STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. FLORIDA HOSPITAL ORLANDO, Respondent.	)	Case No. 09-3160MPI

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case by video teleconference with Respondent appearing from Orlando, Florida, and Petitioner present in Tallahassee, Florida, before J.D. Parrish, a designated Administrative Law Judge of the Division of Administrative Hearings (DOAH) on March 22, 2010.

APPEARANCES

For Petitioner: Debora E. Fridie, Esquire
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For Respondent: John D. Buchanan, Jr., Esquire
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STATEMENT OF THE ISSUES

Whether Respondent, Florida Hospital Orlando (Respondent or FHO), was overpaid by Medicaid for care provided to the patient, L.D., in the amount of $52,606.04, as alleged by Petitioner, Agency for Health Care Administration (Petitioner or AHCA); or, whether, as Respondent maintains, such care was medically necessary and supported by the record presented in this cause. Petitioner also maintains an administrative fine in the amount of $2,000.00 is warranted in this matter.

PRELIMINARY STATEMENT

On June 11, 2009, AHCA referred the instant matter to DOAH for formal proceedings. Pursuant to a Medicaid audit, Petitioner maintains Respondent was overpaid for services rendered in connection with an obstetrics/gynecology (OB/GYN) patient that was identified in the audit period of January 1, 2007, through June 30, 2008. Although, initially, Petitioner asserted an overpayment for more than one patient, at the conclusion of the evidence, AHCA maintained that overpayment related to only one OB/GYN patient, L.D. In that regard, the amount claimed by AHCA as the overpayment was reduced from over $200,000 (for multiple claims) to $52,606.04 (for the single patient).

As it relates to all overpayment claims, Respondent asserts: That the medical care and services provided to L.D.

were medically necessary; that all medical services were pre-approved by Petitioner's fiscal agent; that AHCA is estopped from its claim for reimbursement; and, that as all medical services were medically necessary, an administrative fine is not allowable in this cause. It is undisputed that Respondent timely challenged AHCA's audit and that the matter is properly before DOAH.

At the hearing, Petitioner presented the testimony of Debbie Lynn, medical/health care program analyst with AHCA's Bureau of Medicaid Program Integrity (MPI). Tammie Rikansrud, administrative director of Patient Financial Services for Respondent; Christine Howd, billing manager for Medicaid collections for Respondent; and Cheryl Peasley, former Medicaid coordinator for utilization management for Respondent, testified on behalf of FHO. By stipulation and as indicated in the record and transcript of this proceeding, the parties entered a number of exhibits and depositions that have been considered in this cause. Additionally, the parties agreed that the record would remain open until a late-filled deposition of Dr. Thomas S. Walter could be scheduled and filed. That deposition was filed with DOAH on May 6, 2010.

The Transcript of the hearing was filed on April 8, 2010. The parties timely filed Proposed Recommended Orders that have been fully reviewed in the preparation of this Recommended

Order. Finally, the parties' Joint Prehearing Stipulation filed in anticipation of hearing on March 15, 2010, has been adopted, in pertinent part, and is incorporated in the Findings of Fact below.

FINDINGS OF FACT

1. Petitioner is the state agency charged with the responsibility of monitoring the Medicaid Program in Florida.

2. Petitioner, through MPI, audited FHO for the dates of service from January 1, 2007, through June 30, 2008 (the audit period). At all times material to the audit period, FHO was enrolled as a Medicaid provider, governed by a Medicaid provider agreement, and subject to all pertinent Medicaid rules and regulations related to the provision of Medicaid services to Medicaid recipients/patients.

3. Respondent's Medicaid Provider No. was 0010129001. All services provided to Medicaid patients are billed and identified by patient name, date of service, and provider. For purposes of confidentiality, the names of patients are redacted in MPI proceedings. Although this case began with a number of patients being identified as part of the audit dispute, only one patient, L.D., and the services provided to her remain at issue.

4. Before a Medicaid provider is authorized to bill Medicaid for medical services rendered to a patient, several checks are considered. First, the patient must be

Medicaid-eligible. There is no dispute that L.D. was Medicaid-eligible.

5. Second, before an inpatient stay is reimbursable, a Medicaid provider must seek prior authorization. To do so, at all times material to this case, AHCA enlisted the assistance of, and contracted with, KePro South (KePro) to perform utilization management for inpatient hospital services for Medicaid recipients. This meant the Medicaid provider contacted KePro by email through a system known as "I-Exchange." In this case, FHO followed the protocol and requested prior approval for patient L.D.

6. KePro approved the inpatient stay for L.D.

7. All patient records for L.D. have been revisited in the course of this case and have been thoroughly debated by doctors for both parties.

8. In summary, AHCA's expert, Dr. Walter, opined that the records for L.D. do not support the "medical necessity" for the extended inpatient stay that was provided for her care.

9. In contrast, Dr. Busowski, opined that L.D. required the inpatient stay based upon the medical conditions she and her babies presented.

10. The events leading up to the instant dispute, set in chronological context, are as follows: FHO provided medical services to a patient, L.D.; those services were billed to and

paid by Medicaid; AHCA conducted its audit of FHO for the audit period prior to August 12, 2008; on that date, AHCA issued its Preliminary Audit Report (PAR); the PAR claimed a Medicaid overpayment in the amount of $359,107.65 (overpaid claims for the full audit period); in response, FHO set about to furnish additional documentation to support its Medicaid billings; such documentation was reviewed by Petitioner and its medical consultants before the Final Audit Report (FAR) was entered; then, the FAR reduced the amount claimed as overpayment, gave Respondent the opportunity to challenge the FAR, and forwarded the case to DOAH. Respondent continued to provide additional information to AHCA throughout the pre-hearing and post-hearing times. Subsequent to discovery in this case, AHCA considered information from FHO and, ultimately, the overpayment claim was reduced to $52,606.04 as noted above. Prior to entering the FAR, Petitioner did not have the benefit of testimony from Dr. Busowski or Dr. Fuentes. Additionally, Dr. Walter, AHCA's consultant, did not have the benefit of reviewing the records from Dr. Busowski's point of reference.

11. It is undisputed that FHO billed Medicaid and was paid $52,606.04 for patient L.D.

12. Dr. Busowski is a board-certified physician whose specialty is OB/GYN and whose subspecialty is Maternal Fetal Medicine, also described as "perinatologist" in this record.

13. L.D. presented to a clinic staffed by Dr. Busowski and his former associate, Dr. Fuentes. Both doctors have privileges at FHO and took turns monitoring patients admitted to the hospital. In examining L.D., it was discovered that her cervix had shrunk from 2.6 to 1.2 centimeters. As L.D. was pregnant with twins, the patient was admitted to FHO as a "high risk" pregnancy.

14. Simply stated, the medical concern for L.D. was that she would deliver her children prematurely and, thereby, cause additional medical issues for herself, as well as her babies. L.D. was only 26 weeks, two days along at the time, and it would be very difficult for the twins to be delivered at that time. Further, L.D. had had two prior deliveries by C-section, so it was anticipated that her twins would also be delivered in that fashion. Finally, the twins were locked with one in a breached position so that if the children had prematurely delivered vaginally, other complications would have been likely.

15. L.D. remained at FHO until she was discharged at 35 weeks, six days. During her stay at FHO, doctors were able to monitor contractions, make sure her C-section scar did not dehisce, and chart the growth, well-being, and viability of the children.

16. Some patients, such as L.D., may be monitored in a home setting with "take home" equipment. That device is not

covered by Medicaid and was, therefore, not an option for L.D. It may have provided a less expensive treatment option had it been available to L.D. and had her home environment been suitable for its use. It is unknown whether L.D. and her home environment would have been conducive to the home monitoring some patients can use.

17. Another consideration in keeping L.D. hospitalized was the well-being of the unborn twins. Medical costs for premature babies are higher than full-term children. Had L.D. delivered prematurely, there would have been three Medicaid patients with serious medical needs rather than one.

18. Dr. Busowski candidly admitted that all considerations in keeping L.D. hospitalized were not listed in the patient's chart. As a specialist, Dr. Busowski did not think it was necessary to have certain facts documented. It is not Dr. Busowski's policy to keep any mother hospitalized unnecessarily. It was not Dr. Busowski's practice to write "a whole bunch because nothing has changed."

19. L.D.'s chart contained daily notes from an attending OB/GYN or resident, but orders were not written for medication unless it changed or was new. For example, if an order for prenatal vitamins were written, it would naturally continue throughout the patient's stay without additional orders.

20. In this case, L.D. was on the medication Procardia. It was used to stop pre-term contractions. When L.D. was discharged and the babies were not in danger, presumably, Procardia was not necessary. Until she was stabilized during her hospitalization, it was necessary.

21. Thus, the length of stay ultimately is the issue of this proceeding. Not that L.D. was admitted inappropriately or without medical basis, but that she was kept as an inpatient longer than medically necessary.

22. Since L.D. was admitted at 26 weeks, two days and discharged at 35 weeks, six days, the question then essentially is: When in the interim should she have been discharged because her continued inpatient care was not necessary? Arguably she could have taken the medication to stop contractions at home, monitored herself somehow, and rushed to the emergency room (ER) if delivery was imminent. Delivery of the twins short of a prescribed gestation period would have placed the children at risk. Who would have borne the medical responsibility for pre-term twins born under ER conditions when it was avoidable and was, in fact, avoided in this case?

23. Medicaid has a "pay and chase" policy of paying Medicaid claims as submitted by providers. Audits performed by the Agency then, after-the-fact, reconcile the amounts paid to

providers with the amounts that were payable under the Medicaid guidelines and pertinent rules.

24. The Medicaid provider agreement executed between the parties governs the contractual relationship between FHO and AHCA. The parties do not dispute that the provider agreement, together with the pertinent laws or regulations, control the billing and reimbursement of the claim that remains at issue. The amount, if any, that was overpaid related solely to the period of inpatient treatment that L.D. received from week 27 of her pregnancy until her discharge. Dr. Walter conceded perhaps a week would be required to stabilize the patient under her presenting conditions.

25. The provider agreement pertinent to this case was voluntarily entered into by the parties.

26. Any Medicaid provider whose billing is not in compliance with the Medicaid billing policies may be subject to the recoupment of Medicaid payments.

27. Petitioner administers the Medicaid program in Florida. Pursuant to its authority, AHCA conducts audits to ensure compliance with the Medicaid provisions and provider agreements. The audits are routinely performed and Medicaid providers are aware that they may be audited.

28. Audits are to ensure that the provider bill and receive payment in accordance with applicable rules and

regulations. Respondent does not dispute Petitioner's authority to perform audits. Respondent does, however, dispute that a recoupment is appropriate, because FHO sought and was given prior approval for the inpatient stay for L.D. through the KePro system.

29. If the inpatient length of stay was medically necessary for L.D., Petitioner does not dispute the amount billed as accurately reflecting the services provided to L.D. during that stay. There is no question that L.D. stayed in the hospital for the length of stay noted in the record. Based upon the weight of the persuasive evidence in this case, it is determined that L.D.'s length of stay until week 35 of her pregnancy was medically appropriate and necessary to protect the medical health and well-being of L.D. and her unborn children.

CONCLUSIONS OF LAW

30. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of these proceedings. § 120.57(1), Fla. Stat. (2009).

31. Pursuant to Chapter 409, Florida Statutes (2009), Petitioner is responsible for administering the Medicaid Program in Florida.

32. As the party asserting the overpayment, Petitioner bears the burden of proof to establish the alleged overpayment by a preponderance of the evidence. See Southpointe Pharmacy v.

Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992). AHCA has failed to meet its burden.

33. Section 409.913, Florida Statutes (2009), provides, in pertinent part:

> The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.
>
> (1) For the purposes of this section, the term:
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> * * *
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> (e) "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.
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> * * *
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> (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:
>
> * * *
>
> (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.

*   *   *

(21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

34. In this case, Petitioner seeks reimbursement of an overpayment based upon the lack of documentation to show medical necessity for the length of stay for patient, L.D. It is concluded that it was medically necessary to protect L.D. and her unborn children and to allow the patient to remain in the hospital for the time noted in this record. It is further concluded that FHO did a poor job of documenting the basis for that stay. The questions raised by Dr. Walter, AHCA's expert and peer reviewer, could have been avoided with better documentation. Nevertheless, poor documentation does not justify the denial of the medical necessity for this patient. That the records could have been more detailed does not equate to inadequate documentation. Respondent undoubtedly provided a necessary medical service to the Medicaid recipient and is entitled to compensation for that treatment. In the absence of evidence that the amount billed and claimed was erroneous, the amount of the payment stands as the appropriate compensation for the services provided.

35. In this case, although the FAR supports and constitutes evidence of the overpayment claimed, it is erroneous in light of the totality of all evidence presented in this cause. Respondent presented substantial, credible evidence to rebut the claim of overpayment or lack of medical necessity. FHO has shown that the length of stay for patient L.D. was medically necessary. L.D.'s health and the viability of her unborn children were stabilized and kept from deteriorating. FHO kept L.D. from a condition that threatened life, pain, suffering, or other conditions likely to occur with a premature delivery of twins. L.D. had complicating factors that resulted in a high-risk pregnancy that could have ended with a poor to devastating medical outcome. See § 409.913(1)(d), Fla. Stat. (2009).

36. Finally, Respondent's asserted that AHCA was estopped from pursuing its recoupment claim against FHO. Equitable estoppel against an entity, such as AHCA, is rare. Respondent has not shown exceptional circumstances that would warrant equitable estoppel in this case. See Associated Industries Insurance Company, Inc. v. State of Florida, Department of Labor and Employment Security, 923 So. 2d 1252 (Fla. 1st DCA 2006). Prior approval by KePro cannot estop AHCA from pursuing overpayment claims when an audit does not support the charges and services billed to Medicaid. AHCA has the daunting task of

chasing monies already paid to providers who may or may not have submitted accurate or truthful information to KePro. Prior approval does excuse fraud or misinformation or cases where medical necessity cannot be established. In this case, FHO was able to show that the patient required the length of stay provided. In other cases, a provider who may be motivated by a low census or other financial interests may not be able to, after-the-fact, support its decision to hold a patient for a given length of stay. AHCA must always protect the Medicaid funds it is challenged to conserve so that bona fide recipients receive the medical care they require. Medicaid providers must provide adequate records to support the claims given prior approval through KePro. In this case, while the records could have better documented the necessity for L.D.'s length of stay, it is concluded that the records taken in totality were adequate to meet the recordkeeping requirements of the Medicaid Program.

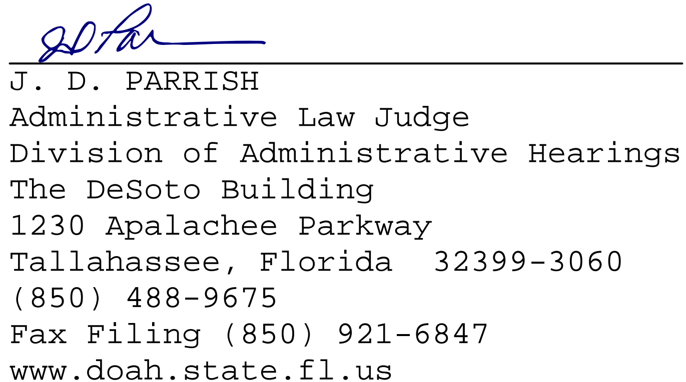
RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Agency for Health Care Administration enter a final order dismissing the case, with each party bearing its own costs and expenses of the litigation. Further, to the extent that Petitioner may have already sought recoupment

against Respondent for the alleged overpayment, it is recommended that those funds be credited back to FHO.

DONE AND ENTERED this 11th day of August, 2010, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
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this 11th day of August, 2010.

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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.