STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 07-1487MPI
WOMESH C. SAHADEO, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

This case came before Administrative Law Judge John G. Van Laningham for final hearing by video teleconference on June 29, 2007, at sites in Tallahassee and West Palm Beach, Florida.

APPEARANCES

For Petitioner: L. William Porter, II, Esquire
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For Respondent: Womesh C. Sahadeo, M.D.
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STATEMENT OF THE ISSUE

The issue for determination is whether Respondent is liable to Petitioner for the principal sum of $2,284.13, which equals

the amount that the Florida Medicaid Program paid Respondent for psychiatric services provided between January 2, 2002, and June 30, 2006, to patients who, at the time of treatment, were residents of custodial care facilities.

PRELIMINARY STATEMENT

Petitioner Agency for Health Care Administration is the agency responsible for administering the Florida Medicaid Program. Respondent Womesh C. Sahadeo, M.D., is a psychiatrist who has furnished goods or services to Medicaid beneficiaries.

In the course of performing a generalized analysis of a category of Medicaid claims involving psychiatric services, Petitioner requested that Dr. Sahadeo produce copies of records showing that his Medicaid eligible patients who resided in custodial care facilities had been seen in the doctor's office or a hospital. Dr. Sahadeo failed to provide the documents that Petitioner demanded to review. Consequently, on February 20, 2007, Petitioner issued a Final Agency Audit Report, wherein it alleged that this physician had been overpaid $2,284.13 for Medicaid claims arising from Respondent's provision of psychiatric services to eligible beneficiaries at ineligible settings (e.g. a nursing home or group home). Petitioner further alleged that Dr. Sahadeo had violated Medicaid's record keeping requirements, and for that it intended to impose a $500

administrative fine, in addition to recovering the alleged overpayment.

By letter dated February 26, 2007, Dr. Sahadeo's office manager requested a hearing to dispute the overpayment assessment. The matter was referred to the Division of Administrative Hearings on March 30, 2007.

At the final hearing, which took place as scheduled on June 29, 2007, Petitioner called as witnesses its employees Terri Dean, an investigator; and Gregory Riley, a registered nurse. In addition, Petitioner's Exhibits lettered A through J were admitted into evidence without objection.

Dr. Sahadeo testified on his own behalf and presented one other witness, his office manager Sonya Robinson. Dr. Sahadeo did not offer any exhibits.

The final hearing transcript was filed on September 26, 2007. Petitioner filed a proposed recommended order ahead of the established deadline, which was October 26, 2007. This was carefully considered in the preparation of the Recommended Order. Dr. Sahadeo did not present any proposed findings or conclusions.

FINDINGS OF FACT

1. Petitioner Agency for Health Care Administration ("AHCA" or the "Agency") is the state agency responsible for administering the Florida Medicaid Program ("Medicaid").

2. Respondent Womesh C. Sahadeo, M.D. ("Sahadeo") is a psychiatrist. At all relevant times, Dr. Sahadeo was a Medicaid provider authorized to receive reimbursement for covered services rendered to Medicaid beneficiaries.

3. Exercising its statutory authority to oversee the integrity of Medicaid, the Agency in 2006 performed a "generalized analysis" of claims involving psychiatric services rendered to patients who, at the time of treatment, had been residing in nursing homes, assisted living facilities, or other custodial care facilities. In a generalized analysis, claims within a category of services are reviewed to determine whether each claim meets a particular condition of coverage or falls within a specific exclusion. The conditions and limitations of interest to AHCA in this instance were (a) the requirement that, to be compensable, psychiatric services must be provided in a hospital or physician's office and (b) the corresponding exclusion from coverage of claims for psychiatric services rendered in any other place, e.g. nursing homes or other custodial care facilities.

4. During the period from January 2, 2002 to June 30, 2006 (the "Audit Period"), Dr. Sahadeo had submitted a number of claims seeking reimbursement for psychiatric services provided to seventeen patients who were residents of group homes or other custodial care facilities. Medicaid had paid these claims, and,

as a result, Dr. Sahadeo had received payments totaling $2,284.13. Being within the scope of the generalized analysis under way in 2006, these claims came to AHCA's attention.

5. By letter dated November 9, 2006, the Agency informed Dr. Sahadeo that the aforementioned claims would not have been compensable if the patients in question had been seen in their respective residential facilities (as opposed to the doctor's office or a hospital). AHCA demanded that Dr. Sahadeo submit records showing that the psychiatric services at issue had been rendered in an eligible setting, to confirm that the subject claims were within Medicaid coverage. The deadline for compliance with this demand was 15 days after receipt of the letter.

6. Dr. Sahadeo did not respond to the letter of November 9, 2006. Consequently, on December 20, 2006, the Agency issued a Preliminary Audit Report, which notified Dr. Sahadeo that, because he had failed to produce records documenting the place(s) of service as requested, each of the claims under review was now deemed to have resulted in an overpayment. Dr. Sahadeo was given the choice of either remitting payment of $2,284.13 or submitting documentation demonstrating that some or all of the claims were properly paid. The deadline for furnishing additional documentation was 15 days after receipt of the report.

7. Dr. Sahadeo did not respond to the Preliminary Audit Report. Consequently, on February 20, 2007, the Agency issued a Final Audit Report. The Final Audit Report echoed the Preliminary Audit Report in regard to the place-of-service issue. This time, however, the Agency added allegations accusing Dr. Sahadeo of violating Medicaid's record keeping requirements, and it gave notice of its intent to impose a $500 fine for his failure to furnish Medicaid related records on demand. According to AHCA, the total amount due from Dr. Sahadeo was now $2,784.13.

8. Dr. Sahadeo timely requested an administrative hearing, giving rise to this case. Before the final hearing, Dr. Sahadeo produced some medical records underlying some of the claims in question. None of these medical records, however, clearly and unambiguously documents the place of service, the critical fact which at all times during this audit has been the focus of AHCA's interest and concern.

9. At hearing, Dr. Sahadeo presented persuasive evidence (his testimony and that of his office manager, Sonya Robinson) that the psychiatric services behind the claims at issue were, in fact, rendered in his office, and not at the respective residences of the patients. The undersigned finds this to be the case.

10. But the evidence also established——and the undersigned finds——that, in addition to medical records, certain professional or business records were created in connection with each of the subject claims, records which, if retained, would have shown that the patients had come to Dr. Sahadeo's office for treatment.

11. One set of such documents comprised the "sign in sheets" that patients signed upon arrival at the doctor's office. Located at the receptionist's desk, the sign in sheet was a paper on which each patient would write his name, time of arrival, and appointment time. Although a sign in sheet was (or should have been) inscribed by every patient each time he was seen in the doctor's office, Dr. Sahadeo either did not keep copies of these documents or was unable, for other reasons, to make them available for inspection by AHCA.

12. The other set of documents which would have shown that the patients of interest had come to Dr. Sahadeo's office for treatment consisted of the "receipts" that the doctor would sign to confirm that a caretaker had transported the patient from the group home or other custodial facility to the doctor's office for his appointment. During the Audit Period, it was Dr. Sahadeo's practice to sign the receipt and return the paper to the caretaker or driver without keeping a copy for his own

records. Consequently, Dr. Sahadeo was unable to make these documents available for inspection by AHCA.

13. Dr. Sahadeo did not satisfy his continuing obligation to retain all of the records relating to the services that he had provided to the patients whose claims AHCA is disputing. Yet, when AHCA paid the Medicaid claims at issue, it did so believing——and in reliance upon the assumption——that Dr. Sahadeo was fulfilling his affirmative duty to provide the underlying services in accordance with all the applicable policies, rules, and laws, including the requirement that records relating to a Medicaid claim be kept for five years. AHCA was mistaken in this regard.

14. As a result of the Agency's mistaken assumption that Dr. Sahadeo was complying with the record keeping requirements, Dr. Sahadeo received from Medicaid a total of $2,284.13 in payments that were not authorized to be paid. This grand total of $2,284.13 constitutes an overpayment that Dr. Sahadeo must return to the Agency.

CONCLUSIONS OF LAW

15. 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 (2007).

16. The Agency is empowered to "recover overpayments and impose sanctions as appropriate." § 409.913, Fla. Stat. (2006).[i]

An "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." § 409.913(1)(e), Fla. Stat.

17. One method of recovering overpayments is through "recoupment," which is "the process by which the department [i.e. AHCA] recovers an overpayment or inappropriate payment from a Medicaid provider." Fla. Admin. Code R. 59G-1.010(245).

18. 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 Admin., 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).[ii]

19. Section 409.907, Florida Statutes, provides as follows:

> The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

(Emphasis added.)

20. Section 409.913(7), Florida Statutes, provides in pertinent part as follows:

> 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:
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> * * *
>
> (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.
> (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.

21. All Medicaid providers must, among other things:

> (b) Maintain in a systematic and orderly manner all medical and Medicaid-related records that the agency requires and determines are relevant to the services or goods being provided.
> (c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the agency.

§ 409.907(3), Fla. Stat.

22. The foregoing record keeping requirements are restated for emphasis, and amplified, in Section 409.913(9), which provides as follows:

> A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

23. AHCA is authorized to pay a Medicaid claim only if the provider furnished goods or services in accordance with all applicable laws. Therefore, if the provider fails to keep Medicaid related records for the five-year period as required, which means that he has not furnished the goods or services in accordance with state law, then AHCA cannot lawfully pay the Medicaid claim for such goods or services. Of course, AHCA does not wait five years to pay a claim, to make certain the provider complies with the record keeping requirements. Rather, AHCA pays the claim upon submission, on the assumption that the provider will comply.

24. The requirement to keep all records pertaining to the goods and services provided to a Medicaid recipient for five years after the furishing thereof is best understood, then, as a *condition subsequent* to the compensability of the claim. If, as here, the condition subsequent is not met, then AHCA's up-front payment of the claim——on the assumption of the provider's future compliance——is proven a mistake.

25. The amounts that Dr. Sahadeo received in payment of the claims at issue were not authorized to be paid owing to his failure to comply with the record keeping requirements; he received these sums as a result AHCA's mistaken assumption that Dr. Sahadeo would fulfill his obligations concerning the retention of records.

26. The undersigned accordingly finds and concludes that the total amount Dr. Sahadeo received for the subject claims—— $2,284.13——is an overpayment, which the Agency is entitled to recover from the provider.

27. There is one final matter to discuss. The Agency seeks to impose a fine of $500 against Dr. Sahadeo. The authority to impose such a fine is given in Section 409.913(16), Florida Statutes, which provides in pertinent part as follows:

> The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

* * *

> (c) Imposition of a fine of up to $5,000 for each violation.

28. Among the acts described in subsection (15) are the following:

> (c) The provider has not furnished or has failed to make available such Medicaid-related records as the agency has found necessary to determine whether Medicaid payments are or were due and the amounts thereof[.]
>
> * * *
>
> (e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program[.]

§ 409.913(15)(c), Fla. Stat.; see also Fla. Admin. Code R. 59G-9.070(7)(b)-(c).

29. Dr. Sahadeo failed to keep records for five years as required by law, and he was, consequently, unable to satisfy the Agency's demand for documentation when questions subsequently arose regarding the compensability of certain claims. Therefore, Dr. Sahadeo committed violations, for each of which

AHCA may impose a fine of up to $5,000. The fine of $500 that AHCA wants to impose is well within its statutory authority.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order requiring Dr. Sahadeo to repay the Agency the principal amount of $2,284.13, together with an administrative fine of $500.

DONE AND ENTERED this 20th day of November, 2007, in Tallahassee, Leon County, Florida.

JOHN G. VAN LANINGHAM
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of November, 2007.

ENDNOTES

[i]/ The substantive Medicaid law that governs this case remained the same throughout the Audit Period——and is not disputed. Thus, rather than burden this Recommended Order with citations to all of the historical statutes, the 2006 Florida Statutes are cited exclusively hereinafter unless otherwise indicated, and each such citation is meant to encompass all of the applicable statute-years for the referenced provision, which might have been renumbered from time to time.

[ii]/ 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(22), 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 Fla. Div. Adm. Hear. LEXIS 6245, *6-*7 (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 (Fla.Div.Admin.Hrgs. June 25, 2001)(adopted in toto, Sept. 28, 2001, AHCA Rendition No. 01-262-FOF-MDO).

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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.