STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

NATIONWIDE HEALTHCARE SERVICES, INC.,

Respondent.

Case No. 09-3547

## RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on July 23, 2010, by video teleconference with connecting sites in Miami and Tallahassee, Florida, before Errol H. Powell, an Administrative Law Judge of the Division of Administrative Hearings.

## APPEARANCES

For Petitioner: Andrew T. Sheeran, Esquire
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For Respondent: Jonathan Ewing, Esquire
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## STATEMENT OF THE ISSUE

The issue for determination is whether Respondent was

overpaid by the Medicaid program as set forth in Petitioner's Final Audit Report dated May 18, 2009, for the period July 1, 2004, through June 30, 2006.

## PRELIMINARY STATEMENT

By Final Audit Report (FAR) dated May 18, 2009, Nationwide Healthcare Services, Inc. (Nationwide) was notified by the Agency for Health Care Administration (AHCA) that, after a review of all documentation submitted regarding Medicaid claims for the period July 1, 2004, through June 30, 2006, a determination had been made that Nationwide was overpaid by the Medicaid program in the amount of $326,866.72 and that a fine of $2,500.00 had been applied, totaling an amount due of $329,366.72. The procedure and formula for the calculation of the overpayment were included in the FAR. Nationwide disputed the FAR and requested a hearing. On July 2, 2009, this matter was referred to the Division of Administrative Hearings.

The final hearing was originally scheduled for September 28, 2009. Upon agreed motions for continuance, primarily on the ground that a review of additional medical records from Nationwide was necessary and that authorization for an amended final audit report was required to be obtained from the federal Centers for Medicare and Medicaid Services, the final hearing was rescheduled. Subsequently, an Agreed Motion to Amend Final Audit Report was filed and was granted.

On January 12, 2010, AHCA filed an Amended FAR, dated January 7, 2010. By the Amended FAR, AHCA notified Nationwide that after a review of new documentation submitted regarding Medicaid claims for the period July 1, 2004, through June 30, 2006, a revised determination had been made that Nationwide was overpaid by the Medicaid program in the amount of $31,756.20 and that a fine of $2,500.00 had been applied, totaling an amount due of $34,265.20. The procedure and formula for the calculation of the overpayment were included in the Amended FAR. Nationwide disputed the Amended FAR and filed an amended response to the Amended FAR. The final hearing was rescheduled. By agreement, continuances were granted and the hearing was rescheduled.

At hearing, AHCA presented the testimony of two witnesses and entered 14 exhibits (Petitioner's Exhibits numbered 1 through 14) into evidence. Nationwide presented the testimony of one witness and entered 17 exhibits (Respondent's Exhibits A through Q) into evidence.

A transcript of the hearing was ordered. At the request of the parties, the time for filing post-hearing submissions was set for more than ten days following the filing of the transcript. The Transcript, consisting of two volumes, was filed on September 16, 2010. The parties timely filed their

post-hearing submissions, which were considered in the preparation of this Recommended Order.

## FINDINGS OF FACT

1. AHCA audited certain of Nationwide's Medicaid claims pertaining to services rendered between July 1, 2004, and June 30, 2006, hereinafter the audit period.

2. Nationwide was an authorized Medicaid provider of home health services to Medicaid recipients during the audit period.

3. During the audit period, Nationwide had been issued Medicaid provider number 650065000.

4. No dispute exists that, during the audit period, Nationwide had a valid Medicaid Provider Agreement with AHCA (Agreement).

5. No dispute exists that, during the audit period, Nationwide received payment for services to Medicaid recipients, including for the services that are being disputed in the Amended FAR.

6. The Agreement provided, among other things, that the submission of Medicaid claims by Nationwide for payment constituted a certification that the services were provided in accordance with state and federal laws, as well as rules and regulations applicable to the Medicaid program, including the Medicaid provider handbooks issued by AHCA.

7. Pursuant to the federal Deficit Reduction Act of 2005, the federal Centers for Medicare and Medicaid Services (CMS) contracted with Catapult Consultants, LLC (Catapult) to conduct several audits in Florida in cooperation with AHCA's Bureau of Medicaid Program Integrity (MPI). MPI's primary responsibility is to audit healthcare providers who participate in the Florida Medicaid Program and to ensure that Medicaid providers are only reimbursed for services that are in accordance with Florida Medicaid handbooks and rules.

8. Catapult conducted the audit on Nationwide. MPI oversaw and reviewed Catapult's audit of Nationwide.

9. Nationwide was noticed by CMS that Catapult would be conducting an audit on Nationwide for the audit period.

10. MPI provided Catapult with a list of sample claims to be audited. Catapult requested from Nationwide (a) documentation and complete medical records for the recipients of the service, and (b) dates of service in the sample claims.

11. Catapult reviewed the documents and records received from Nationwide to determine (a) what services were provided, and (b) whether the services were provided in compliance with Medicaid policies and procedures.

12. Catapult prepared a draft audit report and provided it to CMS. CMS reviewed the draft audit report and forwarded it to MPI for review.

13. On July 7, 2008, CMS sent a Preliminary Audit Report (PAR) to Nationwide. The PAR included seven findings and identified an overpayment of $367,097.10 for claims that, in whole or part, were not covered by Medicaid. Nationwide was requested, among other things, to provide a response, including additional documentation, i.e., documentation not previously provided, that Nationwide wanted considered.

14. Nationwide responded and provided additional documentation for Catapult to consider.

15. Catapult, in cooperation with MPI, reviewed the additional documentation.

16. Catapult completed a final audit report and provided it to CMS for review. CMS reviewed the final audit report and forwarded it to MPI.

17. On May 18, 2009, MPI issued the FAR. The FAR included four findings: Finding No.1, Inadequate Information in the Treatment Plan; Finding No. 2, Services Billed Without a Valid Plan of Care (POC); Finding No. 3, Too Many Hours Billed by Private Duty Nurse; and Finding No. 4, Maintaining Records. The FAR identified and demanded repayment of an overpayment of $326,866.72 and imposed a fine of $2,500.00, totaling a repayment of $329,366.72.

18. Subsequently, Nationwide again submitted additional documentation.

19. On January 7, 2010, MPI issued an Amended FAR which included three findings: Finding No. 1, Services Billed Without a Valid POC; Finding No. 2, Too Many Hours Billed by Private Duty Nurse; and Finding No. 3, Maintaining Records. The Amended FAR identified and demanded repayment of an overpayment of $31,765.20 and imposed a fine of $2,500.00, totaling a repayment of $34,265.20.

20. The Amended FAR and the work papers associated with the audit, which were in the form of a spreadsheet containing contemporaneous notes of the auditor, were admitted into evidence.

21. Only claims included and considered in the FAR were included and considered in the Amended FAR.

Finding No. 1, Services Billed Without a Valid POC

22. Three sub-findings were included in Finding No. 1, Services Billed Without a Valid POC: Sub-Finding No. 1, POC Not Signed by a Physician; Sub-Finding No. 2, Rubber Stamp Used for the Physician's Signature; and Sub-Finding No. 3, Billed for Hours Outside the POC Authorization.

23. Eighteen claims, considered overpayments by AHCA, were associated with Finding No. 1.

24. One of the 18 claims, claim 351, was associated with Sub-Finding No. 1. The POC for claim 351 was signed by a nurse practitioner, not a physician, in violation of the Medicaid

handbook. Nationwide does not dispute that claim 351 is an overpayment.

25. Seven of the 18 claims were associated with Sub-Finding No. 2: claims 6, 12, 46, 71, 120, 189, and 219. Nationwide disputes that the claims were overpayments. All of the seven claims were for the same recipient of the services provided, T. S. T. S.'s attending physician, Carlos Diaz, M.D., approved the care for T. S. Dr. Diaz admitted that the signatures on the POCs were rubber stamped; and that the POCs were rubber stamped either by him or the nurse practitioner, but that he was not always present with the nurse practitioner when she stamped the POCs. Also, Dr. Diaz did not initial the rubber stamped signatures.

26. Ten of the 18 claims were associated with Sub-Finding No. 3: claims 281, 298, 119, 72, 145, 167, 176, 274, 210, and 2. Only claim 2 is disputed by Nationwide as an overpayment. Regarding claim 2, Nationwide billed for services that were rendered after the date that the recipient of the services was discharged by Nationwide.[1]

<u>Finding No. 2, Too Many Hours Billed by Private Duty Nurse</u>

27. The basis for Finding No. 2, Too Many Hours Billed by Private Duty Nurse, is that more hours were billed than were supported by the documentation.

28. Fourteen claims were associated with Finding No. 2: claims 333, 381, 388, 669, 27, 47, 701, 52, 6, 18, 36, 44, 500, and 82. Only claims 333, 27, 47, 701, 6, 18, 36, and 44 are disputed by Nationwide as overpayments.

29. Regarding claim 333, Nationwide billed for seven hours of service. The evidence demonstrates 6.5 hours of service.

30. As to claim 27, Nationwide billed for 12 hours of service. The evidence demonstrates 11.5 hours of service.

31. Regarding claim 47, Nationwide billed for 12 hours of service. The evidence demonstrates 11 hours of service.

32. As to claim 701, Nationwide billed for 15 hours of service. The evidence demonstrates 14 hours of service.

33. Regarding claim 6, Nationwide billed for 12 hours of service. Nursing notes indicate that the recipient of the service received radiation therapy for two hours. The evidence demonstrates 10 hours of service.

34. As to claim 18, Nationwide billed for seven hours of service. The evidence demonstrates 6.5 hours of service.

35. Regarding claim 36, Nationwide billed for seven hours of service. The evidence demonstrates 6.5 hours of service.

36. As to claim 44, Nationwide billed for seven hours of service. The evidence demonstrates 6.5 hours of service.

37. The private duty nurses were LPNs. Private duty nurses are paid an hourly rate. No evidence was presented that

payment was authorized for a portion of an hour. For total service hours that were one-half of an hour, AHCA rounded down to the nearest hour. As a result, claims 333, 18, 36, and 44 were rounded to six hours of service; and claim 27 was rounded to 11 hours of service. The evidence demonstrates that claims 333, 18, 36, and 44 were appropriately rounded to six hours of service; and claim 27 was appropriately rounded to 11 hours of service.

Finding No. 3, Maintaining Records

38. Three claims were associated with Finding No. 3: claims 622, 30, and 507. Nationwide failed to maintain records to support the services provided. Nationwide does not dispute that the three claims were overpayments.

Accuracy of the Formula

39. No dispute exists as to the accuracy of the formula used to calculate the total overpayment.

## CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto pursuant to sections 120.569 and 120.57(1), Florida Statutes (2011).

41. The parties agree that AHCA is responsible for administering the Medicaid program in Florida.

42. AHCA is required to "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." § 409.913, Fla. Stat. (2004), (2005), and (2006).[2]

43. Section 409.913 provides in pertinent part:

> (1) For the purposes of this section, the term:
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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.
>
> * * *
>
> (2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate.[3]
>
> * * *
>
> (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:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

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

* * *

(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.

The agency may deny payment or require repayment for goods or services that are not presented as required in this subsection.

* * *

(9) 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.

* * *

(11) The agency may deny payment or 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.

* * *

(15) The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections . . . (16) . . . if:

* * *

(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;

(d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;

(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;

* * *

(h) The provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims;

* * *

(16) 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. . .

* * *

(20) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid

> for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.
>
> (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.
>
> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. . . .

44. The burden of proof is on AHCA to establish a Medicaid overpayment by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992); S. Medical Services, Inc. v. Ag. For Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995).

45. Having the ultimate burden of proof, AHCA must first present a prima facie case of overpayment. In the instant case, AHCA met its burden of presenting a prima facie case by the admission into evidence of its audit report, supported by its work papers, showing an overpayment to Nationwide. See Ag. for Health Care Admin. v. Orietta Med. Equip., Inc., Case No. 05-0873MPI, 2006 Fla. Div. Adm. Hear. LEXIS 555 *11 (Fla. DOAH December 1, 2006; Fla. AHCA December 22, 2006) ("It is concluded

that the Legislature has determined that the audit reports in these matters may be considered evidence of the overpayment. As such, the Agency met its prima facie burden to establish the overpayment and the amount claimed to be due."); § 409.913(22), Fla. Stat. Once AHCA presents its prima facie case, Nationwide, the provider, is obligated to rebut, impeach, or otherwise undermine AHCA's evidence. See Ag. for Health Care Admin. v. Bagloo, Case No. 08-4921MPI, (Fla. DOAH September 10, 2009; Fla. AHCA November 9, 2010).

46. The Florida Medicaid Home Health Services Coverage and Limitations Handbook, effective October 2003, (Handbook) was incorporated by reference into Florida Administrative Code Rule 59G-4.130(2).

Finding No. 1, Services Billed Without a Valid POC

47. At issue is Sub-Finding No. 2, Rubber Stamp Used for the Physician's Signature, regarding claims 6, 12, 46, 71, 120, 189, and 219.

48. The Handbook requires the attending physician to approve the POC and the approval to be evidenced by the attending physician's "original signature." Handbook, Page 2-6. "A rubber stamp or initialed signature is not acceptable." Id.

49. Nationwide argues that the Handbook conflicts with Florida Administrative Code Rule 59A-8.022, which permits a physician's rubber stamp signature.

50. AHCA argues that no conflict exists in that the said Rule permitting a physician's rubber stamp signature was not in effect at the time that the services were provided to the recipient.

51. Florida Administrative Code Rule 59A-8.022 provides in pertinent part:

> (6) The following applies to signatures in the clinical record:
>
> (a) Facsimile Signatures. The plan of care or written order may be transmitted by facsimile machine. The home health agency is not required to have the original signature on file. However, the home health agency is responsible for obtaining original signatures if an issue surfaces that would require certification of an original signature.
>
> (b) Alternative Signatures.
>
> 1. Home health agencies that maintain patient records by computer rather than hard copy may use electronic signatures. However, all such entries must be appropriately authenticated and dated. Authentication must include signatures, written initials, or computer secure entry by a unique identifier of a primary author who has reviewed and approved the entry. The home health agency must have safeguards to prevent unauthorized access to the records and a process for reconstruction of the records in the event of a system breakdown.
>
> 2. Home health agencies may accept a physician’s rubber stamp signature. The individual whose signature the stamp represents must place in the administrative offices of the home health agency a signed

statement attesting that he/she is the only one who has the stamp and uses it.

52. Florida Administrative Code Rule 59A-8.022 became effective on August 15, 2006. The audit period does not extend beyond June 30, 2006. Therefore, the said rule was not in effect at the time the services were provided to the recipient. The undersigned is persuaded by AHCA's argument. Consequently, a physician's rubber stamp signature was not permitted at the time that the services were provided.

53. The evidence demonstrates that, for claims 6, 12, 46, 71, 120, 189, and 219, the POCs failed to contain the physician's original signature. Hence, the evidence demonstrates overpayments for claims 6, 12, 46, 71, 120, 189, and 219.

54. Additionally, at issue is Sub-Finding No. 3, Billed for Hours Outside the POC Authorization, regarding claim 2.

55. The Handbook requires services to be consistent with the individualized, written physician-approved POC. As a result, the hours billed for one day on a claim should reflect the hours authorized by the POC. Handbook, Page 2-2.

56. Further, the Handbook provides that, when services begin one day and end the next day, billing should reflect the total number of care hours provided on each day. Handbook, Page 2-18. As a result, the claim should reflect the total hours of

service provided on one day and the total hours of service provided on the next day.

57. Regarding claim 2, the evidence demonstrates that the recipient of the services provided was discharged, but that Nationwide billed for services provided beyond the discharge date. Hence, the evidence demonstrates an overpayment for claim 2.

Finding No. 2, Too Many Hours Billed by Private Duty Nurse

58. At issue is that more hours were billed by Nationwide than were supported by the documentation regarding claims 333, 27, 47, 701, 6, 18, 36, and 44.

59. A home health agency is required to maintain reports and medical records that accurately document the services provided to a recipient. See § 409.913(7)(f) and (9), Fla. Stat.; Handbook, Page 2-22. Further, the services provided are required to be documented by records made at the time the services were provided. See § 409.913(7)(f). The Handbook requires certain documentation in the recipient's current medical record, including nursing notes, progress notes, and dates and signatures of practitioners who render care (rubber stamp or initialed rubber stamp signatures are not accepted). Handbook, Page 2-22.

60. Private duty nurses are permitted to round up to the

next hour when any portion of the hour exceeds 30 minutes. Handbook, Appendix, Page D-2.

61. Medicaid does not pay for private duty nursing services provided in a hospital, a physician's office, or a clinic. Handbook, Page 2-17.

62. The evidence demonstrates overpayments for claims 333, 27, 47, 701, 6, 18, 36, and 44.

63. Consequently, AHCA established a case of overpayment and that the overpayment computation is proper and accurate.

64. Hence, AHCA demonstrated that Nationwide received Medicaid overpayments in the amount of $31,765.20 for the audit period.

65. As to sanctions, AHCA suggests that Florida Administrative Code Rule 59G-9.070(7)(c) and (e) is applicable. Florida Administrative Code Rule 59G-9.070, effective April 26, 2006, provides in pertinent part:

> (7) SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed for the following:
>
> * * *
>
> (c) Failure to make available or furnish all Medicaid-related records, to be used by the Agency in determining whether Medicaid payments are or were due, and what the appropriate corresponding Medicaid payment amount should be within the timeframe requested by the Agency or other mutually

> agreed upon timeframe. [Section 409.913(15)(c), F.S.];
>
> * * *
>
> (e) Failure to comply with the provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, the requirements and provisions in the provider's Medicaid provider agreement, or the certification found on claim forms or transmittal forms for electronically submitted claims by the provider or authorized representative. [Section 409.913(15)(e), F.S.] . . . .

66. Regarding the Medicaid-related records, Nationwide did not fail to make available or furnish, upon the request of AHCA, the Medicaid-related records to support the services rendered, but failed to maintain the Medicaid-related records to support the services rendered. The evidence does not demonstrate that Nationwide committed a violation of Florida Administrative Code Rule 59G-9.070(7)(c) and, therefore, the said rule is not applicable.

67. However, the evidence demonstrates that Nationwide committed a violation of Florida Administrative Code Rule 59G-9.070(7)(e).

68. The corresponding penalty guideline provides that, for a first offense, the penalty is a $500.00 fine per provision, not to exceed $1,500.00 per agency action. Fla. Admin. Code R. 59G-9.070(10)(i).

69. AHCA suggests a $2,500.00 fine. No evidence was presented to demonstrate that Nationwide has committed any other offense, and, therefore, the fine should not exceed $1,500.00. The suggested fine exceeds the maximum allowable fine and is, therefore, not appropriate. See Fla. Admin. Code R. 59G-9.070(10)(i).

70. A fine of $1,500.00 is appropriate and should be imposed.

## 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 finding that Nationwide Healthcare Services, Inc., received overpayments from the Medicaid program in the amount of $31,765.20 for the audit period July 1, 2004, through June 30, 2006; imposing a fine of $1,500.00; and requiring Nationwide Healthcare Services, Inc., to repay the overpayment of $31,765.20, plus a fine of $1,500.00, totaling $33,265.20.

DONE AND ENTERED this 11th day of July, 2011, in Tallahassee, Leon County, Florida.

ERROL H. POWELL
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 11th day of July, 2011.

ENDNOTES

[1/] Nationwide submits as a proposed finding of fact that the POC of the recipient of the services reflects that Nationwide was approved to provide further care for the recipient beyond the date of the discharge and, therefore, should not be an overpayment. Nationwide's argument is not persuasive.

[2/] Unless otherwise provided, all citations to Florida Statutes are 2004, 2005, and 2006. The parties agree that applicable Florida Statutes are 2004, 2005, and 2006.

[3/] Versions 2005 and 2006, contained the following additional wording: "At least 5 percent of all audits shall be conducted on a random basis."

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.