STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HARDY L. PASCHAL, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 02-2690MPI

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted on April 25, 2003, by video teleconference between Miami and Tallahassee, Florida, before Administrative Law Judge Claude B. Arrington of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Neil Flaxman, Esquire
Neil Flaxman, P.A.
550 Biltmore Way, Suite 780
Coral Gables, Florida 33134

For Respondent: Jeffries H. Duvall, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station 3
2727 Mahan Drive
Tallahassee, Florida 32308

STATEMENT OF THE ISSUE

Whether Petitioner, a home and community support services coordinator, was overpaid by the Medicaid program as alleged in the Final Agency Audit Report (FAAR) dated March 25, 2002.

PRELIMINARY STATEMENT

Respondent's FAAR alleged that Petitioner was overpaid the sum of $45,574.92, for services rendered during the audit period beginning January 1, 2000, and ending January 31, 2001. Petitioner requested a formal administrative hearing to challenge the alleged overpayment, the matter was referred to the Division of Administrative Hearings, and this proceeding followed. After Petitioner submitted additional information and documentation, Respondent reduced the alleged overpayment to $39,797.35, which is the amount at issue in this proceeding.

To facilitate the presentation of evidence at the final hearing, Respondent presented its case before Petitioner presented his. Respondent presented the testimony of Marcie Brittain (a Medicaid Waiver Coordinator for the Florida Department of Children and Family Services) and Effie Stephan (an analyst who audits Medicaid providers on behalf of Respondent). Respondent presented three exhibits, each of which was admitted into evidence. Respondent's first two exhibits were lengthy composite exhibits. Petitioner testified on his own behalf, and presented one exhibit, which was admitted into evidence.

A Transcript of the proceedings was filed on July 10, 2003. Each party filed a Proposed Recommended Order, which has been considered by the undersigned in the preparation of this

Recommended Order. All citations are to Florida Statutes (2000) unless otherwise noted.

FINDINGS OF FACT

1. Respondent is the agency of the State of Florida responsible for oversight of the integrity of the Medicaid program in Florida.

2. At all times pertinent to this proceeding, Petitioner was a home and community services coordinator who provided services to Medicaid recipients in Florida pursuant to certification from Respondent. Petitioner billed the Medicaid program on a monthly basis and received payments from the Medicaid program based on those billings.

3. As a community services coordinator, Petitioner served developmentally disabled clients who resided in the community, as opposed to residing in an institution. Petitioner coordinated the receipt of the services his clients received, including services from Developmental Services, which is a division of the Department of Children and Family Services.

4. As a support coordination provider, Petitioner is required to determine the needs of each client, prepare a support coordination plan for that client, and, after the support coordination plan is approved by Respondent, coordinate the provision of the services required by the plan. Petitioner

is required to document the services he provides for each client.

5. Respondent routinely audits the records of Medicaid providers to ensure compliance with Medicaid requirements. The audit at issue in this proceeding covered the period January 1, 2000, to January 31, 2001.

6. The unnumbered opening sentence of Section 409.913 provides as follows:

> The agency shall operate a program to oversee the activities of Florida Medicaid . . . providers and their representatives, . . . to recover overpayments and impose sanctions as appropriate.

7. During the audit period, Petitioner was subject to all duly enacted statutes, laws, rules, and policy guidelines that generally govern Medicaid providers. During the audit period, the applicable statutes, laws, rules, and policy guidelines in effect required Petitioner at Respondent's request to provide Respondent all Medicaid-related records and other information that supported all the Medicaid-related invoices or claims that Petitioner made during the audit period.

8. Section 409.913(7) provides, in pertinent part, as follows:

> (7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty . . . 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:
>
> * * *
>
> (e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

9. Section 409.913(1)(d) defines the term "overpayment" as follows:

> (d) "Overpayment" includes 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.

10. Following the audit, Respondent sent Petitioner the FAAR dated March 25, 2002, which asserted that Petitioner had received an overpayment in the amount of $45,574.92 and demanded repayment of the overpayment. Respondent stated the following basis for concluding that the claims were overpayments:

> You billed and were paid for Support Coordination Services when the documentation was not found to substantiate the services billed.

11. The audit letter provided, in part, as follows:

> In determining payment pursuant to Medicaid policy, the Medicaid program utilizes procedure codes, descriptions, policies, limitations and exclusions found in the Medicaid provider handbooks and (sic) Section 409.913, Florida Statutes (F.S.) and Florida Administrative Code 59G-8.200 (F.A.C.). In applying for Medicaid

> reimbursement, providers are required to follow the guidelines set forth in the applicable rules. . . . Medicaid cannot pay for services that do not meet these guidelines.

12. Following his receipt of the audit letter, Petitioner provided Respondent with additional documentation. As a result of that information, Respondent reduced the amount of the claimed overpayment to the sum of $39,797.35.

13. Petitioner was required to follow the billing and documentation requirements set forth in the Support Coordinator Guidebook (the Guidebook). The Guidebook was made available to Petitioner upon his enrollment as a home and community services support coordinator. Petitioner knew or should have known the billing and documentation requirements set forth in the Guidebook, and he knew or should have known that he was required to follow those requirements to be entitled to compensation from the Medicaid program.

14. The Guidebook[1] provided, in part, as follows:

> Payment to support coordination providers is made when all necessary support coordination activities have been provided to assist an individual in achieving or making progress toward achieving the outcomes identified on the support plan and when all documentation for these supports and services have been completed.
>
> 1. Prior to requesting a monthly reimbursement for support coordinator services, the following must be met:

> The individual's current support plan and district-approved cost plan are filed in the individual's central record. . . .
>
> At least one face-to-face contact with the person for the month being billed has occurred. . . .
>
> At least once every three months, the monthly face-to-face contact occurs in the individual's or family's place of residence.. . .
>
> The support coordinator conducts at least one other activity during the month being billed. These contacts: (1) directly relate to implementing the outcomes identified on the individual's support plan, (2) directly relate to facilitating the development of natural and community supports, or (3) directly relate to facilitating the effective provision of supports and services needed by the individual. These contacts and activities may be either with the individual or other persons such as family members, service vendors, [or] community members. They may also be conducted face-to-face or by phone.
>
> Administrative activities such as typing, filing, mailing, billing, letter writing, or leaving messages shall not qualify as contacts or activities meeting the minimum billing criteria for a given month. Additionally, scheduling time to develop the support plan, setting up face-to-face contact, setting up meetings with other persons, and meeting with one's supervisor or co-workers do not qualify as meeting the minimum billing criteria. At least one of the contacts or activities shall be conducted on a different day within the month from the face-to-face contact with the individual.

15. There was a dispute between the parties as to whether Petitioner satisfied the billing criteria that the support coordinator have at least one face-to face meeting the each

client each month and, in addition, that the support coordinator perform at least one non-administrative activity on behalf of the client during the month. The greater weight of the credible evidence established that Petitioner did not meet the billing criteria for the claims at issue. While it is clear that Petitioner performed valuable services to his clients, he did not meet the clear billing criteria set forth in the Guidebook. Specifically, Petitioner did not have both a face-to-face meeting with the client and perform a non-administrative activity on behalf of the client during the month for any of the monthly billings at issue. Respondent correctly determined that Petitioner had received an overpayment within the meaning of Section 409.913(1)(d), and it correctly determined the amount of the overpayment to be $39,797.35.

16. The Medicaid program does not provide for partial payments to a provider based on the work the provider actually performed if the provider's billings do not meet the billing criteria set forth in the applicable Guidebook. The Medicaid program provides for no payment to a provider if the provider's billings do not meet the billing criteria set forth in the applicable Guidebook.

CONCLUSIONS OF LAW

17. The Division of Administrative Hearings has jurisdiction over the subject matter parties to this case pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2002).

18. The Medicaid billing requirements for providers such as Petitioner are clearly set out in the Guidebook. Petitioner submitted billings to the Medicaid Program that do not meet the billing criteria. Consequently, the payments made by the Medicaid Program to Petitioner based on his billings constitute overpayments.

19. Unless created by constitution, an administrative agency has only such powers as the legislature chooses to confer upon it by statute. It has no inherent powers to apply the type remedy Petitioner seeks in this proceeding. In the absence of an authorizing statute or an order from a court of competent jurisdiction, Respondent cannot pay claims that do not meet the billing criteria set forth in the Guidebook. *See S. T. v. School Board of Seminole County*, 783 So. 2d 1231 (Fla. 5th DCA 2001); and *Mathis v. Fla. Dept. of Corr.*, 726 So. 2d 389 (Fla. 1st DCA 1999).

20. Petitioner's contention that Respondent should have notified him sooner that his billings were insufficient is rejected as being without merit. It was Petitioner's

responsibility to ensure that his claims met the billing criteria set forth in the Guidebook. That responsibility never shifted to Respondent.

RECOMMENDATION

Based on the foregoing findings of fact and conclusions of Law, it is RECOMMENDED that Respondent enter a final order finding that Petitioner received an overpayment from the Medicaid program in the amount of $39,797.35 and requiring that Petitioner repay that overpayment.

DONE AND ENTERED this 8th day of September, 2003, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 8th day of September, 2003.

ENDNOTE

1/ This text is found in Respondent's Exhibit 1, Tab 9, at pages 31-34.

COPIES FURNISHED:

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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.