STATE OF NORTH CAROLINA	IN THE OFFICE OF ADMINISTRATIVE HEARINGS
COUNTY OF PITT	11 DHR 08755

At Home Personal Care Services Inc. Petitioner	))	
vs.	)	**DECISION**
NC Dept of Health & Human Services Division of Medical Assistance Respondent	)))	

This contested case was heard before Donald W. Overby, Administrative Law Judge, on October 20, 2011, in Greenville, North Carolina.

APPEARANCES

For Petitioner: Curtis B. Venable, Attorney at Law
Ott Cone & Redpath, P.A.
P.O. Box 3016
Asheville, NC 28802

For Respondent: Brenda Eaddy, Assistant Attorney General
N.C. Department of Justice
Post Office Box 629
Raleigh, North Carolina 27602-0629

ISSUE

Whether the Department of Health and Human Services correctly determined that Petitioner, At Home Personal Care Services, Inc. received an overpayment of $102,361.28 as a result of allegedly improperly documenting claims for personal care services delivered to Medicaid recipients; or whether the requested recoupment amount constituted over-payments and were improper.

EXHIBITS

As stipulated by the parties as to authenticity and admissibility:

Petitioner's Exhibits:

Patient records and documents of patient L.Ch., Exhibit Petitioner – 1.
Patient records and documents of patient C.C., Exhibit Petitioner – 2.
Patient records and documents of patient W.C., Exhibit Petitioner – 3.

Patient records and documents of patient B.G., Exhibit Petitioner – 4.
Patient records and documents of patient R.H., Exhibit Petitioner – 5.
Patient records and documents of patient J.L., Exhibit Petitioner – 6.
Patient records and documents of patient A.P., Exhibit Petitioner – 7.
Patient records and documents of patient Q.B., Exhibit Petitioner – 8.
Patient records and documents of patient J.B., Exhibit Petitioner – 9.
Patient records and documents of patient L.Cr., Exhibit Petitioner – 10.
Patient records and documents of patient F.E., Exhibit Petitioner – 11.
Patient records and documents of patient M.E., Exhibit Petitioner – 12.
Patient records and documents of patient B.Gu., Exhibit Petitioner – 13.
Patient records and documents of patient G.L., Exhibit Petitioner – 14.
Patient records and documents of patient H.M., Exhibit Petitioner – 15.
Patient records and documents of patient M.M., Exhibit Petitioner – 16.
Patient records and documents of patient C.M., Exhibit Petitioner – 17.
Patient records and documents of patient E.S., Exhibit Petitioner – 18.
Patient records and documents of patient F.S., Exhibit Petitioner – 19.
Patient records and documents of patient E.W., Exhibit Petitioner – 20.

Respondent's Exhibits admitted:

Treatment notes for Patient A.P., Exhibit, Respondent A.

WITNESSES

Witness for Petitioner:

Regina Gilliam, RN, Owner
At Home Personal Care Services, Inc.

Witness for Respondent:

Dionne Manning, RN, MS
N.C. Division of Medical Assistance
Program Integrity Unit

APPLICABLE STATUTES, RULES AND POLICIES

42 U.S.C. §§ 1396a – 1396v
42 C.F.R. Parts 455 and 456, generally
N.C. Gen. Stat. Ch. 108A, Article 2, Parts 1 and 6
N.C. Gen. Stat. Ch. 150B
10A N.C.A.C. 22, O & F et seq.
N.C. State Plan for Medical Assistance
Medical Coverage Policy #3C (revised, dated August 1, 2007)

FINDINGS OF FACT

1. The Division of Medial Assistance (DMA) section of Respondent state agency is responsible for administering and managing North Carolina's Medicaid plan and program. Pursuant to N.C. Gen. Stat. §108A-54, Respondent DMA is authorized to adopt rules, regulations, and policy for program operation.

2. This Court will take official notice to Respondent's rules, regulations, and policy.

3. Petitioner is a personal care services (PCS) provider. Petitioner has entered into a Medicaid Participation Agreement contract with Respondent wherein Petitioner agreed to provide nurse and nurse aide services to Medicaid recipients pursuant to Medicaid rules, regulations and policy, and generally recognized community nursing standards.

4. This matter is before the Court due to a recoupment action. Respondent has determined that claims submitted by Petitioner for payment did not follow Medicaid rules and regulations.

5. Regarding this post payment review, Respondent maintains Petitioner errors included:

a. The nurse assessor failing to record the time spent on the PACT form assessments;

b. Providing services to recipients who did not meet medical necessary criteria;

c. Missing documentation and billing for services not provided.

6. Respondent's witness, Ms. Dionne Manning testified to the effect that the purpose of the audit is to find out if the services that were paid for had been actually rendered.

I. PACT FORM ASSESSMENT TIME

7. Respondent identified instances in the cases where the nurse assessor did not document the time in and/or the time out on the PACT form. Respondent contends that in all the cases identified as noncompliant regarding time in - time out requirements, Section 7.9 of Clinical Coverage Policy 3C is applicable.

8. Section 7.9 of Clinical Coverage Policy 3C is applicable to the Registered Nurse supervisor making supervisory visits in the recipient's home. All of the cases at issue herein concerning recording the time in/time out are for the assessment performed as part of the PACT form; and therefore Section 7.4 of Clinical Coverage Policy 3C applies.

9. As relevant to this issue, Section 7.4.1 provides "[t]he PACT form documents all of the following: a. The date, time and duration of the assessment." The only parts at issue

herein are the time and the duration in that the Petitioner did not provide the time in and time out. The date of the assessment is given.

10. Section 7.4.2 requires the RN assessor to certify that he or she completed the in-home assessment, determined the need of the recipient and developed a plan of care. It then, in bold type, specifies what happens if the assessor certifies to a material and false statement, including being investigated for fraud and being reported to the licensing Board. Similar requirements are established for the certifying physician, including referral to the NC Board of Medicine.

11. In accord with the requirements of the policy, each Pact form requires the certification, which states "I certify that I, and no one else, have completed the above in-home assessment. . . ."

12. Petitioner's owner, Ms. Regina Gilliam, RN, performed all of the questioned assessments, with the exception of two. All of the questioned assessments have the assessor's printed name, are signed and dated.

13. The essential and critical part of assessment is that it is actually being performed in person and at the recipient's home. Failure to do so is actionable by fraud investigation and being reported to the proper licensing board. In each instance herein the assessor has attested to the fact that she and no one else did in fact perform an in home assessment of the patient's condition. There is ample other evidence on the form to confirm to the degree possible that the assessment was in fact performed on that recipient in the recipient's home on the date as stated.

14. In each instance, Ms. Gilliam offered that the time in/time out was not recorded because she was not going to bill for those services because she was concerned that it would take time away from the actual provision of services—a reasonable explanation.

15. Section 7.4.1 states that the documentation on the PACT form "serves as the basis for determining whether the recipient qualifies or continues to qualify for PCS." It also requires that "all fields on the form must be completed <u>as applicable</u>." (Emphasis added) While providing the time in/time out is useful information and would not ordinarily be seen as surplusage, such information certainly is not critical to forming an opinion of whether or not the recipient would qualify for PCS.

16. Petitioner concedes its non-compliance in not providing the time in/time out; however, likewise, Respondent's witness concedes no attempt was made by Respondent to try to correct the omission, nor to give Petitioner any opportunity to correct the documentation. There is no suggestion of fraud or any other impropriety in the completion of these PACT forms. There is no assertion that the recipients did not qualify and need the services.

II. DOCUMENTING MEDICAL NECESSITY

17. Respondent maintains Petitioner accepted and provided services to Medicaid recipients who did not need assistance with 2 activities of daily living (ADL).

18. Section 7.4 "Physician Authorization for Certification and Treatment (PACT) Form of Respondent's Clinical Coverage Policy No. 3C (revised date August 1, 2007) states the documentation requirements with which providers of personal care services must comply prior to receiving either authorization to deliver personal care services or to obtain payment for the services delivered. The PACT form of Section 7.4 is the basis which outlines the findings of medical necessity and what services are to be rendered based on those findings.

19. Section 3.2 articulates what constitutes "medical necessity." It states "medical necessity means that if the plan of care is not implemented, the recipient's medical condition will deteriorate."

20. Section 3.2.1 addresses Activities of Daily Living. It states in pertinent part: "PCS covers aide services rendered in the private residence of a recipient who requires assistance with a minimum of two unmet activities of daily living (ADLs). . . . An unmet need exists when the recipient cannot <u>independently</u> perform at least two personal care tasks because of a physical or cognitive impairment; . . ." (Emphasis added)

21. This issue centers on interpretation of the plain language of Section 3.2.1, particularly the word "independent." Section 3.2.1 requires that the recipient cannot "independently perform at least two personal care tasks. . . ." Column A of the PACT form is labeled "ADL Self-Performance Scores." A score of "0" (zero) is INDEPENDENT. (Capitals in original) Common sense and logic dictate that anything beyond this rating is NOT independent; i.e., that the recipient cannot perform that task independently as set forth in Section 3.2.1. A score of "1" requires assistance, and, logically if the recipient does not get that assistance then he or she may not accomplish that task.

22. Column B of the PACT form is labeled "ADL Support Provided Scores." A score of "0" (zero) means that recipient does not need any help for set up or physical help. A score of 1 means that the recipient needs help with set up only; i.e., that recipient cannot perform that task completely independently.

23. Respondent's witness, Ms. Manning, testified that a recipient only qualifies if he or she is rated at least #2 in both Column A and Column B of the PACT form. She further testified that one only qualifies if "hands-on" assistance is required.

24. When questioned by the court, Ms. Manning could provide no other or further authority for this requirement other than it was the Respondent's requirement. There is nothing within the policy nor otherwise presented that states that the recipient only qualifies if he or she requires hands-on assistance.

25. The plain language of the policy and the face of the PACT form are not consistent with Respondent's interpretation.

26. Recipients LC and CC both have met the requirements of Section 3.2.1, and it was error for Respondent to attempt to recoup for payments made for their care.

27. For Recipients WC and JL, there are discrepancies on the face of the PACT form. For each, only one ADL is rated "1" or more in Column A and 2 or more are rated "1" or more in Column B. In the third column, which is to be checked "if agency assistance is needed (unmet needs)", WC has four checks and JL has three. (Parenthesis in the original) Each has two or more ADLs identified by number from page two of PACT as being a "Task to Be Accomplished" page 4. The forms in their entirety show that there was "medical necessity" requiring the services rendered for WC and JL.

28. Petitioner notes that the RN did not correctly understand filling out the form and she was sent for more training as soon as the error was discovered.

29. The PACT assessment form for L.Ch., C.C., W.C. and J.L. reflect that each had unmet personal care needs in at least two categories, and met the requirements for medical necessity. Respondent was in error in finding that the medical necessity requirements were not met.

30. Respondent's witness, Ms. Manning, stated that if she had conducted the audit and found incomplete information she would have asked questions. She did not do this audit and the auditor performed this audit did not ask any questions to try to ascertain accurate information.

III. QUESTIONABLE DOCUMENTATION ON SERVICE LOGS

31. Respondent also identified cases where Petitioner did not produce the required and proper documentation of the in-home visits for review.

32. Section 7.10 of Clinical Coverage Policy No. 3C sets forth the parameters for the in-home visits by the aides and their required documentation of each visit.

33. In the matter of recipient BG, the question arises concerning the ADL for mobility, particularly "ambulation" as recorded on the aide's timesheet which appears to be the weekly log for this recipient. The aide wrote in "as needed" beside "ambulation assistance" and then no other checks were put down for any other dates to indicate any assistance for ambulation.

34. The PACT form notes on page 4, tasks to be accomplished, that 15 minutes is allotted each day for section #19—ambulation. Within that section a subset is "non-ambulatory/ transfer." The form also shows that "one person physical assist" is required for BG when being helped with either the tub or shower.

35. From the method used to record the activities for BG, it is impossible to tell to the minute exactly how much time is spent on each ADL. The timesheet records time spent for "full bath/partial bath" each day the aide was there. The non-ambulation could be subsumed within that time spent.

36. It is reasonably expected that to be in compliance with the policy that some amount of time would be spent on each ADL identified in the PACT form in accord with the time allotments in the plan of care. Common sense would also dictate that if the entire 15 minutes allotted are not used in any one ADL, that time could be used for another ADL; or conversely if more time is used than allotted, time could be "borrowed" from another ADL. It is ludicrous to think that an exact amount of time would be used for each service each day without variation, and that to vary that amount of time would be sanctionable by demanding the return of money spent on the service.

37. Section 7.10 requires recording the "date, time spent providing services, and tasks provided." "Services" is in the plural; in the aggregate. There is no requirement to record the exact amount of time spent on each ADL on each day. To engage in that amount of detailed record-keeping would be both very cumbersome and very time consuming for the Providers.

38. It is obvious from BG's PACT form that she is in need of the services, requiring far more help than the minimum of two ADLs. For this particular week, the aide only provided two hours of service on two days.

39. Regarding the services to AP, the discrepancy is reflected in two separate timesheets submitted for the same week, February 18, 2010. One timesheet shows no time spent in "transfer assistance" whereas the other time sheet has checked that transfer assistance was provided by the aide every day. Petitioner does not know how or when the change was made, whether or not both timesheets were in the file simultaneously, and when or if one was removed from the file, or by whom. While Petitioner is an otherwise credible witness, she attempts to explain this situation by what she has been told and by speculating, to no avail.

40. Regarding the services to RH, the discrepancy is primarily reflected on the aide timesheet for the week of December 24, 2009. The notations "per request" by foot care, "non-ambulatory" beside ambulation assistance, and "as needed" beside incontinence care make it difficult to determine the time spent overall in attending to the ADLs for RH. Although the timesheet has space for employee comments, there were no explanations for this time period. The discrepancies on this log and the existence of two different logs make these records suspect. Petitioner contends that reference to the call logs could help fill in the missing information but that the auditor did not request any further information.

41. Respondent was in error to attempt to recoup money for services rendered to BG. Respondent was not in error in attempting to recoup money for services to AP and RH.

IV. APPLICATION OF APA RULE-MAKING

42. Petitioner contends alternatively that Respondent has unique authority to create binding requirements through a process outside of the Administrative Procedure Act. N.C. Gen. Stat. § 108A-54.2. It is true that our legislature has made clear that agencies can bind citizens only through the Administrative Procedure Act rule-making process. N.C. Gen. Stat. §150B-18. The key to the Respondent's unique exemption to the rule-making requirements of this State lies in the specific authority granted which is to create "medical coverage policies." For the time in

question, “medical coverage policy” had not been defined by our legislature. See, Session Law 2011-399, Sections 4 and 6.

43. Giving the words their ordinary and customary usage and understanding, the word “medical” would seemingly be referring to policies concerning medical determinations. The word “coverage” would logically refer to applicable coverage for medical programs. Taken together, the General Assembly has given the Respondent the authority to create binding policies upon citizens outside the Administrative Procedure Act rule-making process that relate to defining how particular ”medical” conditions are “covered” by our State’s Medicaid program. This exemption from the Administrative Procedure Act rule-making requirement does not equate all policies and procedures of Respondent being considered as “medical coverage policy.” Otherwise, our legislature would have granted an unlimited exemption from the rule-making requirements within the Administrative Procedure Act. See e.g. N.C. Gen. Stat. §150B-1(d).

44. While this Tribunal is in agreement in general terms with Petitioner’s argument as to the applicability and/or enforceability of the rule-making provisions of the APA, that argument is specifically not addressed herein.

CONCLUSIONS OF LAW

1. This matter is properly before the Office of Administrative Hearings for this contested case hearing. Jurisdiction and venue are proper, and this matter was filed in a timely and appropriate fashion. All parties necessary are properly joined.

2. The burden of proof is with the Petitioner.

3. A critical part of the issue herein is whether or not Respondent should be allowed to recoup money from Petitioner when services have been rendered but there has been error in documentation.

4. The Code requires proper documentation. Likewise, each provider signs a “participation agreement” wherein he or she agrees to operate and provide services in accordance with state law and all manner of rules, regulations, policies, manuals, bulletins and the like which would command proper documentation.

5. The North Carolina Administrative Code has two provisions which are entitled “Recoupment”, 10A NCAC 22F .0601 and 10A NCAC 22F .0706.

6. 10A NCAC 22F .0706 speaks to recoupment of overpayments and how the money will be distributed.

7. The Code states at 10A NCAC 22F .0601 “the Medicaid agency will seek full restitution of any and all improper payments made to providers by the Medicaid program.” (Emphasis added) “Improper payments” are not defined in the Code; however, in reading *in pari materi* other sections one may discern the meaning and intent.

8. 10A NCAC 22F .0103 also similarly states that the Division shall institute methods and procedures to, among other things, "recoup improperly paid claims."

9. The Administrative Code states at 10A NCAC 22F .0103 that "The 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." (Emphasis added). "Error" is the only misdeed applicable; i.e., there are no allegations of fraud, abuse, overutilization or use of medically unnecessary or inappropriate services.

10. 10A NCAC 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.

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

12. In section 10A NCAC 22F .0602 the code addresses "administrative sanctions and remedial measures" for program abusers. 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. There has been no assertion or allegation in this proceeding that Petitioner was in any way responsible for program abuse; however, it is instructive that program abusers are allowed remedial measures whereas the Providers are allowed no latitude for error when audited.

13. 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 the 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.

14. Respondent contends that petitioner improperly was paid for services which were not "medically necessary" but those allegations were based on pact forms which were not filled out correctly. Other wise, there is no allegation or assertion that petitioner provided medically unnecessary or medically inappropriate services. In reading the pact forms in their totality for these questioned recipients, each of the questioned pact forms shows that each recipient did indeed meet the requirements for services. Respondent's interpretation of needing scores of 2 or more and needing "hands-on" assistance are incorrect.

15. In this audit, the auditor did not ask any questions or make any attempts to try to ascertain the true status of these cases. No remedial measures were offered, other than those initiated by the Provider. It seems inconceivable that remedial measures are offered to those identified as abusers of the program but not those who make clerical errors.

16. Respondent's approach in this audit allows for no errors in documentation without very serious consequences. That approach ignores the very human element that humans will make mistakes—including this auditor and the Respondent in general. "To err is human"—no one is above making mistakes, but there should not be such drastic consequences as here without some ability to rectify errors.

17. Respondent's witness Ms. Manning stated to the effect that the purpose of the audit is to find out if the services that were paid for had been actually rendered. That interpretation is consistent with the code provisions and whether or not the payments were "improper." Applying that interpretation, then it should not be sufficient to recoup money from the provider when there is no question that the services were rendered but clerical errors were made in the documentation. To allow such is tantamount to a "taking" by the agency from someone who has provided a service to the state.

18. It is incongruous to recoup the money paid to render needed and valuable services provided by this Petitioner for not providing times for a particular service which was not even billed. Respondent is out nothing, and in fact, has profited by Petitioner not billing for the service. The "punishment does not fit the crime."

19. Respondent was in error in concluding that the PACT forms did not justify paying for services for LC, CC, WC and JL.

20. Respondent was in error to attempt to recoup monies from petitioner based on Petitioner's failure to record on the pact form the time in/time out while performing the assessment. Therefore, respondent was in error with respect to the following patients: Q.B., J.B., L.Cr., F.E., M.E., B.Gu., G.L., H.M., M.M., C.M., E.S., F.S., and E.W.

21. There is sufficient and reliable documentation concerning BG to justify payment for the services rendered. Respondent was in error to attempt to recoup money for services rendered to BG. Petitioner failed to carry its burden concerning AP and RH because the discrepancies within the documentation for those two cases is such as to render the documentation questionable and unreliable. Respondent was not in error in attempting to recoup money for services to AP and RH.

22. The amount of the recoupment should be adjusted in accordance with these findings and conclusions of law.

23. In making the findings and conclusions herein, it is not necessary to address Petitioner's argument as to the applicability and/or enforceability of the rule-making provisions of the APA to the provisions of the Code cited herein.

DECISION

The amount of the recoupment should be adjusted in accordance with these findings and conclusions of law.

NOTICE

The agency making the final decision in this contested case shall adopt the Decision of the Administrative Law Judge unless the agency demonstrates that the Decision of the Administrative Law Judge is clearly contrary to the preponderance of the admissible evidence in the official record. The agency is required to give each party an opportunity to file exceptions to this Decision issued by the Undersigned, and to present written arguments to those in the agency who will make the final decision. N.C. Gen. Stat. §150B-36(a).

In accordance with N.C. Gen. Stat. §150B-36, the agency shall adopt each finding of fact contained in the Administrative Law Judge's decision unless the finding is clearly contrary to the preponderance of the admissible evidence, giving due regard to the opportunity of the Administrative Law Judge to evaluate the credibility of witnesses. For each finding of fact not adopted by the agency, the agency shall set forth separately and in detail the reasons for not adopting the finding of fact and the evidence in the record relied upon by the agency. Every finding of fact not specifically rejected as required by Chapter 150B shall be deemed accepted for purposes of judicial review. For each new finding of fact made by the agency that is not contained in the Administrative Law Judge's decision, the agency shall set forth separately and in detail the evidence in the record relied upon by the agency establishing that the new finding of fact is supported by a preponderance of the evidence in the official record.

The agency that will make the final decision in this case is the North Carolina Department of Health and Human Services. This agency is required by N.C. Gen. Stat. §150B-36(b) to serve a copy of the final decision on all parties and to furnish a copy to the parties' attorneys of record and to the Office of Administrative Hearings.

This the 13th day of February, 2012.

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Donald W. Overby
Administrative Law Judge