STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

CASE NO. 09-0097MPI
PROVIDER NO.: 68583296
C.I.NO.: 07-5931-000

ALL BIG TEN, INC. / PREMIER HEALTH CENTER,

Respondent.
_____/

FINAL ORDER

The Respondent having withdrawn its Petition for Formal Administrative Hearing, there remains no disputed issues of fact or law. Therefore the Respondent owes the Agency $404,630.34 in Medicaid overpayments and an administrative fine of $3,500.00. The total amount owed the Agency is $408,130.34, and shall bear annual interest of 10% from issuance of this Final Order pursuant to Section 409.913(25)(c), Florida Statutes. Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 22nd day of June, 2009, in Tallahassee, Florida.

HOLLY BENSON, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Daniel M. Lake, Esquire
Agency for Health Care
Administration
(Interoffice Mail)

William F. Sutton, Jr., Esquire
Ruden, McClosky, Smith, Schuster & Russell
Post Office Box 4950
Orlando, Florida 32802-4950
(U.S. Mail)

Daniel M. Kilbride
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060

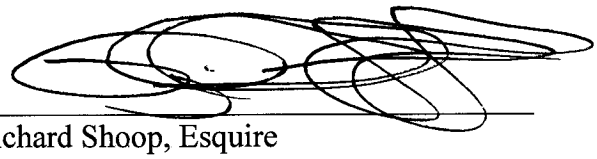
Ken Yon, Chief, Medicaid Program Integrity

Lawrence E. Stivers, Medicaid Program Integrity

Finance and Accounting

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail on this the 26th day of June, 2009.



Richard Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
(850) 922-5873

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. ALL BIG TEN, INC./PREMIER HEALTH CARE, Respondent.	)	Case No. 09-0097MPI

ORDER RELINQUISHING JURISDICTION AND CLOSING FILE

This cause having come before the undersigned on Respondent's Motion to Withdraw Petition for Formal Hearing, filed April 10, 2009, and the undersigned being fully advised in the premises, it is, therefore,

ORDERED that:

1. Respondents Motion to Withdraw Petition is GRANTED.

2. The file of the Division of Administrative Hearings in the above-captioned matter is hereby closed, and jurisdiction is hereby relinquished to the Agency for Health Care Administration.

DONE AND ORDERED this 15th day of April, 2009, in Tallahassee, Leon County, Florida.

DANIEL M. KILBRIDE
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of April, 2009.

COPIES FURNISHED:

Daniel Lake, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Suite 3431
Fort Knox Building III, MS 3
Tallahassee, Florida 32308

William F. Sutton, Jr., Esquire
Ruden, McClosky, Smith, Schuster &
Russell, P.A.
111 North Orange Avenue, Suite 1750
Orlando, Florida 32801

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

ALL BIG TEN, INC./PREMIER HEALTH CARE,

Respondents.

CASE NO.: 09-0097MPI
685832596
07-5931-000

RESPONDENTS' MOTION TO WITHDRAW PETITION FOR FORMAL HEARING

COMES NOW Respondents, ALL BIG TEN, INC./PREMIER HEALTH CARE (hereinafter "Respondents"), by and through its undersigned attorneys and moves to withdraw its petition for a formal hearing in response to the decision of the Agency for Health Care Administration ("AHCA") to seek reimbursement in the amount of $404,630.34, plus a fine of $3500 from Respondents based on AHCA's Final Audit Report C.I. No. 07-5931-000/W/RS ("Final Audit Report"), and as grounds submits as follows:

1. By letter dated December 2, 2008, AHCA advised Respondents of its findings as set forth in the Final Audit Report, in which AHCA sought to recover the amount of $404,630.34, plus a $3500 penalty, in Medicaid monies paid to Respondents.

2. In response to the Final Audit Report, Respondents, through counsel, timely filed a Petition for Formal Hearing to contest the Final Audit Report, thereby resulting in the referral of this matter to the Division of Administrative Hearings.

3. Subsequent to AHCA sending the Final Audit Report to Respondents, the State of Florida Agency for Persons for Disabilities ("APD") elected to terminate its Medicaid Waiver

Services Agreement (the "Agreement") with Respondents. Without this Agreement, Respondents are unable to bill and receive Medicaid payments from the State of Florida.

4. As a result of APD's decision to terminate the Agreement, Respondents were forced to cease operations as they could no longer receive payments for services rendered to Florida Medicaid recipients.

5. As a consequence of ceasing operations, Respondents' business entity was administratively dissolved by the State of Florida Division of Corporations.

6. Presently, Respondents are no longer an active, ongoing business entity, have no funds, and have no ability to receive funds given APD's decision to terminate the Agreement. With this in mind, a continuation of any proceeding to contest AHCA's Final Audit Report is both futile and, ultimately, a collective waste of time for all concerned.

WHEREFORE, given the matters set forth herein, Respondents move for an Order remanding this matter back to AHCA for any action that the agency deems appropriate.

Respectfully submitted,

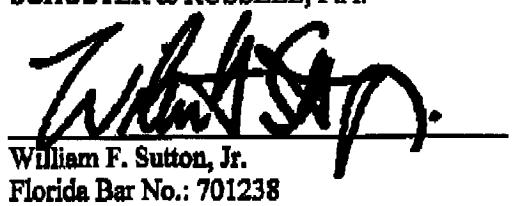
By: _____

William F. Sutton, Jr.
Florida Bar No.: 701238
RUDEN, MCCLOSKY, SMITH,
SCHUSTER & RUSSELL, P.A.
111 N. Orange Ave., Suite 1750
Orlando, Florida 32801
Telephone: (407) 244-8003
Facsimile: (407) 244-8080
Attorneys for Respondents
All Big Ten, Inc./Premier Health Care

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy hereof was furnished via U.S. Mail this 10th day of April, 2009 to: Daniel Lake, Esq., Assistant General Counsel, Agency for Health Care Administration, 2727 Mahan Drive, Building MS#3, Tallahassee, Florida 32308.

RUDEN, MCCLOSKY, SMITH,
SCHUSTER & RUSSELL, P.A.



William F. Sutton, Jr.
Florida Bar No.: 701238

CHARLIE CRIST
GOVERNOR

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION
Better Health Care for all Floridians

HOLLY BENSON
SECRETARY

CERTIFIED MAIL No.: 7006 3450 0003 8979 9217

December 2, 2008

09.0097MPI

Provider No: 685832596

All Big Ten, Inc / Premier Health Care
8051 North Tamiami Trail
Box 35, Suite F-6
Sarasota, Florida 34243

In Reply Refer to
FINAL AUDIT REPORT: C.I. No. 07-5931-000/W/RS

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period April 1, 2006, through June 30, 2006. A preliminary audit report dated February 18, 2008 was sent to you indicating that we had determined you were overpaid $517,905.28. Based upon a review of all documentation submitted, we have determined that you were overpaid $404,630.34 for services that in whole or in part are not covered by Medicaid. A fine of $3,500 has been applied. The total amount due is $408,130.34.

Be advised of the following:

(1) Pursuant to Section 409.913(23)(a), Florida Statutes (F.S.), the Agency is entitled to recover all investigative, legal, and expert witness costs.

(2) In accordance with Sections 409.913(15), (16), and (17), F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. This letter shall serve as notice of the following sanction(s):

- A fine of $3,500 for violation(s) of Rule Section 59G-9.070, 7(c) and 7(e) F.A.C.
- A corrective action plan in the form of a Provider Acknowledgement Statement and is due within 30 calendar days of receipt of this notice (please see the attachment regarding the requirements for this sanction)

In addition to the above, be advised that in a separate case, Case No. 07-2136RU, Custom Mobility, Inc., vs. Agency for Health Care Administration, the Division of Administrative Hearings' law judge ruled that, while Cluster Sampling is a valid and accepted statistical methodology, the formula that the Agency uses should be published in an administrative rule. The Agency has appealed the judge's order. Since the ruling has been appealed, the application of the order is postponed and the Agency is continuing the audit process. In light of the above, you should continue to adhere to any instructions, communication, request for hearing, time deadlines, etc., referenced in the audit report. In regard to payment of the overpayment identified and sanctions imposed during the review, you may choose to pay the overpayment and comply with any sanctions imposed or you may request a hearing since the outcome of the appeal may affect the audit determinations. If you properly request a hearing, the Agency will work with you to place the audit in abeyance until the outcome of the appeal and any impact on this audit is known.

This review and the determination of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining the appropriateness of Medicaid payment pursuant to Medicaid policy, the Medicaid program utilizes procedure codes, descriptions, policies, limitations and requirements found in the Medicaid provider handbooks and Section 409.913, F.S. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Below is a discussion of the particular guidelines related to the review of your claims, and an explanation of why these claims do not meet Medicaid requirements. The audit work papers are attached, listing the claims that are affected by this determination.

REVIEW DETERMINATION(S)

1. **Incorrect, Illegible, Insufficient and/or Incomplete Documentation. Documentation provided did not meet guidelines set forth in the Developmental Disabilities Waiver Services Coverage and Limitations Handbook. These infractions are considered overpayments and will be recouped by Medicaid. 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 claims, unacceptable practices, fraud, abuse or mistake.**

   - Employee background checks (FDLE & FBI), DCF clearance (where required) experience, education, training and certification records, and proof of drivers' license (for those who transport recipients) were requested. All of these records were not included in the documentation provided by the provider. Claims submitted for services that were performed by an employee whose records were either incomplete or not provided were denied.

- Support Plans / Plans of Care, Individualized Implementation Plans (IIP), Annual Report, monthly summaries and contact logs were requested for each recipient. Numerous recipient files were missing the requested documentation. Claims missing the required supporting documentation were denied.
- Missing required type of service, date and time of service, detailed activities and signatures on service logs, IIP and/or monthly summaries. These claims were denied.
- Numerous instances of falsified documentation were observed where the provider Xeroxed a log entry and then changed the date(s). These claims were denied.

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook states the following:

Appendix C-8, Chapter 2.1, Required Training:
"The provider and its employees will ensure they receive the specific training required to successfully serve each recipient."

Appendix C-10, Chapter 3.2, Screening Requirement:
"Each provider will maintain on file, and make available upon request, documentation that include:

A. Level two background screening requirements.
C. All employees meet qualifications in this document and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, including copies of licenses, certificates, high school and college diplomas and certified college transcripts as required."

Chapter 1-7, Service Authorization Form:
"A Department approved form sent to a waiver provider from the waiver support coordinator authorizing the provision of specific services or supports to a recipient. Without the service authorization form the provider is not authorized to provide the service and cannot submit a claim nor be reimbursed for the service. Services provided without authorization may be subject to recoupment of funds from the provider."

Chapter 2-5, Service Authorization Requirements:
"In order for a recipient to receive a service, it must be identified on a recipient's support plan and cost plan, also known as the plan of care, and approved by the District Office before the service may be provided. Providers of DD Waiver services are limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan."

Chapter 2-7, Documentation Requirements:
"Medicaid will only reimburse for waiver services, at an approved rate, that are specifically identified in the approved plan of care by service type, frequency and duration for which there is sufficient documentation supporting the provision of a service to the recipient," and

Chapter 2-11, Implementation Plan
Supported Living and Non-Residential Support Services:
"A plan developed with direction from the recipient, which includes information from the recipient's current support plan, and other pertinent sources." Additionally, "The progress toward achieving the goal(s) identified on the implementation plan shall be documented in daily progress notes or monthly summaries."

Chapter 2-14, Service Log:
"The service log shall include documentation that includes the recipient's name, social security number, recipient's Medicaid ID number, the description of the service, activities, supplies or equipment provided and corresponding procedure code, times and dates service was rendered, amount billed for each service, provider's name and provider Medicaid ID number."

Chapter 2-49, Documentation Requirements:
"If the provider plans to transport the recipient in his private vehicle, at the time of enrollment, the provider must be able to show proof of valid: 1) driver's license, 2) car registration; and 3) insurance. Subsequent to enrollment, the provider is responsible for keeping this documentation up-to-date."

Chapter 2-55, Non-Residential Support Services, Documentation Requirements:
"Reimbursement and monitoring documentation to be maintained by the provider: (4) Copy of individual implementation plan and/or behavior analysis services plan with supporting data is warranted. In addition to those requirements for an implementation plan found in the definition, the implementation plan for this service shall contain strategies to reduce the reliance on paid supports, to include the transfer of the support to a more cost effective service, or unpaid supports. The strategies to reduce the reliance on paid supports should be measurable and addressed in the monthly summary of progress and the annual report."

Chapter 2-60, Personal Care Assistance:
"Personal care assistance in the family home should be provided only to assist the parent or primary caregiver of children in meeting the personal care needs of the child." Also, "Recipient's living in foster or group homes are not eligible to receive this service, except: When a group home resident is recovering from surgery, does not require the care of a nurse and the group home operator is unable to provide the personal care attention required to insure the recipient's personal care needs are being met. Once the recipient has recovered, the service must be discontinued."

2. **Incorrect, unnecessary and inconsistent billing.**
   The provider billed for units of service beyond those documented on the service logs and/or as stated in the recipient's plan of care and service authorization. Additionally, the provider failed to follow service schedules as determined by the WSC and indicated in the recipients Support Plan. These claims were adjusted or denied.

The Medicaid Provider Reimbursement Handbook, Non-Institutional 081, states the following:

Chapter 2-1, Service Authorization Requirements, Home and Community-Based Services:
"All home and community-based services (HCBS) must be service authorized by the recipient's case manager or support coordinator and be included in the recipient's plan of care. Medicaid may recoup reimbursement for services that were not service authorized or authorized in the recipient' plan of care."

Additionally, The Developmental Disabilities Waiver Services Coverage and Limitations Handbook states the following:
Chapter 2-7, Introduction, General Service Documentation Requirements:
"DD waiver services are based on recipient needs that are documented in an approved plan of care. Medicaid will only reimburse for waiver services, at an approved rate, that are specifically identified in the approved plan of care by service type, frequency and duration and for which there is sufficient documentation supporting the provision of a service to the recipient. All documentation must be dated and signed by the individual rendering the service."

3. **PCA, SLC, Companion, IHSS and NRSS services provided did not correlate with recipient's support plan goals. This documentation should address all recipient and provider activities that were attempted, accomplished or incomplete, and any setbacks experienced toward reaching the goals stated in the recipient's support plan. The provider billed PCA for services not included in the recipients' Support Plan. Activities beyond those stated in the recipients Support Plan were performed, resulting in an excessive number of units of services being utilized and billed. During completion of activities, "Other" was often checked on the recipient's log without clarification of activities. The provider independently completed housekeeping (SLC/IHSS) tasks without the participation of the recipient. This service is meant to teach the recipient new skills to increase his independence and should not be completed without participation from the recipient. These claims were denied.**

The Developmental Disabilities Waiver Services Coverage and Limitations Handbook states the following in:

Chapter 2-7, Introduction, General Service Documentation Requirements:
"DD waiver services are based on recipient needs that are documented in an approved plan of care. Medicaid will only reimburse for waiver services, at an approved rate, that are specifically identified in the approved plan of care by service type, frequency and duration and for which there is sufficient documentation supporting the provision of a service to the recipient. All documentation must be dated and signed by the individual rendering the service."

Chapter 2-9, Daily Progress Note:
"Daily, on days service was rendered, notes of the recipient's progress towards achieving his support plan goals for the periods being billed or the summary describing the treatment or training provided to the recipient or tasks accomplished."

Chapter 2-14, Service Log:
"The service log shall include documentation that includes the recipient's name, social security number, recipient's Medicaid ID number, the description of the service, activities, supplies and dates service was rendered, amount billed for each service, provider's name and provider Medicaid ID number."

Chapter 2-27, Companion Services:
"This service must be provided in direct relation to achievement of the recipient's goals per his support plan," and

Chapter 2-29, Special Considerations:
"Companion services are provided in accordance with an outcome on the recipient's support plan and are not merely a diversion."

Chapter 2-54, Non-Residential Support Services, Limitations:
"Non-residential support services are limited to the amount, duration and scope of the services described in the recipient's support plan and current approved cost plan."

Chapter 2-57, Personal Care Assistance:
"Personal care assistance is a service that assists a recipient with eating, meal preparation, bathing, dressing, personal hygiene, and other self-care activities of daily living. The service also includes activities essential to the health, safety and welfare of the recipient and when no one else is available to perform them. Personal care assistance may not be used solely for supervision. Personal care assistance is limited to the amount, duration and scope of the services described in the recipient's support plan and current plan of care.

Furthermore, the Medicaid Provider General Handbook states the following:

Chapter 2-44, Record Keeping Requirement:
Medicaid requires that the provider retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient. In order to qualify as a basis for reimbursement, the records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media.

Chapter 2-45, Record Retention:
"Records must be retained for a period of at least five years from the initial date of service."

Chapter 2-45, Right to Review Records
Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian.

Chapter 2-46, Incomplete Records:
Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of

Medicaid payments. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.

OVERPAYMENT CALCULATION

A random sample of 30 recipients respecting whom you submitted 1,381 claims was reviewed. For those claims in the sample, which have dates of service from April 1, 2006 *, through June 30, 2006, an overpayment of $89,727.80 or $64.97306300 per claim, was found. Since you were paid for a total (population) of 7,687 claims for that period, the point estimate of the total overpayment is 7,687 x $64.97306300 = $499,447.94. There is a 50 percent probability that the overpayment to you is that amount or more.

We used the following statistical formula for cluster sampling to calculate the amount due the Agency:

$$E - t\sqrt{\frac{U(U-N)}{N(N-1)}\sum_{i=1}^{N}(A_i - YB_i)^2}$$

Where:

E = point estimate of overpayment = $F\left[\sum_{i=1}^{N} A_i \Big/ \sum_{i=1}^{N} B_i\right]$

F = number of claims in the population = $\sum_{i=1}^{U} B_i$

A_i = total overpayment in sample cluster

B_i = number of claims in sample cluster

U = number of clusters in the population

N = number of clusters in the random sample

Y = mean overpayment per claim = $\sum_{i=1}^{N} A_i \Big/ \sum_{i=1}^{N} B_i$

t = t value from the Distribution of t Table

All of the claims relating to a recipient represent a cluster. The values of overpayment and number of claims for each recipient in the sample are shown on the attachment entitled "Overpayment Calculation Using Cluster Sampling." From this statistical formula, which is generally accepted for this purpose, we have calculated that the overpayment to you is $404,630.34 with a ninety-five percent (95%) probability that it is that amount or more.

If you are currently involved in a bankruptcy, you should notify your attorney immediately and provide a copy of this letter for them. Please advise your attorney that we need the following information immediately: (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division); and, (4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit by certified check in the amount of $408,130.34, which includes the overpayment amount as well as any fines imposed. The check must be payable to the **Florida Agency for Health Care Administration**. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 488-5869. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Agency for Health Care Administration
Medicaid Accounts Receivable
P.O. Box 13749
Tallahassee, Florida 32317-3749

If payment is not received, or arranged for, within 30 calendar days of receipt of this letter, the Agency may withhold Medicaid payments in accordance with the provisions of Chapter 409.913(27), F.S. Furthermore, pursuant to Sections 409.913(25) and 409.913(15), F.S., failure to pay in full, or enter into and abide by the terms of any repayment schedule set forth by the Agency may result in termination from the Medicaid Program. Likewise, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Any questions you may have about this matter should be directed to: **Ms. Robin Satchell, Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 921-1802, facsimile (850) 410-1972.**

Sincerely,

Robi Olmstead

Ms. Robi Olmstead
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity

RO/RS/kj

Enclosure(s): FAR worksheets, staff spreadsheet
cc: William F. Sutton, Jr., c/o Ruden McCloskey, PA