STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MONEF HEALTH SERVICES, INC.,
     Petitioner,
vs.
AGENCY FOR HEALTH CARE ADMINISTRATION,
     Respondent.

Case No. 00-4924

RECOMMENDED ORDER

On April 24, 2001, in Miami, Florida, Administrative Law Judge John G. Van Laningham of the Division of Administrative Hearings convened a formal hearing in this matter, which was completed that day.

APPEARANCES

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and

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STATEMENT OF THE ISSUE

The issue for determination is whether Petitioner must reimburse Respondent for payments totaling $29,701.19 that Petitioner admittedly received from the Medicaid Program between May 1, 1996, and March 31, 1998, in compensation for the provision of home health services. Respondent contends that Petitioner is not entitled to retain the payments in question, primarily on the allegations that the compensated services were not medically necessary, were improperly documented, or both.

PRELIMINARY STATEMENT

Respondent Agency for Health Care Administration (the "Agency") is the agency responsible for administering the Florida Medicaid Program. Petitioner Monef Health Services, Inc. ("Monef") is a licensed home health agency which is enrolled as a Medicaid provider.

On October 5, 2000, the Agency issued a Final Agency Audit Report demanding that Monef reimburse the Agency $30,266.35 in alleged Medicaid overpayments for services (home health aide and skilled nursing care) that Monef had rendered to Medicaid recipients between May 1, 1996, and March 31, 1998.

By letter dated October 30, 2000, Monef timely requested a formal administrative hearing, and the Agency referred the matter to the Division of Administrative Hearings. Thereafter,

the parties were duly notified that a final hearing would begin at 10:00 a.m. on April 24, 2001, at the Miami-Dade County Courthouse in Miami, Florida. Both sides appeared at the scheduled time and place; the final hearing lasted one day.

When the hearing began, the Agency represented that, after further consideration, it had decided to give Monef the benefit of the doubt on some disputed claims, reducing the amount in controversy to $29,701.19.

Also at the outset of the hearing, the parties announced their agreement that if the Agency's physician-consultant, Dr. John Sullenburger, were to take the stand, his expert testimony, based on the patients' medical records, would be that the services alleged by the Agency to be medically unnecessary were, in his opinion, medically unnecessary. There being no dispute regarding this witness's ultimate opinion, the parties stipulated that Dr. Sullenburger would not need to testify, and that the factfinder could consider and rely upon his opinion as though he had expressed it under oath, upon examination. With the Agency's consent, Monef——which conceded that it had brought no expert witness of its own to rebut Dr. Sullenburger's testimony——reserved the right to argue that the medical records and other materials expected to be offered in evidence would

support findings of medical necessity, contrary to Dr. Sullenburger's opinion.

The Agency identified 42 exhibits, numbered 1 through 42, and offered them into evidence. Without objection, Respondent's Exhibits 1 through 42, many of which were composites drawing together agency work papers and patients' medical records, were admitted.

The Agency called two witnesses: Ellen Williams, Medicaid/Healthcare Program Analyst; and Claire Balbo, R.N. These women are Agency employees who had been personally involved in the Medicaid audit of Monef. Monef's only witness was its Director of Nursing, Nse Essiet, R.N., B.A., B.S.C.N., M.P.A. Monef proffered no exhibits.

A transcript of the final hearing was filed with the Division on July 18, 2001. The parties filed proposed recommended orders, and these papers were carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

The evidence presented at final hearing established the facts that follow.

1. The Agency is responsible for administering the Florida Medicaid Program. As one of its duties, the Agency must recover "overpayments . . . as appropriate," the term "overpayment"

being statutorily defined to mean "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." See Section 409.913(1)(d), Florida Statutes.

2. This case arises out of the Agency's attempt to recover alleged overpayments from Monef, a Florida-licensed home health agency. As an enrolled Medicaid provider, Monef is authorized, under a Medicaid Provider Agreement with the Agency, to provide home health services to Medicaid recipients.

3. Under the Medicaid Provider Agreement, Monef assented to comply with "all local, state and federal laws, rules, regulations, licensure laws, Medicaid bulletins, manuals, handbooks and Statements of Policy as they may be amended from time to time."

4. The home health services at issue consisted of skilled nursing care rendered either by a registered nurse ("RN") or a licensed practical nurse ("LPN"), as the needs of the recipient required, together with personal care provided by a home health aide.

5. The "audit period" that is the subject of the Agency's recoupment effort is May 1, 1996 to March 31, 1998. During this audit period, the Medicaid Program reimbursed Monef for all of

the skilled nursing and home health aide services that are the subject of this dispute.

6. Largely (though not entirely) on the allegation that the home health services in question were not medically necessary, the Agency contends that Monef collected overpayments totaling $29,701.19 in compensation for services rendered to nine separate patients.

7. The following table summarizes the Agency's allegations.

PATIENT NAME	GROUND(S) FOR DENIAL	ALLEGED OVERPAYMENT
Louisiana S.	No medical necessity	$8,498.17
Robert M.	No medical necessity	$3,615.54
Mario P.	No medical necessity	$2,403.33
Angel S.	No medical necessity	$2,089.12
Ana G.	No medical necessity	$2,015.94
Joann N.	No medical necessity	$1,705.12
C. Watson	No medical necessity	$1,268.76
Yvette F.	Service refused	$122.16
Rosa P.	Multiple	$7,983.05

Medical Necessity

8. The proof was in conflict concerning the medical necessity of the challenged home health services that Monef

provided to the foregoing patients. There were three categories of expert opinion evidence on this issue, described below.

9. The attending physicians' opinions. To be Medicaid compensable, home health services must be provided pursuant to a written treatment plan that is prepared individually for each recipient and approved by his or her attending physician. The treatment plan——called a "plan of care" or "plan of treatment"——must be reviewed and updated periodically (about every two months) and also as the patient's condition changes.

10. A required component of all plans of care is the attending physician's certification that the services specified in the plan are medically necessary.[1]

11. The fact that a treating doctor, by prescribing, recommending, or approving a medical service, has attested to its medical necessity is not sufficient, in itself, to support a finding that the resulting care was medically necessary. See Rule 59G-1.010(166)(c), Florida Administrative Code. Nevertheless, the attending physician's opinion regarding medical necessity is relevant evidence, even if it is not inherently dispositive.

12. In this case, all of the services that the Agency contends were not medically necessary had been determined to be medically necessary by the respective patients' treating physicians.

13. The peer-review organizations' opinions. During the audit period, the Medicaid Program would not reimburse a home health agency for any home visits in excess of 60 visits per recipient per fiscal year unless the provider had obtained authorization to provide such care, in advance, from the Agency or its designee. Such "prior authorization" was required to be based on medical necessity.

14. At times during the audit period the Agency was under contract with a company called Keystone Peer Review Organization ("KePRO"), which acted as the Agency's designee in regard to pre-approving services above the 60-visit limit. At other times this function was performed by Florida Medical Quality Assurance, Inc. ("FMQAI"). In a couple of instances, the Agency itself gave Monef prior authorization to perform services that it now contends were not medically necessary.

15. By statute, a peer-review organization's written findings are admissible in an administrative proceeding as evidence of medical necessity or lack thereof. See Section 409.913(5), Florida Statutes.

16. Monef had obtained prior authorization based on medical necessity for most of the services that the Agency has challenged as medically unnecessary. The opinions of the Agency's designees, KePRO and FMQAI, are relevant evidence of medical necessity.

17. Dr. Sullenburger's opinion. Dr. John Sullenburger is the Agency's Medicaid physician. He would have testified at the final hearing as an expert witness for the Agency, but the parties stipulated that Dr. Sullenburger's ultimate opinion, based on the medical records, was that each of the claims that the Agency alleges was not medically necessary was, in fact, unnecessary.

18. By entering into this stipulation, Monef effectively waived its right to cross-examine Dr. Sullenburger and thereby expose the particular facts upon which his opinion was based. For its part, the Agency relinquished the opportunity to have the doctor explain the reasons why he had concluded that the patients' attending physicians——and also, in many instances, the Agency's designated peer-review organizations——had erred in making their respective determinations that the subject services were medically necessary.

19. As a result of the parties' stipulation concerning Dr. Sullenburger's testimony, the factfinder was left with a naked expert opinion that merely instructed him to decide the ultimate factual issue of medical necessity in the Agency's favor.

20. In making findings regarding medical necessity, the factfinder settled on the following rules of thumb. Greatest weight was accorded the opinions of KePRO and FMQAI. These were

deemed to have the highest probative value because the peer-review organizations' determinations of medical necessity were made before the services in question were provided, and neither of the Agency's designees had any discernable motive to stretch the truth one way or the other. Certainly, the peer-review organizations more closely resemble a disinterested, neutral decision-maker than either the patient's treating physician or the Agency's expert witness (whose opinions were formed after the services had been rendered and the claims paid); indeed, if anything, KePRO and FMQAI might be expected to tilt in the Agency's direction (although there was no evidence of such bias in this case).[2]

21. The hearsay opinions of the treating physicians, on the one hand, and Dr. Sullenburger, on the other, were considered to be about equally persuasive——and none was particularly compelling.[3] It should be stated that the attending physicians' certifications of medical necessity, each of which lacked analysis that might have connected the facts concerning a patient's medical condition with the need for services, were as conclusory as Dr. Sullenburger's ultimate opinion.

22. Consequently, in those instances where a peer-review organization gave Monef a mandatory prior authorization to render services that the attending physician had certified as

being medically necessary, it has been found that, more likely than not, the services in question were medically necessary.

23. In contrast, a closer question arose in those instances where there was no evidence of prior authorization when such was required. The expert opinions——the attending physician's on one side, Dr. Sullenburger's on the other——essentially canceled each other out. While ordinarily in an evidential tie the party without the burden of proof (here, Monef) would get the nod, in this case the Agency had the slightest edge, on the strength of Rule 59G-1.010(166)(c), Florida Administrative Code. Under this Rule, an attending physician's approval of a service is not, "in itself," sufficient to support a finding of medical necessity.[4] Because of the Rule, Monef needed to introduce some additional, persuasive evidence (e.g. the attending doctor's testimony regarding the need for the service) to overcome Dr. Sullenburger's opinion.[5]

Louisiana S.

24. At the time that the services in question were provided, from May 7, 1997, until December 20, 1997, this patient, an obese woman in her late 60s, was being treated for diabetes, hypertension, and coronary artery disease. She was not able to self-administer the insulin shots that were needed to prevent complications from diabetes.

25. For the period from May 5, 1997, through June 30, 1997, KePRO gave prior authorization to 53 skilled nursing visits and 23 home health aide visits.[6] Monef was reimbursed for 42 skilled nursing visits and 23 home health aide visits conducted in this period.

26. From July 1, 1997, until September 1, 1997, Monef provided a total of 66 combined skilled nursing and home health aide visits to Louisiana S. The Medicaid Program paid for 60 of them. Because these were the first 60 visits of the fiscal year, which began on July 1, 1997, prior authorization was neither needed nor obtained.

27. During the period between September 1, 1997, and November 1, 1997, Monef made 96 skilled nursing visits, out of 124 that KePRO had pre-approved, and 20 of 27 authorized home health aide visits.

28. KePRO gave prior authorization for 124 skilled nursing and 27 home health aide visits for the period from November 1, 1997 to January 1, 1998, of which 54 and 18, respectively, were made.

29. Based on the levels of service that KePRO had approved before July 1, 1997, and then after September 1, 1997, it is reasonable to infer, and so found, that the first 60 combined visits to this patient in fiscal year 1997-98 would have been

pre-approved had Monef been required to obtain prior authorization.

30. The home health care services that Monef provided to Louisiana S. between May 9, 1997, and December 30, 1997, for which the Medicaid Program paid $8,498.17, were medically necessary.

Robert M.

31. Robert M., a man in his mid-40s who received home health care from Monef from November 26, 1997, through March 27, 1998, suffered from arteriosclerosis, hypertension, acute bronchitis, and schizophrenia. His residence was an assisted living facility ("ALF").[7]

32. FMQAI gave prior authorization for 61 skilled nursing and 61 home health aide visits to occur between November 26, 1997, and January 26, 1998. Monef provided 55 nursing and 59 home health aide visits during this period.

33. Monef requested prior approval for 25 skilled nursing and 63 home health aide visits for the period from January 26, 1998, and March 26, 1998. Although prior authorization was needed for these services, which exceeded the limit for fiscal year 1997-98, there is no evidence in the record that FMQAI granted Monef's request for approval.

34. FMQAI authorized 23 skilled nursing visits and 30 home health aide visits for the period from March 26, 1998, to

May 28, 1998. However, Monef provided just one skilled nursing visit during this time, on March 27, 1998.

35. The home health care services that Monef provided to Robert M. between November 26, 1997, and January 26, 1998, and on March 27, 1998, were medically necessary.

36. Lack of medical necessity was established, however, for the services provided between January 26, 1998, and March 26, 1998. The Medicaid Program paid the following claims, totaling $1,442.49, for this period: One RN visit, $34.04; 21 LPN visits, $549.99; and 51 home health aide visits (35 at $17.46 apiece and 16 at $15.46 each), $858.46.

Mario P.

37. From November 25, 1997, through March 28, 1998, Mario P., a septuagenarian who was being treated for acute gastritis, an enlarged prostate, and mental illness, received home health visits at the ALF where he lived, the services provided by Monef.

38. FMQAI approved 43 skilled nursing and 61 home health aide visits for the period from November 26, 1997, through January 26, 1998; 11 skilled nursing and 62 home health aide visits for January 26, 1998, until March 26, 1998; and 25 skilled nursing visits for March 1, 1998, through May 1, 1998 (overlapping the immediately preceding period by about three-and-a-half weeks).

39. The actual number of skilled nursing and home health aide visits for which the Medicaid Program reimbursed Monef was within the pre-approved service levels for each period.

40. The home health care services that Monef provided to Mario P. between November 26, 1997, and March 28, 1998, for which the Medicaid Program paid $2,403.33, were medically necessary.

Angel S.

41. Angel S. was a man in his middle 50s who had been diagnosed with gastroduodenitis (an inflammation of the stomach and duodenum) and mental illness.

42. Monef obtained prior authorization from KePRO to provide Angel S. with 34 skilled nursing and 62 home health aide visits between November 25, 1997, and January 25, 1998. During this time, the Medicaid Program reimbursed Monef for 32 skilled nursing and 44 home health aide visits.

43. FMQAI pre-approved 26 skilled nursing and 27 home health aid visits for January 25, 1998, through March 25, 1998. Monef was reimbursed for 20 and 21 such visits, respectively.

44. The home health care services that Monef provided to Angel S. between November 25, 1997, and March 25, 1998, for which the Medicaid Program paid $2,089.12, were medically necessary.

Ana G.

45. When she was a client of Monef, Ana G., a woman in her 60s, was suffering from acute gastritis and major depression. She lived in an ALF.

46. FMQAI pre-approved 50 skilled nursing visits and 40 home health aide visits for the period from November 25, 1997, through January 25, 1998. In that time, Monef rendered 28 skilled nursing visits and 42 home health aide visits for which it received compensation from the Medicaid Program.

47. For the period from January 25, 1998, through March 25, 1998, FMQAI gave prior authorization for 9 skilled nursing and no home health aide visits. During this time, Monef provided 15 skilled nursing visits and 15 home health aide visits for which Medicaid paid.

48. The services that Monef rendered to patient A. Garcia between November 25, 1997, and March 23, 1998, were medically necessary except for 17 home health aide visits (at $17.46 apiece) and 6 skilled nursing visits (at $24.19 each), making a total of $441.96 in overpayments.

Joann N.

49. In her late 30s at the time of the services in question, Joann N.'s principal diagnosis was major depression. She also suffered from hypertension and a type of diabetes.

50. Because Joann N.'s primary diagnosis was a mental illness, the home health services provided to her may not have been Medicaid-compensable due to an exclusion that bars coverage for mental health and psychiatric services.[8] The Agency, however, did not disallow Monef's claims on this basis, relying instead exclusively on the allegation that the services were not medically necessary.

51. None of the skilled nursing and home health aide visits that Monef provide Joann N. between February 16, 1997, and September 1, 1997, was pre-approved. There is evidence that Monef sought KePRO's prior authorization of 26 skilled nursing and ten or 12 home health aide visits for the period from April 16, 1997, to June 16, 1997, but no proof was adduced showing that approval was granted.

52. Based on the number of combined visits that Monef provided both before and after July 1, 1997 (the start of fiscal year 1997-98), it does not appear that prior authorization was required. There are no grounds in the record, however, from which to infer that prior authorization(s) would have been given if needed.

53. Accordingly, lack of medical necessity was established for all of the home health services that Monef provided Joann N, for which the Medicaid Program paid a total of $1,705.12.

C. Watson

54. C. Watson was a teenager with cerebral palsy and quadriplegia who received care in her home between May 12, 1997, and March 31, 1998. The Agency alleges that all of the skilled nursing services that Monef provide C. Watson were medically unnecessary but acknowledges that the home health aide visits were appropriate and covered.

55. The Agency itself pre-approved the home health care visits that Monef had requested for the period from May 12, 1997, through June 30, 1997, namely, 24 skilled nursing and 40 home health aide visits. The Medicaid Program reimbursed Monef for 12 skilled nursing and 38 home health aide visits made during this period.

56. The Agency gave prior authorization for home health care to be provided between July 1, 1997, and September 1, 1997. FMQAI also pre-approved the following services for the same period: five skilled nursing visits and 43 home health aide visits. Monef was reimbursed for 17 skilled nursing visits made during this time.

57. For the periods of September 1, 1997 to November 1, 1997; November 1, 1997 until January 1, 1998; and January 1, 1998 through March 1, 1998, KePRO pre-approved levels of skilled nursing services (nine, four, and nine visits, respectively)

that were not exceeded by Medicaid-paid claims for these services rendered by Monef during the subject timeframes.

58. FMQAI gave prior authorization for four skilled nursing visits to occur between March 1, 1998 and May 1, 1998, but Monef did not submit any claims for such services rendered during this period.

59. Lack of medical necessity was established for 12 skilled nursing visits made during the period from July 1, 1997 through September 1, 1997. The Medicaid Program paid a total of $319.13 for these visits (One RN visit at $31.04 and 11 LPN visits at $26.19), and this sum constitutes an overpayment subject to recoupment. The rest of the skilled nursing visits that Monef furnished to C. Watson were medically necessary.

Yvette F.

60. Yvette F. was a patient in her 30s suffering from complications relating to HIV infection. On Christmas Day, 1997, Yvette F. refused most of the skilled nursing services that had been scheduled, to spend time with her family.

61. The Agency has sought to recoup the $122.16 that the Medicaid Program paid for an RN's visit to Yvette F.'s home on December 25, 1997. This sum reflects four hours of service.

62. The medical records in evidence establish that the patient's refusal of treatment occurred after the RN had arrived

at her residence, and that, despite the patient's refusal of service, the RN did perform an assessment on Yvette F. that day.

63. The Agency failed to establish that, under these circumstances, Monef is entitled to no reimbursement. Yet, common sense instructs that the covered claim should not encompass four hours of services when clearly that much time was not spent on this particular visit. Unfortunately, nothing in the record, including the parties' legal arguments, provides guidance for resolving this particular problem.

64. In the absence both of controlling authority and evidence of the actual time spent, the factfinder has determined that the claim should be equitably apportioned to do rough justice, with Monef being compensated for one hour of service and the balance returned to the Medicaid Program.

65. On this basis, then, lack of medical necessity has been shown for three hours of skilled nursing services, making an overpayment of $91.62.

Rosa P.

66. Rosa P. was a woman in her late 30s with multiple health problems, including uncontrolled diabetes, recurring infections, renal failure, respiratory insufficiency, and mental illness. Monef rendered home health care to Rosa P. from November 22, 1996, until February 1, 1998, for which the Medicaid Program paid $24,543.27 on 1,012 separate claims.

67. The Agency seeks to recoup a little more than one-third of the amount previously paid to Monef for this patient's home health care, alleging a number of grounds to disallow a number of claims. The following table summarizes the Agency's contentions regarding the challenged claims. ("Doc." is an abbreviation for "documentation." "PC" is an acronym for plan of care. The alphanumeric claim identifiers in the left-hand column were assigned by the Administrative Law Judge for ease of reference.)

CLAIM ID	DATE(S)	SERVICE(S)	GROUND(S) FOR DENIAL	ALLEGED OVERPAYMENT
RP-1	11-22-96	Nursing	No doc.	$29.04
RP-2	12-9-96, 12-10-96, 12-14-96	Aide	No doc./POT not followed (x3)	$52.38
RP-3	12-25-96 to 1-5-97	Aide	No PC rendered (x11)	$192.06
RP-4	1-6-97, 1-7-97, 1-9-97, 1-10-97, 1-11-97, 1-12-97	Aide	POT not followed (x6)	$104.76
RP-5	1-22-97 to 3-22-97	All	POT not signed by MD or RN	$4,009.37
RP-6	3-24-97 to 5-2-97	Aide	No PC rendered (x40)	$698.40
RP-7	5-2-97	Nursing	No doc.	$29.04
RP-8	5-3-97 to 7-4-97	Aide	No PC rendered (x62)	$1,032.52
RP-9	7-21-97 to 7-26-97	Aide	POT not followed (x6)	$87.30[9]
RP-10	8-4-97 to 8-10-97	Aide	PC not rendered (x7)	$122.22
RP-11	10-29-97	Nursing	Documented only 1 of 2 billed visits	$31.04
RP-12	11-3-97	Aide	No doc.	$17.46
RP-13	11-4-97	Aide	No doc.	$17.46

RP-14	11-14-97	Aide	No doc.	$17.46
RP-15	11-15-97	Aide	No doc.	$17.46
RP-16	11-16-97	Aide	No doc.	$17.46
RP-17	11-22-97 to 11-26-97	Aide	No doc. (x10) (2 billed visits per day)	$52.38[10]
RP-18	12-1-97	Aide	No doc.	$17.46
RP-19	12-2-97	Aide	No doc.	$17.46[11]
RP-20	12-3-97	Aide	No doc.	$17.46
RP-21	12-28-97 to 2-28-98	Nursing	POT not signed by MD or RN	$1,724.37

The total of these alleged overpayments, without adjustment for the several minor arithmetic or typographical errors in the Agency’s papers, <u>see</u> endnotes 9 - 11, is $7,983.05. Each claim or claim set will be addressed in turn below.

68. <u>RP-1.</u> The medical records contain a "Time Record Nursing Progress Note" dated November 22, 1997, that documents a skilled nursing visit to the patient on that day. Therefore, the Agency failed to prove its allegation of overpayment regarding RP-1.

69. <u>RP-2.</u> Included in the patient's records is a "Weekly Activity Report and Time Slip" for the week beginning Monday, December 9, 1996, that was filled out by the home health aide who cared for Rosa P. during that seven-day period. To keep track of tasks performed, the form instructed the aide to check boxes in a table that cross-referenced particular duties (<u>e.g.</u> oral hygiene, change linens, turn & position), which are described in the left-hand column, with the days of the week, which are listed, Monday through Sunday, in the top row.

70. For the days in question (December 9, 10, and 14, 1996), the aide checked boxes showing that, among other things, she had given the patient a shower and assisted her in a wheelchair, both of which are Medicaid-covered services. See Paragraphs 133, 137, infra.

71. Handwritten notes inscribed on the Agency's work papers next to each of the three dates at issue state: "only p/c [personal care] [is a] shower -- not following POT [plan of treatment]." The first of these points is incorrect: assistance with a wheelchair, like showering a patient, is a covered home health aide service.

72. The plan of care that covered the subject dates disproves the second assertion. The written treatment plan explains that the home health aide will "provide personal care, asst [assist] [with] ADL's [activities of daily living] including bath, skin/foot care." The aide was following this course of action on December 9, 10, and 14, 1996.

73. The Agency did not prove an overpayment in connection with RP-2.

74. RP-3. The Agency seeks to recoup payments of $17.46 apiece for 11 home health aide visits made between December 25, 1996 and January 5, 1997, on the ground that the aide did not perform any covered personal services. Although a dozen such visits were made during this particular period, the Agency's

work papers reveal that the claim for services rendered on December 29, 1996, was approved.

75. The aide's time sheets for the relevant period substantiate the Agency's allegation, with one exception. The aide's entry on December 26, 1996, is identical to that of December 29, 1996, the latter which the Agency correctly deemed sufficient to make Medicaid financially responsible. On both days, the aide helped the patient with a tub bath and shampoo, which are covered personal services.

76. For the other ten days, review of the aide's time sheets reveals that many services were rendered in the category of "light housekeeping" and "meal preparation." These fall within the exclusion for "housekeeping, homemaker, and chore services, including shopping" and hence are not covered services. Handbook, at p. 2-6; see also Rule 59G-4.130(8)(a)2., Florida Administrative Code (1996).[12] (Curiously, the Agency did not specifically rely upon this exclusion.)

77. In its Proposed Recommended Order, Monef points out that the aide made a written notation each day concerning the patient's voiding of bowel and bladder. Because the non-exclusive list of covered home health aide services included "toileting and elimination," see Rule 59G-4.130(5)(b)3.b., Florida Administrative Code (1996), it is possible that the aide was providing a compensable service during the period in

question. The trouble is, it cannot be determined from the evidence whether the aide actually assisted the patient——or whether the aide merely wrote down on the time sheet what had been observed regarding the patient's use of the bathroom facilities.

78. Although the question is close, it is determined that simply observing and commenting daily about the patient's elimination of bodily wastes is not enough, without more, to constitute a Medicaid-compensable home health aide service.[13] Being unable on the present record to find that the aide did more than watch and write, it is determined that covered services in the area of "toileting and elimination" were not persuasively shown to have occurred.

79. Consequently, lack of medical necessity has been established as to 10 home health aide visits. The total overpayment on RP-3 is $174.60.

80. <u>RP-4.</u> For the week from Monday, January 6 through Sunday, January 12, 1997, the Agency alleges that six home health aide visits are not covered because the aide failed to follow the plan of treatment. Notations on the Agency's work papers suggest another basis: "only shower - incomplete," meaning, presumably, that the only covered personal care provided was assistance in the shower. <u>See</u> discussion regarding RP-2, <u>supra</u>.

81. The aide's time sheet for the relevant period contradicts the Agency's contention. First, bathing assistance was not the only covered personal care rendered on the days in question. The aide also helped the patient with her wheelchair, which is a service covered under the rubric of "transfer and ambulation." Rule 59G-4.130(5)(b)3.e., Florida Administrative Code (1996).

82. Second, the aide's entry for January 8, 1997——for which claim the Agency is not seeking to recover——is substantially the same as those for the challenged days. The only material difference is that on January 8 the aide checked the box indicating that she had shampooed the patient's hair. Nothing in the Rule or the Handbook, however, provides that a shower with shampoo is covered but a shower without shampoo is excluded from coverage, and the Agency failed to prove a factual basis, or advance a logical one, for drawing such distinction.

83. Consequently, the Agency did not establish an overpayment with regard to RP-4.

84. RP-5. The medical records in evidence contain a "Home Health Certification and Plan of Care" for Rosa P. that was signed and dated, on January 22, 1997, by the RN and by the patient's attending physician, Dr. John Prior. This plan of care covers the period from January 22, 1997 through March 22, 1997.

85. The Agency did not present any evidence that either the doctor's or the nurse's signature appearing on this form are inauthentic or that either or both failed to sign on January 22, 1997, as recorded.

86. Therefore, the Agency's allegation that the plan of treatment for the period in question is invalid was not proved.

87. RP-6. This claim set encompasses five full weeks plus five days of home health aide service, or 40 visits in all. The Agency alleges that no covered personal care was provided during these visits.

88. The time sheets demonstrate that the aide provided a covered service, namely assistance in the shower, on all days between March 24, 1997 and April 6, 1997, and also on the five days from April 28 through May 2, 1997. The Agency therefore failed to prove its allegation as to these 19 visits.

89. The Agency made its case, however, in connection with the remaining 21 visits from April 7 to April 27, 1997, inclusive. The time sheets for these dates do not adequately document the provision of a covered service.[14]

90. Accordingly, lack of medical necessity was established for 21 home health aide visits at $17.46 each, making a total overpayment on RP-6 of $366.66.

91. RP-7. The Agency has sought to recover payment of $29.04 for an RN visit to the patient on May 2, 1997, alleging lack of documentation.

92. The medical records show that on this particular date, an LPN treated the patient from 8:00 a.m. to 8:45 a.m. Later that same day, at 5:00 p.m., an RN arrived to provide care, which she did, afterwards leaving the patient's residence at 5:45 p.m. These two visits are documented in separate "Time Record Nursing Progress Note" forms. The Agency did not establish that the nursing notes are inauthentic or incredible.[15]

93. Thus, the allegation regarding RP-7 was not proved.

94. RP-8. The Agency contends that 62 home health aide visits between May 3, 1997, and July 4, 1997, were not compensable because no covered personal care was provided.

95. The aide's time sheets establish that a covered personal care (assistance in the shower) was given on May 3 through May 17, inclusive (15 visits at $17.46 apiece), and also on June 20 through 22, 1997 (three visits at $17.46 each). Shower assistance was also provided on May 26 through June 1, 1997 (seven visits at $15.46 each). Skin care, a covered service, was provided on June 7, 1997 (one visit, $15.46). And ambulation assistance, a covered personal care service, was rendered on seven visits from June 9, 1997, through June 15, 1997, at $15.46 per visit.

96. For the remaining 29 visits, however, the aide's time sheets fail adequately to document the provision of a covered service. Ten of these visits were billed at $15.46, the others at $17.46 apiece.

97. Thus, with respect to RP-8, the Agency established an overpayment of $486.34.

98. RP-9. This claim set involves six home health aide visits on the dates of July 21 through July 26, 1997, inclusive, during which, the Agency alleges, the plan of treatment was not obeyed. (The Agency did not seek to recoup the payment made for aide services rendered on Sunday, July 27, 1997, even though that date's visit is included within the same time sheet as the Monday through Saturday visits, and the services rendered on July 27 were identical to those performed earlier in the week.)

99. According to the pertinent time sheet, covered personal care services (bathing and assistance with ambulation) were provided in connection with the challenged claims. Further, the plan of treatment in effect at that time stated that the aide would "assist with personal care, ambulation, prepare meals, grocery shop, wash clothes, [and] straighten bedside unit." The time sheet establishes that the aide complied with these instructions.

100. Accordingly, the Agency failed to prove its allegation regarding RP-9.

101. RP-10. The Agency alleges that none of the home health aide visits from August 4 through August 10, 1997, entailed covered personal care services.

102. The aide's time sheet for that week, however, documents that bathing care, specifically showering, was provided. Because showering the patient is clearly a covered item, the Agency failed to carry its burden of proof in respect of RP-10.

103. The patient's medical records contain two "Time Record Nursing Progress Note" forms dated October 29, 1997, which document separate RN visits on that date, one lasting from 4:30 p.m. to 5:15 p.m., the other from 6:00 p.m. until 7:40 p.m.

104. The Agency therefore did not establish, by a preponderance of evidence, its allegation that Monef had provided documentary support for only of one of two nursing visits on October 29, 1997.

105. RP-12, -13, -14, -15, and -16. The Agency alleges that these five home health aide visits, occurring over a two-week period from November 3, 1997 to November 16, 1997, are not adequately documented.

106. The visits of Monday, November 3, and Tuesday, November 4, 1997, which the Agency challenges, are reported on the same time sheet as those of November 5 through 9, 1997,

which the Agency accepts. The duties performed on each of these days, both challenged and unchallenged, were identical, except that on November 4 and 8 the aide shampooed the patient. Numerous covered personal care services were rendered each day during the week, including bathing, oral hygiene, skin care, and assistance with ambulation.

107. The duty descriptions on the aide's time sheet for the week beginning Monday, November 10, 1997——a week that included three challenged visits (November 14 through 16)——are substantially similar to one another (though the Agency accepted claims for November 10 through 13) and nearly identical to those given for the preceding week. Once again, covered personal care services rendered consistently throughout the week of November 10 to 16, 1997, included bathing, oral hygiene, skin care, and ambulation assistance.

108. The evidence, therefore, does not support the Agency's allegation that the services in question were not adequately documented.

109. <u>RP-17.</u> The Agency alleges that home health aide visits made from November 22 through November 26, 1997, were not documented. The medical records demonstrate that one such visit per day was provided, for a total of five. The records show further, however, that Monef was reimbursed for two visits for

each of the days in question, receiving double the amount to which it was entitled based on the documented number of visits.

110. The Agency, therefore, has proved an overpayment of $87.30 (five visits at $17.46 apiece).

111. RP-18, -19, and -20. The Agency contends that there is insufficient documentation for home health visits on December 1 through 3, 1997. But the aide's time sheet for the week beginning Monday, December 1, 1997, adequately establishes that such visits actually occurred——and that covered personal care services (bathing, oral hygiene, skin care, and ambulation assistance) were provided during each of them.

112. However, as with RP-17, the records show that Monef was reimbursed for two visits for each of the days in question, receiving double the amount to which it was entitled based on the documented number of visits.

113. The Agency, therefore, has proved an overpayment of $50.38 (two visits at $17.45 apiece and one billed at $15.46) with regard to RP-18, RP-19, and RP-20.

114. RP-21. The Agency seeks to recover payments for all nursing services rendered from December 28, 1997 through February 28, 1998, on the ground that the plan of treatment for the subject period was not signed and dated by the attending physician, as required.

115. In fact, the pertinent treatment plan was signed by a Dr. Roxana Lopez, and by the RN. Neither signature, however, was dated. Thus, the Agency is correct in its assertion that the plan of treatment is deficient.

116. But, the record also contains a letter from KePRO dated December 29, 1997, which grants prior authorization for 124 skilled nursing and 61 home health aide visits for the period from December 28, 1997 through February 28, 1998. According to this letter, Monef's request for pre-approval was made on December 22, 1997.

117. One of the items that must be submitted to the peer-review organization with a request for prior authorization is the written plan of treatment. Thus, it is reasonable to infer, and so found, that KePRO had in its possession the deficient plan of treatment and, in granting prior authorization, overlooked the fact that the doctor had not dated her signature.

118. Monef did not urge that KePRO's pre-approval of the services in question effected a waiver of the Agency's right to disallow the ensuing claims based on what is, in these circumstances, clearly a technicality,[16] or that the Agency should be estopped from raising this particular objection, although little imagination is required to perceive the potential merit in either argument.

119. It is not necessary to reach waiver or estoppel issues, however, for KePRO's approval letter establishes persuasively that the doctor and the nurse signed the plan of treatment before December 29, 1997——and hence at or before the start of care and services thereunder. Plainly, in other words, the attending physician timely approved the plan of treatment, even though she failed to date her signature.

120. Under the particular facts of this case, therefore, where the treatment plan is in substantial compliance with the requirements, and neither the Medicaid Program nor the patient suffered any conceivable prejudice as a result of a demonstrably harmless (on these facts) and unintentional deficiency, it is determined that the Agency has failed to prove a sufficient basis to recoup payments totaling $1,724.37 for pre-approved, medically necessary services that were actually provided to an eligible patient.

121. The following table summarizes the foregoing findings relating to claims for services to Rosa P.

CLAIM ID	DATE(S)	SERVICE(S)	GROUND(S) FOR DENIAL	ACTUAL OVERPAYMENT
RP-1	11-22-96	Nursing	No doc.	$0
RP-2	12-9-96, 12-10-96, 12-14-96	Aide	No doc./POT not followed (x3)	$0
RP-3	12-25-96 to 1-5-97	Aide	No PC rendered (x11)	$174.60

RP-4	1-6-97, 1-7-97, 1-9-97, 1-10-97, 1-11-97, 1-12-97	Aide	POT not followed (x6)	$0
RP-5	1-22-97 to 3-22-97	All	POT not signed by MD or RN	$0
RP-6	3-24-97 to 5-2-97	Aide	No PC rendered (x40)	$366.66
RP-7	5-2-97	Nursing	No doc.	$0
RP-8	5-3-97 to 7-4-97	Aide	No PC rendered (x62)	$486.34
RP-9	7-21-97 to 7-26-97	Aide	POT not followed (x6)	$0
RP-10	8-4-97 to 8-10-97	Aide	PC not rendered (x7)	$0
RP-11	10-29-97	Nursing	Documented only 1 of 2 billed visits	$0
RP-12	11-3-97	Aide	No doc.	$0
RP-13	11-4-97	Aide	No doc.	$0
RP-14	11-14-97	Aide	No doc.	$0
RP-15	11-15-97	Aide	No doc.	$0
RP-16	11-16-97	Aide	No doc.	$0
RP-17	11-22-97 to 11-26-97	Aide	No doc. (x10) (2 billed visits per day)	$87.30
RP-18	12-1-97	Aide	No doc.	$17.46
RP-19	12-2-97	Aide	No doc.	$15.46
RP-20	12-3-97	Aide	No doc.	$17.46
RP-21	12-28-97 to 2-28-98	Nursing	POT not signed by MD or RN	$0

The Agency, in sum, proved overpayments totaling $1,165.28 in relation to Rosa P.

The Bottom Line

122. The Agency established that Monef received overpayments in connection with six patients. The following table summarizes these overpayments.

PATIENT NAME	GROUND(S) FOR DENIAL	OVERPAYMENT
Robert M.	No medical necessity	$1,442.49
Ana G.	No medical necessity	$441.96
Joann N.	No medical necessity	$1,705.12
C. Watson	No medical necessity	$319.13
Yvette F.	Service refused	$91.62
Rosa P.	Multiple	$1,165.28

Accordingly, the Agency is entitled to recover from Monef the principal sum of $5,165.60.

CONCLUSIONS OF LAW

123. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

124. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on the Agency. South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

125. Although the Agency bears the ultimate burden of persuasion and thus must present a prima facie case through the introduction of competent substantial evidence before the provider is required to respond, Section 409.913(21), Florida

Statutes, provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, the Agency can make a prima facie case merely by proffering a properly supported audit report, which must be received in evidence. See Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, DOAH Case No. 97-3791, 1998 WL 870139, *2 (Recommended Order issued Mar. 20, 1998); see also Full Health Care, Inc. v. Agency for Health Care Administration, DOAH Case No. 00-4441, 2001 WL 729127, *8-9 (Recommended Order issued June 25, 2001).

126. In addition, Section 409.913(21), Florida Statutes, heightens the provider's duty of producing evidence to meet the Agency's prima facie case, by requiring that the provider come forward with written proof to rebut, impeach, or otherwise undermine the Agency's statutorily-authorized evidence; it cannot simply present witnesses to say that the Agency lacks evidence or is mistaken.

127. The pertinent statutes, rules, Handbook, and Medicaid Provider Reimbursement Handbook that were in effect during the audit period govern this dispute. See Toma v. Agency for Health Care Administration, DOAH Case No. 95-2419, 1996 WL 1059900, *23 (Recommended Order issued July 26, 1996) (adopted in toto, Sept. 24, 1996, 18 F.A.L.R. 4735).

128. The relevant provisions of the governing statutes, rules, and Handbook (which were cited and, at times, quoted in the foregoing Findings of Fact) are clear and unambiguous as a matter of law, capable of being relied upon, and applied to the historical events at hand, without a simultaneous examination of extrinsic evidence or resort to principles of interpretation.

129. Accordingly, some findings of fact followed directly from the unambiguous language of Rule 59G-4.130, Florida Administrative Code (1996); the plain provisions of Section 409.913, Florida Statutes; and the clear terms of the Handbook. To the extent these fact findings are deemed to constitute or reflect legal conclusions, they are hereby incorporated by reference as if set forth in this Conclusions of Law section of the Recommended Order and adopted as such.

130. The fact findings also were informed by several statutory, rule, and Handbook provisions that were not set forth at length in Findings of Fact above. The most important of these are quoted below.

131. Section 409.913, Florida Statutes (1997), provides in pertinent part:

> (1) For purposes of this section, the term:
>
> * * *
>
> (c) "Medical necessity" or "medically necessary" means any goods or services

necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

* * *

(5) A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceedings as evidence of medical necessity or the lack thereof.

* * *

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

* * *

(b) Are Medicaid-covered goods or services that are medically necessary.

* * *

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

* * *

(10) The agency may require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

132. Rule 59G-1.010(166), Florida Administrative Code, amplifies the statutory definition of medical necessity and provides:

"Medically necessary" or "medical necessity" means that the medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

4. Be reflective of the level of service that can be safely furnished, and for which no equally cost effective and more

> conservative or less costly treatment is available statewide;
>
> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> (b) "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

133. Rule 59G-4.130(5), Florida Administrative Code (1996), in effect during the audit period, provided as follows:

> Covered Services. The following in-home services are covered under the fee-for-service home health program.
>
> * * *
>
> (b) Home health aide visits.
> 1. To be reimbursed, home health aide visits, to children or adults, must be:
> a. Medically necessary, prescribed by the attending physician and provided in accordance with a physician-approved written treatment plan; and
> b. Provided under the supervision of a registered nurse;
> 2. The tasks required to be performed by the home health aide must be specified in writing by the registered nurse and must be consistent with the physician approved plan of treatment.

> 3. Examples of services that require the skills of a home health aide included:
> a. Bathing, (includes tub, shower or bed bath);
> b. Toileting and elimination;
> c. Nail and skin care;
> d. Oral hygiene;
> e. Transfer and ambulation;
> f. Range of motion and positioning; and
> g. Oral feeding and fluid intake.

134. Rule 59G-4.130(6), Florida Administrative Code (1996), which dealt with "Service Limitations," provided, in part, as follows:

> (a) Home visits are limited to no more than three licensed nurse visits and one home health aide visit per day per eligible recipient. The licensed nurse visits shall be the lowest skill level that will adequately and appropriately meet the needs of the recipient.
> (b) Home health visits are limited to a maximum of 60 visits per fiscal year. An exception to the maximum limit on home health visits shall be granted only by prior authorization from the agency or agency designees, based on medical necessity.

135. Rule 59G-4.130(7), Florida Administrative Code (1996), contained the following relevant provisions pertaining to plans of treatment:

> (a) All services furnished under the fee-for-service home health program must be furnished in accordance with an individualized written plan of treatment established by the attending physician. Services which are provided before the attending physician signs the treatment plan shall be considered to be provided under a plan established and approved by the attending physician where there is a signed

verbal order from the physician for the service(s) documented in the medical record. The plan of treatment must be signed and dated by he recipient's attending physician within 14 days of the start of care and services.

* * *

(c) . . . . The plan must be reviewed at least every 62 days and when the condition of the recipient changes.
(d) The treatment plan must specify:

* * *

5. Certification of medical necessity for in-home services[.]

* * *

(e) The treatment plan must be personally signed and dated by the attending physician.

136. Rule 59G-4.130(8), Florida Administrative Code (1996), set forth exclusions from Medicaid coverage, as follows:

(a) The following services are excluded from coverage under the fee-for-service home health program:
1. Transportation;
2. Housekeeping and chore services not related to medical necessity;
3. Mental health and psychiatric services;
4. Escort services;
5. Social services;
6. Meals on wheels;
7. Normal newborn services;
8. Hearing aide services;
9. Therapy services for recipients 21 years and older; and
10. Private duty nursing or personal care services for recipients 21 years and older; and
11. Home health services provided to recipients residing in community residential homes, adult congregate living facilities

(ACLFs), foster care facilities, group homes, intermediate care facilities for the mentally retarded/developmentally disabled (ICF/MR-DD), nursing facilities, or hospitals when those services duplicate services that are required to be provided by such residents, facilities or institutions.

137. The Handbook defined Medicaid compensable home health aide services to include:

- assisting with the change of a colostomy bag;
- assisting with transfer or ambulation;
- reinforcing a dressing;
- assisting the individual with prescribed range of motion exercises which have been taught by the RN;
- assisting with an ice cap or collar;
- conducting urine test for sugar, acetone or albumin;
- measuring and preparing special diets; and
- providing oral hygiene.

Handbook, at p. 2-8.

138. The Handbook listed the following services for which Medicaid would not pay:

- audiology services;
- housekeeping, homemaker, and chore services, including shopping;
- meals-on-wheels;
- mental health and psychiatric services;
- normal newborn services;
- respite care;
- services which can be safely, effectively and efficiently obtained outside the recipient's place of residence;
- services provided by a family member or the caregiver, including baby-sitting;
- services to a recipient in a community residential facility when those services

duplicate services the facility or institution is required to provide;
- social services;
- transportation services.

Handbook, at p. 2-6.

139. As set forth in the Findings of Fact above, upon review of the relevant rules, statutes, and Handbook provisions, as applied to the facts at hand, it has been determined as a matter of ultimate fact that the Agency established the existence of Medicaid overpayments to Monef totaling $5,165.60.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order requiring Monef to repay the Agency the principal amount of $5,165.60.

DONE AND ENTERED this 14th day of November, 2001, in Tallahassee, Leon County, Florida.

____

JOHN G. VAN LANINGHAM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 14th day of November, 2001.

ENDNOTES

[1]/ The Rule in effect during the audit period required that a treatment plan specify, among other things, "[c]ertification of medical necessity for the in-home services." Rule 59G-4.130(7)(d)5., Florida Administrative Code (1996). Accordingly, the approved plan of treatment form, entitled "Home Health Certification and Plan of Care," included a box, which was located next to the line for the attending physician's signature, that contained the following language:

> I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.

In addition, the form warned that "[a]nyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

[2]/ The Agency sought to diminish the significance of the peer-review organizations' findings by (a) emphasizing the undisputed fact that prior authorization is not based upon the patient's entire medical record and (b) arguing, correctly, that a peer-review organization's determination of medical necessity is not binding on the Agency. <u>See</u> Section 409.913(1)(c), Florida Statutes ("For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity."). These separate but interrelated points merit discussion.

Concerning the data upon which prior authorizations are based, the Agency's position is accurate but, without more, is not a persuasive basis for discounting the peer review organizations' opinions. This is because a peer-review organization acts on behalf, and under the direction, of the Agency. The Agency obviously can dictate to its designee the nature and scope of information that a provider must submit to obtain pre-approval. Thus, while it is true that providers requesting prior authorization are not required to submit complete medical files, it is equally true that the required information comprises all that the Agency considers to be sufficient for a meaningful pre-determination of medical need——

otherwise, there would be little point in requiring prior authorization.

That said, the legislature plainly has granted the Agency the power to second-guess a peer-review organization. Several circumstances in which the Agency might legitimately disregard a prior authorization come quickly to mind. First, a particular patient's complete file could contain information that, if known to the peer-review organization, reasonably would have affected the finding of medical necessity. Second, it is possible that a provider might have misled the peer-review organization by misrepresenting or omitting material facts. Third, the Agency might genuinely disagree with the peer-review organization, reaching a different, but logically and factually sustainable, conclusion based upon the same required data that were made available to the designee.

But the Agency cannot be allowed arbitrarily to exercise its authority to overrule the peer-review organization. In a formal administrative hearing, the Agency must prove one of the foregoing (or some other reasonable) grounds in support of a determination that the peer-review organization's finding of medical necessity should be given less weight than the Agency's contrary conclusion.

In this case, a preponderance of evidence shows that Monef provided to the peer-review organizations all of the required information, and that the data it submitted were true; Monef, in other words, was blameless in terms of its compliance with the procedures for prior authorization. The Agency failed to demonstrate, for any patient, that additional information in the medical records, not provided to the peer-review organization, would have made a difference in the assessment that led to prior authorization. The Agency likewise failed to establish any reasons for its many disagreements with the peer-review organizations' findings of medical necessity. In short, the Agency failed to undermine the prior authorizations or otherwise justify departing from them.

[3]/ By stipulating to the summary presentation of Dr. Sullenburger's ultimate opinion, which obviated the need for his taking the stand, Monef waived the hearsay objection. As for the attending physicians' certifications of medical necessity (and the peer-review organizations' prior authorizations), these were all contained within the exhibits that the Agency, without objection, moved unqualifiedly into evidence. Having offered

the proof, the Agency waived any hearsay objections it might otherwise have asserted. See Ohler v. United States, 529 U.S. 753, 755, 120 S.Ct. 1851, 1853 (2000)("Generally, a party introducing evidence cannot complain on appeal that the evidence was erroneously admitted."). Put another way, the Agency cannot successfully argue that its own exhibits are insufficient to support findings of fact——not, at least, where the documents were introduced without any expressed limitations of purpose. This situation is clearly distinguishable from that which arises when the party against whom hearsay was offered, having failed timely to object at hearing, subsequently challenges a fact finding based on the "unobjected-to hearsay." See Harris v. Game and Fresh Water Fish Commission, 495 So. 2d 806, 808 (Fla. 1st DCA 1986)(notwithstanding appellant's failure to object at hearing to introduction of hearsay evidence, agency's order was reversed because findings were based solely on inadmissible hearsay); Scott v. Department of Professional Regulation, 603 So. 2d 519, 520 (Fla. 1st DCA 1992)(appellant's failure to appear at hearing did not preclude her from successfully raising hearsay objection on appeal); but see Tri-State Systems, Inc. v. Department of Transportation, 500 So. 2d 212, 215 (Fla. 1st DCA 1986), rev. denied, 506 So. 2d 1041 (1987)("[A]s unobjected-to hearsay the testimony became part of the evidence in the case and was usable as proof just as any other evidence, limited only by its rational persuasive power.")

[4]/ Rule 59G-1.010(166)(c), Florida Administrative Code, provides: "The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service."

[5]/ Monef elicited the testimony of its owner and Director of Nursing, Nse Essiet, R.N., on the medical necessity for some of the services in question. Unfortunately for Monef, Ms. Essiet was not called as an expert witness, and, more important, her testimony lacked specificity. Although Ms. Essiet appeared as a lay witness, that alone would not have precluded the trier from relying upon her testimony as against that of the Agency's expert. See Weygant v. Fort Meyers Lincoln Mercury, Inc., 640 So. 2d 1092, 1094 (Fla. 1994)("[W]hen jurors are faced with lay testimony which is in conflict with expert medical testimony, it is within their province to reject the expert testimony and base their verdict solely on the lay testimony."). Here, however, the factfinder ultimately determined that Ms.Essiet's testimony,

though believable, was not sufficiently persuasive, taken as a whole, to refute the Agency's contrary expert opinion evidence, as presented through the parties' stipulation.

[6]/ The term "skilled nursing" is used herein to refer, collectively, to RN and LPN visits. Almost uniformly, the prior authorizations given for the services at issue in this case were specifically for RN visits rather than LPN visits, yet in actual practice the latter significantly outnumbered the former. Because the Rule in effect at the time limited Medicaid coverage for nurse visits to "the lowest skill level that will adequately and appropriately meet the needs of the recipient," see Rule 59G-4.130(6)(a), Florida Administrative Code (1996), it is understandable that Monef frequently used LPNs in place of RNs. None of the disputed claims, it should be noted, involved Monef's use of RNs to carry out pre-approved LPN visits, which (unlike the reverse situation at hand) would raise serious coverage questions. There being no basis in the record for distinguishing between RN visits and LPN visits for present purposes, then, the inclusive term "skilled nursing" is appropriate.

[7]/ Several of the patients for whom Monef provided the challenged services lived in ALFs, and this fact in many instances appears to have been a factor, if not a decisive one, in the Agency's determinations that these patients received care that was not medically necessary. As the applicable Home Health Services Coverage and Limitations Handbook ("Handbook") makes clear, however, ALFs were among the places of residence where a person could live and be eligible for home health services under the Medicaid Program. Handbook, at p. 2-3; see also Rule 59G-4.130(3)(a)2., Florida Administrative Code (1996). Thus, the fact that a patient lived in an ALF could not, without more, justify a finding that home health services provided him were not medically necessary. Further, while there was, as would be expected, an exclusion for home health services provided to ALF residents that duplicated services which the facility was required to provide, see Rule 59G-130(8)(a)11., Florida Administrative Code (1996), the Agency did not invoke this exclusion, nor did it prove such duplication of services in regard to any patient.

[8]/ See Handbook, at p. 2-6; see also Rule 59G-4.130(8)(a)3., Florida Administrative Code (1996).

[9]/ Based on the number of visits during the referenced period and amount paid for each claim, the alleged overpayment should be $104.76.

[10]/ Based on the number of visits during the referenced period and amount paid for each claim, the alleged overpayment should be $174.60.

[11]/ Monef was reimbursed $15.46 for this visit.

[12]/ Meal preparation would be covered if the task entailed the "measuring and prepar[ation] [of a] special diet[]." Handbook, at p. 2-8. None of the medical records, documents, or other evidence, however, suffices to show that this patient——or any of the others——received special meals.

[13]/ Neither the applicable Rule nor the Handbook describes the services that comprise "toileting and elimination." For guidance, the undersigned reviewed Rule 59A-8.002(3)(f), Florida Administrative Code, which defines the term "toileting" in a different, but related, regulatory context. There, "toileting" is enumerated as one of the chores that a home health aide may perform when providing "assistance with activities of daily living" and is defined to mean:

> Reminding the patient about using the toilet, assisting him to the bathroom, helping to undress, positioning on the commode, and helping with related personal hygiene, including assistance with changing of an adult brief. Also includes assisting with positioning the patient on the bedpan, and helping with related personal hygiene.

Rule 59A-8.002(3)(f), Florida Administrative Code. Recognizing that this Rule does not control the instant dispute, the undersigned nevertheless found persuasive the fact that this broad definition of "toileting" makes no mention of observing and commenting upon the patient's use of the toilet.

[14]/ On these days, the aide performed some unspecified task in connection with the patient's movement that was reported simply as "other" on the time sheet. Without more detail, however, this is not sufficient evidence of a covered service, because the factfinder can only guess at what assistance, if any, the aide may have provided the patient.

[15]/ In its Proposed Recommended Order, Monef declared that it was unable to refute the Agency's position on this alleged overcharge. Having determined before receiving Monef's post-hearing papers that the Agency's allegation regarding this payment was not true, however, the undersigned declined to change a correct finding of fact that is amply supported by substantial competent evidence.

[16]/ Pointing out that the Agency's argument here rests on a technicality is not to belittle the Agency's position——rules are rules, after all, and those who seek Medicaid money must follow them, even the technical ones. On the other hand, when a provider plainly has been attempting to follow the myriad Medicaid rules and has been tripped up by an inadvertently overlooked detail, and when the deficiency is clearly a harmless error that caused no discernable prejudice to the Medicaid Program or the patient, requiring the provider to forfeit payments for competently performed, medically necessary services would serve no constructive purpose, would strike most fair-minded people as unreasonable and perhaps arbitrary or capricious——and might result in the unintended consequence of causing some providers to avoid caring for Medicaid patients.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.