to meet individual state mental health laws and policies." (Aff. Duggins, Ex. 4) (emphasis added)

33. To the extent that the National Program Standards for ACT Teams provide any guidance for ACTT providers within the State of North Carolina, such guidance is intended to be construed as instructive, but not as a replacement for the plain language requirements of DMA Clinical Coverage Policy No. 8A and the attached ACTT service definition. Specifically, the 2011 DMA Clinical Coverage Policy No. 8A demonstrates that the National Program Standards for ACT Teams are merely instructive when it states that "ACT Teams **should** make every effort to meet critical standards contained in the most current edition of the National Program Standards for ACT Teams as established by the National Alliance for the Mentally Ill or US Department of Health and Human Services, Center for Mental Health Services." (Resp't. Ex. 4 at 68) (emphasis added)

34. Pursuant to the August 2012 *Olmstead* settlement between the State of North Carolina and the U.S. Department of Justice, all ACT Teams in North Carolina are required to operate consistent with standardized fidelity measures. Such fidelity is monitored by DHHS using the Tool for Measurement of Assertive Community Treatment ("TMACT").

35. Fidelity measures for ACT Teams using TMACT are separate and distinct from the other requirements found in the ACT service definition of DMA Clinical Coverage Policy No. 8A. Specifically, the 2013 DMA Clinical Coverage Policy No. 8A states that "[a]long with the fidelity evaluation rating, teams must meet all the minimum requirements for an ACT team as outlined in this service definition." (Resp't. Ex. 7 at 70)

36. Fidelity scores produced by a TMACT review do not excuse a provider's failure to strictly follow the plain language requirements of the ACTT service definition as found in DMA Clinical Coverage Policy No. 8A.

37. The 2011 and 2013 DMA Clinical Coverage Policies impose minimum requirements on ACTT service providers such as Petitioner, including, but not limited to, team composition and staffing, team size, staff-to-beneficiary ratio, staff licensure, and service type and setting. (Resp't. Exs. 4 and 7)

MARION ACT TEAM 2012

38. The documentation and testimony provided during the Reconsideration Review showed that Petitioner's ACT Team based in Marion, NC did not meet the 2011 DMA Clinical Coverage Policy No. 8A Service Definition requirements for Team Composition during August 2012.

39. The 2011 DMA Clinical Coverage Policy No. 8A was in full force and effect during August 2012. (Resp't. Ex. 4)

40. Petitioner was required to comply with the 2011 DMA Clinical Coverage Policy No. 8A.

41. Pursuant to the plain language of the 2011 DMA Clinical Coverage Policy No. 8A, ACT Team sizing depends on the number of consumers being served by that Team. For example,

"Mid-size teams serving 51-75 recipients shall employ a minimum of 8 to 10 FTE multidisciplinary clinical staff person…" (Resp't. Ex. 4 at 70)

42. Petitioner's Marion ACT Team was comprised of fifty-five (55) consumers during August 2012. (Resp't. Ex. 5) Therefore, this team was considered "mid-size" based on the requirements of the 2011 DMA Clinical Coverage Policy No. 8A.

43. The 2011 DMA Clinical Coverage Policy No. 8A requires that mid-size ACT Teams must employ a *minimum* of "2 FTE registered nurses (RNs)." (Resp't. Ex. 4 at 70)

44. Petitioner employed only one (1) FTE RN on its Marion ACT Team during the month of August 2012. Accordingly, all services provided by the Marion ACT Team in August of 2012 were noncompliant with the plain language requirements of the 2011 DMA Clinical Coverage Policy No. 8A.

45. The 2011 DMA Clinical Coverage Policy No. 8A makes no mention of aggregating staff overtime hours in order to create new RN FTEs. As such, Petitioner's argument that other members of its Marion ACT Team staff worked twenty-four (24) overtime hours does not excuse its failure to provide the required level of RN staffing for a "mid-size" team during August of 2012. (Resp't. Ex. 6)

MARION ACT TEAM 2013

46. The 2013 DMA Clinical Coverage Policy No. 8A was in full force and effect during August 2013. (Resp't. Ex. 7)

47. Petitioner was required to comply with the 2013 DMA Clinical Coverage Policy No. 8A.

48. Pursuant to the plain language of 2013 DMA Clinical Coverage Policy No. 8A, "Large [ACT] Teams" are defined as serving 75-120 beneficiaries and require 3.0 FTE RN staffing. (Resp't. Ex. 7 at 70)

49. Petitioner staffed its Marion ACT Team with only 2.0 FTE RNs in August 2013.

50. The 2013 DMA Clinical Coverage Policy No. 8A provides additional guidance for team sizing related to consumers moving onto and off of ACT Teams. Specifically, the 2013 DMA Clinical Coverage Policy No. 8A states that "[m]ovement on to (admissions) and off of (discharges) the team may temporarily result in breaches of the maximum caseload. Therefore, teams will be expected to maintain an annual average not to exceed 50, 74, and 120 beneficiaries respectively." (Resp't. Ex. 7 at 73)

51. Taking into account the average number of consumers found on the Marion ACT Team for 2013, the Marion ACT Team was determined to be a "Large" size ACT Team.

52. By staffing its Marion ACT Team with only 2.0 FTE Nurses during August of 2013, Petitioner failed to comply with the plain language requirements of the 2013 DMA Clinical Coverage Policy No. 8A for the staffing of Nursing for the month of August 2013. Accordingly, all services provided by the Marion ACT Team in August of 2013 were noncompliant with the 2013 DMA Clinical Coverage Policy No. 8A.

53. The 2013 DMA Clinical Coverage Policy No. 8A expressly allows for the "[p]rorating of FTE" for Nurses, but "[n]o more than two individuals can share a 1.0 FTE." Additionally, Large Teams must staff at least two Nurses as RNs or APRNs, "with at least one having a minimum of 1 year experience working with adults with serious mental illness and working knowledge of psychiatric medications. The remaining 1.0 nurse can be an RN or LPN." (Resp't. Ex. 7 at 71-72)

54. While Petitioner argues that staff overtime on the Marion Team in August of 2013 amounted to a total of thirteen (13) hours, again this is insufficient to meet the 2013 DMA Clinical Coverage Policy No. 8A Nurse staffing requirements. (Resp't. Ex. 6) Not only is thirteen (13) hours short of the hours required to account for 1.0 FTE, but Petitioner failed to specify which or how many employees accounted for the aggregation of the purported thirteen (13) hours of overtime.

55. Petitioner's argument that its ACT Teams enjoyed a superior Staff-to-Beneficiary Ratio, and therefore, it was not required to strictly comply with the language of DMA Clinical Coverage Policy No. 8A and corresponding service definition for ACTT services, is unsupported and unconvincing. Staff-to-Beneficiary Ratio is considered a different requirement than Team Leader or Nurse Staffing levels in both the 2011 and 2013 versions of DMA Clinical Coverage Policy No. 8A. (Resp't. Ex. 4 at 70; Ex. 7 at 70)

56. Meeting the required Staff-to-Beneficiary Ratio does not excuse Petitioner's failure to comply with all other requirements of DMA Clinical Coverage Policy No. 8A.

MORGANTON ACT TEAM

57. Effective August 1, 2013, DMA Clinical Coverage Policy No. 8A and ACTT Service Definitions were amended ("2013 DMA Clinical Coverage Policy No. 8A"). (Resp't. Ex. 7) At all times relevant, Petitioner was aware of these amendments, and it understood that such amendments would require that the ACT Team Lead would need to be "Masters Level with a minimum of a Licensed Professional Counselor Associate (LPCA) License. . . The date for ACT Team leaders to have a minimum of an Associate LPC license was after 8/1/2013." (Resp't. Ex. 6)

58. Petitioner was required to comply with the 2013 DMA Clinical Coverage Policy No. 8A as it relates to the credentialing requirements of Team Leaders.

59. The 2013 DMA Clinical Coverage Policy No. 8A very specifically requires that each ACT Team shall have one Team Leader and "[t]his position is to be occupied by only one person." (Resp't. Ex. 7 at 71) Moreover, the Team Leader must be a mental health professional

holding any of the following licenses: Licensed Psychologist, Licensed Psychological Associate, Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Licensed Pediatric Nurse Practitioner, Clinical Nurse Specialist certified as an advanced practice psychiatric nurse specialist. (Resp't. Ex. 7 and 73)

60. At the time of her appointment to "interim Team Lead" until September 29, 2013, Ms. Hermann was not a licensed mental health professional. Petitioner acknowledges that there is no evidence to suggest that Ms. Hermann was properly licensed to serve as an ACT Team Leader under the 2013 DMA Clinical Coverage Policy No. 8A until September 30, 2013.

61. From August 22, 2013 through September 29, 2013, Petitioner's Morganton ACT Team did not have a properly licensed Team Leader pursuant to 2013 Clinical Coverage Policy 8A. Accordingly, all services provided by the Morganton ACT Team during this time were noncompliant with the 2013 DMA Clinical Coverage Policy No. 8A.

YADKINVILLE ACT TEAM

62. Petitioner was required to comply with the 2013 DMA Clinical Coverage Policy No. 8A as it relates to the credentialing requirements of Team Leaders.

63. At all times relevant, Petitioner was aware that its current Yadkinville Team Leader, Ms. Janell Jordan, lacked the requisite licensure as required by the 2013 DMA Clinical Coverage Policy No. 8A. (Resp't. Ex. 6)

64. Despite the fact that Ms. Jordan previously served as Team Lead for Petitioner's Yadkinville ACT Team, from August 1, 2013 through May 29, 2014, Ms. Jordan was not properly licensed to serve as Petitioner's ACT Team Lead pursuant to the requirements of the 2013 DMA Clinical Coverage Policy No. 8A.

65. Petitioner argues that Dr. Shah, a psychiatrist, "provided Clinical Team Lead duties" while Ms. Jordan awaited the receipt of her licensure. Further, Petitioner claims that "Dr. Shah worked on [the Yadkinville ACT Team] approximately 50% more than was required of a doctor on the Team. This time was used to provide the ACT Team Lead duties supporting [Ms. Jordan]." (Resp't. Ex. 6) However, Dr. Shah was not authorized to serve as an ACT Team Lead.

66. The 2013 DMA Clinical Coverage Policy No. 8A provides an exhaustive list of mental health professional licenses permitted to be held by the Team Lead employee. (Resp't. Ex. at 73) Psychiatrist, the license held by Dr. Shah, is not part of this exhaustive list. As such, Dr. Shah was not among the categories of professionals properly licensed and authorized to serve as ACT Team Lead.

67. Further, the 2013 DMA Clinical Coverage Policy No. 8A states that the Team Leader position shall "be occupied by only one person." (Resp't. Ex. 7 at 71) Petitioner's claim that Dr. Shah "supported [Ms. Jordan]" therefore demonstrates that Dr. Shah's assistance to the Team Leader, Ms. Jordan, would have caused the Yadkinville Team Leader position to be staffed

by two employees. Assigning more than one Team Leader per ACT Team is strictly prohibited by the plain language of 2013 DMA Clinical Coverage Policy No. 8A. (Resp't. Ex. 7 at 71)

68. From August 2013 and October through December 2013, Petitioner's Yadkinville ACT Team did not have a properly licensed Team Lead pursuant to 2013 Clinical Coverage Policy 8A. Accordingly, all services provided by the Yadkinville ACT Team during this time were noncompliant with the 2013 Clinical Coverage Policy 8A.

RECOVERY OF THE OVERPAYMENT

69. A significant part of the issue in this contested case is whether Smoky has the authority to recover the identified overpayment from Petitioner via recoupment from claims or other collection mechanism when services have been rendered by Petitioner but Petitioner did not comply with the requirements set forth in the ACTT service definition found in DMA Clinical Coverage Policy No. 8A.

70. Petitioner is required to maintain proper documentation of all services provided. See paragraph 21, above.

71. The 2012 and 2013 Provider Contracts clearly contemplate that Smoky must recover any identified final overpayment, and that any failure by the Petitioner to remit a final overpayment may result in the assessment of penalty and interest. (*See* Article VI, Section 3 of Resp't Ex. 1 and Article II, Section 5 of Resp't. Ex. 2)

72. Through its contract with DMA in operation of the 1915(b)/(c) Medicaid Waiver, Smoky is required to conduct post-payment reviews and identify overpayments in accordance with 42 C.F.R. § 455.1, *e seq.*, 456.1, *et seq.*, and 42 C.F.R. § 438.608.

73. N.C.G.S. §108C-2(5) defines "final overpayment" to mean: "[t]he amount the provider owes after appeal rights have been exhausted, which shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings…." Accordingly, unless Petitioner timely appeals and obtains a stay from a Superior Court, Petitioner shall be required to remit the final overpayment to Smoky within thirty (30) days from the date of this Order, or be subject to assessment of penalty and interest in accordance with the terms and conditions of the 2012 and 2013 Provider Contracts.

74. Petitioner's failure to abide by the plain language requirements enunciated in DMA Clinical Coverage Policy No. 8A, and corresponding ACTT service definitions constitutes provider abuse as that term is defined at 42 C.F.R. § 455.2 and 10A N.C.A.C. 22F.0301.

75. Petitioner billed Smoky for Medicaid reimbursement for the aforementioned services and was paid for such services with Medicaid funds.

76. Smoky has demonstrated that there are no genuine issues of material fact and that Smoky is entitled to judgment as a matter of law that the services delivered to Medicaid consumers by Petitioner as set forth herein and paid by Smoky through Medicaid funds were in fact not

appropriately billed to Medicaid due to Petitioner's noncompliance with DMA Clinical Coverage Policy No. 8A and the ACTT service definition and that such overpayment for those noncompliant services by Smoky constituted abuse as defined at 42 C.F.R. § 455.2 and 10A N.C.A.C. 22F.0301.

77. Smoky did not act erroneously, exceed its authority, fail to use proper procedure, act arbitrarily or capriciously, fail to act as required by law or rule, or otherwise substantially prejudice Petitioner's rights when it issued its December 29, 2014 Notice of Decision outlining its finding of overpayment against Petitioner in the amount of $104,449.68.

FINAL DECISION

NOW, THEREFORE, based on the foregoing Findings of Fact and Conclusions of Law, the Undersigned determines that Respondent Smoky Mountain Center LME/MCO did not substantially prejudice Petitioner's rights nor act outside its authority, act erroneously, act arbitrarily and capriciously, use improper procedure, or fail to act as required by rule or law when it determined that Petitioner owed a payback of $104,449.68.

NOTICE

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

Under the provisions of N.C. Gen. Stat. § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file a Petition for Judicial Review in the superior court of the county 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, the Rules of Civil Procedure, N.C. Gen. Stat. 1A-1, *et. seq.*, **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 the Final Decision.** N.C. Gen. Stat. § 150B-46 describes the contents of the Petition and requires proper 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.

The 26th day of August, 2015.

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Selina M. Brooks
Administrative Law Judge