STATE OF NORTH CAROLINA

COUNTY OF UNION

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
15 DHR 07943

CECILIA NWAUCHE, HEALTHCARE INSTITUTE OF CHARLOTTE LLC PETITIONER, V. PUBLIC CONSULTING GROUP (PCG) FOR NC DMA/DHHS RESPONDENT.	**FINAL DECISION**

This matter was heard before the undersigned Administrative Law Judge on February 3, 2016 in Charlotte, North Carolina.

APPEARANCES

For Petitioner: Cecelia Nwauche
Healthcare Institute of Charlotte, LLC
Pro Se

For Respondent: Rajeev K. Premakumar
Assistant Attorney General
North Carolina Department of Justice
Raleigh, North Carolina

ISSUE

The issue in this matter is whether the North Carolina Department of Health and Human Services, (hereinafter "Department" or "DHHS") acted erroneously when it determined that the Petitioner received overpayments for providing Personal Care Services ("PCS") to Medicaid beneficiaries in violation of Medicaid Clinical Coverage Policy 3L. The Department, through its post-payment review contractor Public Consulting Group ("PCG"), determined that the overpayment amount at issue was $16,184.32.

EVIDENCE

The parties stipulated that Respondent's Exhibits 1–13 were properly relevant and admissible. Petitioner's Exhibits 1-4 were admitted.

WITNESSES

For Petitioner: None

For Respondent: Mary Jane Plowman, RN
Home Care Review/Oversight and Investigations
Appeals Team Lead, PCG

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing and the entire record in this proceeding, the Undersigned makes the following findings of fact. 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 witnesses 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 this case. After considering the testimony of witnesses, exhibits admitted into evidence, and the parties' arguments, the Undersigned makes the following:

FINDINGS OF FACT

1. The Division of Medical Assistance ("DMA"), a division of the Respondent, is responsible for administering and managing North Carolina's Medicaid plan and program. Pursuant to N.C. Gen. Stat. § 108A-54, DMA is authorized to adopt rules, regulations, and policies for program operation.

2. At all times material to this matter, Petitioner was an enrolled PCS provider in the North Carolina Medicaid Program and entered into a Medicaid Participation Agreement with DMA as part of its enrollment. (Respondent's Ex. 1)

3. By entering into the Medicaid Participation Agreement, Petitioner agreed to "comply with all [F]ederal and [S]tate laws, regulations, and rules, State Medicaid Plan, and policies, provider manuals, and Medicaid bulletins published by the Department, its Divisions, and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference." (Respondent's Ex. 1)

4. Further, the Petitioner agreed to "submit claims for services rendered to eligible recipients of the Department's medical or behavioral health care benefits…in accordance with rules and billing instructions in effect at the time the service is rendered." (Respondent's Ex. 1)

5. Respondent, acting through DMA, and its auditor PCG, initiated and conducted an audit of Petitioner. The auditor sought to examine Petitioner's paid Medicaid claims for the audit period 8/12/2013 to 12/31/2013. The audit was denoted as Program Integrity No. 814-00259 and the

initial letter to the Petitioner requesting records for a sample of claims was dated 05/04/2015. (Respondent's Ex. 3)

6. DMA Clinical Coverage Policy 3L Personal Care Services (original effective date of January 1, 2013, amended date October 1, 2013 and amended date December 1, 2013) is applicable to providers of PCS in North Carolina. Policy 3L was in effect and applicable to the services and dates of service that were audited during this audit. (Respondent's Ex. 2)

7. In a Tentative Notice of Decision ("TND") dated July 16, 2015, PCG notified Petitioner of an alleged overpayment of $26,686.20. (Respondent's Ex. 5)

8. The Petitioner requested a reconsideration review by the DHHS Hearing Office and a reconsideration review took place on August 27, 2015. Following the reconsideration review, and additional documentation submitted by Petitioner, the DHHS Hearing Officer issued a Notice of Decision dated September 17, 2015 modifying the alleged overpayment amount to $16,184.32. (Respondent's Ex. 10)

9. Petitioner timely appealed the Notice of Decision to the Office of Administrative Hearings.

10. The matter came on for hearing on February 3, 2016.

11. Mary Jane Plowman of PCG testified at the hearing of this case. Ms. Plowman is a Registered Nurse and has been employed by PCG in the position of Home Care Review/Oversight and Investigations Appeals Team Lead since August of 2012. (Respondent's Ex. 13)

12. Ms. Plowman reviewed the documentation submitted by the Petitioner in response to the audit initiated and conducted by PCG. (See Respondent's Ex. 11)

13. For Beneficiary S.B.:

- Date of Service: 11/15/13
  The Petitioner billed for 10 units; however, the aide documented only 6 units provided.

` - Date of Service: 11/20/13
  The Petitioner billed for 12 units; however, the aide documented only 10 units provided .

(Respondent's Ex. 11A)

14. For Beneficiary E.D.:

- Dates of Service: 8/12/13 through 12/27/13, 12/30/13, and 12/31/13
  The aide note did not document that the toileting task was provided and there was no documentation to explain why the task was not performed.

- Date of Service: 11/20/13
  The Petitioner billed for 14 units; however, the aide documented only 12 units provided.

- Date of Service: 11/27/13
  The Petitioner billed for 14 units; however, the aide documented only 12 units provide.

(Respondent's Ex. 11B)

15. For Beneficiary R.F.:

- Date of Service: 8/25/13
  Petitioner failed to submit an aide log .

- Dates of Service: 9/11/13, 9/18/13, and 9/25/13
  The Petitioner billed for 12 units; however, the aide documented only 10 units provided.

- Date of Service: 10/20/13
  The Petitioner billed for 10 units; however, the aide documented only 2 units provided.

- Dates of Service: 8/12/13 through 12/31/13
  The Petitioner failed to submit a Plan of Care.

(Respondent's Ex. 11C)

16. For Beneficiary P.J.:

- Dates of Service: 8/13/13 through 12/31/13
  The Petitioner failed to provide a Certified Nursing Assistant (CNA) I for beneficiary; the in-home aide was not on the Nurse Aide Registry.

(Respondent's Ex. 11D)

17. For Beneficiary G.R.:

- Dates of Service: 9/11/13, 9/18/13, 9/25/13, 11/20/13, and 11/27/13
  The Petitioner billed for 12 units; however, the aide documented only 10 units provided.

- Dates of Service: 12/21/13 through 12/31/13
  The Petitioner failed to provide a Certified Nursing Assistant (CNA) I for beneficiary; the in-home aide was not on the Nurse Aide Registry.

(Respondent's Ex. 11E)

18. Petitioner testified that, as a new provider, it was difficult to understand and comply with the Clinical Coverage Policy, though she made every effort to do so. Petitioner also introduced exhibits that showed how her agency had created new documentation and controls that demonstrate the agency's commitment to adhering to Clinical Coverage Policies going forward. (Petitioner's Exs. 1-4)

CONCLUSIONS OF LAW

1. All parties are properly before the Office of Administrative Hearings, and this tribunal has jurisdiction of the parties and of the subject matter at issue.

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

3. Under 10A NCAC 22F .0103(b)(5), DMA "shall institute methods and procedures to recoup improperly paid claims."

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

5. By entering into the Medicaid Participation Agreement, Petitioner agreed to "comply with all [F]ederal and [S]tate laws, regulations, and rules, State Medicaid Plan, and policies, provider manuals, and Medicaid bulletins published by the Department, its Divisions, and/or its fiscal agent in effect at the time the service is rendered, which are incorporated into this Agreement by this reference."

6. DMA Clinical Coverage Policy 3L was adopted according to the procedures set forth in N.C. Gen. Stat. § 108A-54.2.

7. DMA Clinical Coverage Policy 3L, Attachment A, Section E provides that, "[t]he provider shall report the appropriate procedure code(s) used which determine the billing units. 1 unit of service = 15 minutes."

8. DMA Clinical Coverage Policy 3L, Section 5.4.15(c) (Section 6.1.5(c), Amended Date October 1, 2013; Section 5.4.13(c), Amended Date December 1, 2013) requires that the provider "[d]ocument all deviations from the plan of care; this documentation shall include, at a minimum, care tasks not performed and reasons tasks were not performed."

9. DMA Clinical Coverage Policy 3L, Section 5.4.15(a) (Section 6.1.5(a), Amended Date October 1, 2013; Section 5.4.13(a), Amended Date December 1, 2013) requires that the provider "[m]aintain documentation that demonstrates all care tasks identified on the independent assessment as unmet needs are performed at the frequency indicated on the independent assessment."

10. DMA Clinical Coverage Policy 3L, Section 5.4.14(a) (Section 6.1.4(a), Amended Date October 1, 2013; Section 5.4.12(a), Amended Date December 1, 2013) requires that the provider

"[c]onduct an internal assessment, review the independent assessment conducted by the IAE for beneficiaries in private residences, conduct an internal assessment and develop a plan of care."

11. 10A NCAC 13J .1107(b) requires that "[i]f the client's plan of care requires the in-home aide to provide extensive assistance as defined in Rule .0901(9) of this Subchapter, the in-home aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-255."

12. The Undersigned finds, through the testimony and evidence presented, that the Petitioner violated the above-referenced provisions of the North Carolina Administrative Code and DMA Clinical Coverage Policy 3L for the beneficiaries named in the audit at issue in this case.

13. Petitioner did not meet her burden of showing by a preponderance of the evidence that the Department acted erroneously in its identification of the overpayment or any subsequent action to recoup such overpayment.

14. Under N.C. Gen. Stat § 150B-34, based upon the preponderance of the evidence and "giving due regard to the demonstrated knowledge and expertise of the agency with respect to facts and inferences within the specialized knowledge of the agency," Respondent properly identified an overpayment in the amount of $16,184.32 in this case.

DECISION

The Decision by Respondent Department of Health and Human Services to recoup $16,184.32 is supported by the evidence and is hereby AFFIRMED.

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 29th day of March, 2016.

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Selina M Brooks
Administrative Law Judge