STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 10-10840MPI

FLORIDA HOSPITAL ORLANDO,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this case by video teleconference with Respondent appearing from Orlando, and Petitioner present in Tallahassee, before J. D. Parrish, a designated Administrative Law Judge of the Division of Administrative Hearings (DOAH) on May 2 and 3, 2013.

APPEARANCES

For Petitioner: David W. Nam, 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 patients in the amount of $34,644.10, as alleged by Petitioner, Agency for Health Care Administration (Petitioner or AHCA); or, 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 and that it is entitled to recover costs associated with the case in the sum of $7,635.27.

PRELIMINARY STATEMENT

On December 22, 2010, AHCA referred the instant matter to DOAH for formal proceedings. Pursuant to a Medicaid audit, Petitioner alleges Respondent was overpaid for services rendered in connection with Medicaid claims that were identified in an audit. Respondent asserts that the medical care and services provided to patients associated with the disputed claims were medically necessary; that all medical services were pre-approved by Petitioner's fiscal agent; and that, as all medical services were medically necessary, an administrative sanction is not allowable in this cause. It is undisputed that Respondent timely challenged the audit and that the matter is properly before DOAH.

At the request of, and with the stipulation of the parties, this case was continued on several occasions. The parties

continued to review documents related to the disputed claims and attempted to narrow the issues to be resolved at hearing. Respondent maintained that prior approval of the claims by a fiscal agent rendered the overpayment claim moot. Initial approval of the proposed services does not, however, equate to the claims being "medically necessary" as that term is defined by law.

At the hearing, Petitioner presented the testimony of Johnnie L. Shepard, Shevaun Harris, Kia Tollett, and Ferdinand Richards, M. D. AHCA Exhibits 3 through 8, 31, 32, 34 through 42, 51 through 53, and 56 were admitted into evidence.

Ross Edmundson, M. D. (by deposition), John Busowki, M. D. (by deposition), Susan Bihler, Tammie Rikansrud, and Christine Howd testified on behalf of Respondent. Respondent's Exhibits 1 through 13 were also received into evidence.

The Transcript of the hearing, volumes I through IV, was filed on June 20, 2013. Thereafter, the parties requested and were granted 30 days within which to file their proposed recommended orders. The parties timely filed proposed orders that have been fully reviewed in the preparation of this Recommended Order. Finally, the parties' Joint Prehearing Stipulation filed in anticipation of the hearing on April 25, 2013, has been incorporated, in pertinent part, 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. Centers for Medicare and Medicaid Services (CMS) is the federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program. CMS initiated an audit of Respondent's Medicaid claims and contracted with Booz Allen Hamilton (BAH), a Medicaid Integrity Contractor, to perform the audit.

3. At all times material to the instant audit, Respondent 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 goods and services to Medicaid recipients/patients. Respondent was required to retain records documenting goods and services billed to the Medicaid program for a period of not less than five years. All of the disputed claims occurred within that five-year period. BAH requested medical records pertinent to the claims and FHO produced medical records in response to BAH's audit. Respondent intended to produce all of its medical records as requested by BAH.

4. 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 audit proceedings. All goods and services billed to Medicaid must be medically necessary. If an audit determines that goods or services billed to Medicaid were, in fact, not medically necessary, Petitioner is entitled to recover monies paid as an overpayment claim against the Medicaid provider. The amount of the alleged overpayment is the subject of this proceeding.

5. Before a Medicaid provider is authorized to bill Medicaid for medical goods and services rendered to a patient, several checks are considered. First, the patient must be Medicaid-eligible. There is no dispute that all recipients of care in this case were Medicaid-eligible patients.

6. 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 e-mail through a system known as "I-Exchange." In this case, FHO followed the protocol and requested prior approval for all of the claims at issue that required prior approval. All claims at issue were either approved by KePro or were exempt from the authorization requirement. Petitioner agrees that Respondent followed all of the protocols for approval of claims through the

KePro system. Respondent agrees that all claims at issue as identified in the final audit report (FAR) were billed and paid. KePro approval does not mean goods and services billed to Medicaid are, in fact, medically necessary.

7. All patient records for the claims at issue have been re-visited in the course of this case and have been thoroughly debated by doctors for both parties. In summary, AHCA's expert, Dr. Ferdinand Richards, opined that the records for the disputed claims do not support the "medical necessity" for the claims paid by Medicaid.

8. In contrast, Dr. John Busowski and Dr. Ross Edmundson opined that the disputed claims were accurately billed and all care rendered was medically necessary.

9. Medicaid has a "pay and chase" policy of paying Medicaid claims submitted by providers. Audits performed after-the-fact reconcile the amounts paid to providers with the amounts that were payable under the Medicaid guidelines, pertinent rules, and law.

10. 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 claims that remain at issue. The provider agreement pertinent to this case was voluntarily

entered into by the parties. Although Respondent claims it could not negotiate the terms of the agreement, it is undisputed that Respondent agreed to be bound by the agreement. Respondent was not obligated to become a Medicaid provider.

11. Any Medicaid provider whose billing is not in compliance with the Medicaid billing policies may be subject to the recoupment of Medicaid overpayments. Medicaid providers are aware that they may be audited. Audits are to assure that providers bill and receive payment in accordance with applicable rules and regulations. Respondent does not dispute Petitioner's authority to perform audits.

12. If services rendered in this case were medically necessary, Petitioner does not dispute the amount billed as accurately reflecting the services. There is no question that Respondent provided the services identified in the disputed claims.

13. For billing purposes, this case centers on three types of billing practices dictated by the medical circumstances of the patient. A Medicaid patient may be treated in an emergency room setting and once the presenting condition is addressed the stay may be considered outpatient, observation, or inpatient depending on the nature of the patient’s illness. Outpatient services may also be appropriate when a patient presents for a scheduled test or procedure. Observation services may be appropriate when

additional time is needed to evaluate a patient's condition. Inpatient care is dictated when the patient requires medical services or treatments because the severity of an illness or condition dictates an intensity of care that could not be provided at a less acute level. The levels of care at issue in this case are defined and specified in the Medicaid Hospital Services Coverage and Limitation Handbook and by Florida Administrative Code Rule. In this case, the disputed claims center on whether the claims were billed at the appropriate level of care. That is, if billed at the inpatient level should the claim have been billed as observation or outpatient? If billed as observation, should the claim have been billed as outpatient? Each disputed claim is listed and explained below. Each claim is described and evaluated based upon the medical documentation available to the treating physician at the time the services were rendered. The expert opinions of the parties' witnesses have been fully considered and weighed in reaching the findings noted.

14. The first five claims, identified as Adventist-FL-3006, 6, 7, 8, 9 and 11, concerned a three-year-old patient with Acute Lymphocytic Leukemia. The child required five separate intravenous chemotherapy treatments. The five claims ($1,503.04 per day) were billed at an inpatient rate. For each of the claims, the patient's hospital stay was for less than 24 hours, the patient had no significant complications from the treatments,

and was able to return home at the conclusion of the treatment. Based upon the weight of the persuasive evidence in this case, it is determined that these claims should have been billed as scheduled outpatient services. Petitioner is entitled to recoup the difference between the inpatient rate and an outpatient rate for these five claims. The amount of the overpayment is $7,515.20.

15. Claim Adventist-FL-3006-21 concerned a 40-year-old morbidly obese female who went to the hospital emergency room (ER) on July 28, 2007. This patient complained of shortness of breath and chest pains. By history, it was known this patient had bipolar disorder, sarcoidosis, hypertension, and a record of being non-compliant with medications. A pulmonary function test was administered by ER staff and it was discovered the patient was at 50 percent of the expected function level. Although the initial admission to inpatient status was well documented, the record in this case is deficient, and the physicians who reviewed the record could not indicate why a four-day admission was required for this patient. Once the patient was provided a treatment for asthma (including IV steroids) and the evaluation for congestive heart failure proved negative, the patient should have been discharged. Based upon the weight of the persuasive evidence in this case, it is determined that this claim should be discounted to only two days of inpatient stay and not the four

days billed. The exact amount of the overpayment for this claim cannot be determined from the evidence but is less than the $5,723.60 claimed by Petitioner.

16. Claim Adventist-FL-3006-22, involved the same patient as described in paragraph 14. Less than two months after the visit described above, the patient returned to the ER with mild wheezing, and the patient was admitted for three days as an inpatient. Given the history of this patient, and the lack of significant change to the presenting symptoms, it is determined that the weight of the persuasive evidence would require this claim to be reduced to two days of observation, not inpatient services. This patient did not have a medical condition to justify a three-day stay. It may have been that the patient needed a place to stay, and her shortness of breath was a convenient excuse for her to seek medical attention; in any event, she did not have a medical condition of the acuity requiring a multi-day inpatient stay. Respondent does not turn patients away. Nevertheless, Medicaid does not provide for housing of patients who need care other than to meet medical needs. It is undoubted Respondent provided a meaningful service to this patient, but the level of medical care is not supported by the record in this case. AHCA is entitled to recover $2,717.52 for this claim.

17. The next disputed claim, Adventist-FL-3006-30, concerned a 31-year-old male who went to the ER after having thrown-up blood. The patient reported a history of blood in his stools and gastro-esophageal reflux disease. Although the patient's vital signs were normal, and there was no evidence of bleeding in the ER, the patient was admitted to the intensive care inpatient unit (ICU) and monitored. After a period of time in the ICU, it was noted that the patient's hemodynamic was stable and he was moved to a "step down" inpatient room. The weight of the persuasive evidence would require this claim to be reduced to two days of observation services not the two days of inpatient billed. The record does not support any acuity requiring intensive care services. Moreover, the endoscopy resulted in normal findings. Had the endoscopy been performed on admission, the normal findings could have ruled out the need for inpatient services. In this case, the treating physician did not think the patient's condition required an emergency endoscopy. Based upon that determination and the patient's normal hemoglobin and hematocrit, it was unlikely the patient required more than observation. Giving Respondent the benefit of the doubt with regard to this claim, and assuming this patient required more care than observation to rule out a more acute illness, that determination could have easily been concluded within a one-day

inpatient stay. AHCA accepts a two-day observation stay for this patient thereby reducing the overpayment to $2,716.18 for this claim.

18. Adventist-FL-48 claim was a 44-year-old male who, while working on a ladder, touched a live electrical wire. This patient was taken by rescue squad to the ER and presented with atrial fibrillation. The patient was admitted to inpatient status, and it was recommended he be given a full cardiac work-up. At some point during his ER stay, and prior to the cardiac testing, the patient returned to a normal cardiac rhythm. Against the recommendation of medical staff, the patient left the hospital. Approximately three days later this patient returned to the ER and requested the cardiac testing he had declined on his prior visit. When he returned, the patient had a normal heart rhythm, had no other symptoms to suggest a cardiac irregularity, and had normal vital signs. Instead of billing the cardiac testing as outpatient services, the patient was admitted for inpatient status and given the full complement of cardiac tests to rule out any adverse cardiac condition resulting from the electrical shock. The weight of persuasive evidence supports that the testing should have been given with this patient in an outpatient status. There was no medical instability supporting a more acute setting for the testing that was done. The overpayment for this claim is $1,503.04.

19. The patient described in Adventist-FL-78 claim was a 63-year-old female who went to the ER with stomach discomfort, nausea, and headache. It was feared the patient was in a cardiac-related condition as the patient had multiple risk factors including atrial fibrillation. By history, the patient had suffered a heart attack in the recent past, and the ER physician rightly admitted the patient for inpatient care to perform a cardiac work-up and to rule out any cardiac event. The inpatient stay was for a 24-hour period so that the testing could be concluded. The weight of persuasive evidence supports this stay. Respondent has shown the medical necessity for the treatment provided for this patient.

20. Adventist-FL-96 claim concerned a patient with a significant bone marrow disorder similar to leukemia. The patient had had a bone marrow transplant. Upon admission to the hospital he suffered nausea, vomiting, and abdominal pain. He was admitted for a one-day inpatient stay and treated for dehydration. He was given a white blood count test and once stabilized was discharged (within 24 hours) with the recommendation that the patient return to his regular provider in Tampa. The weight of persuasive evidence supports this stay. Respondent has shown the medical necessity for the treatment provided for this patient.

21. The patient in Adventist-FL-98 claim was a 45-year-old male with a history of Chronic Obstructive Pulmonary Disease (COPD), smoking, and alcohol abuse. The patient had a history of hospitalizations related to COPD and upon admission complained of shortness of breath. At the time of admission, the patient had normal vital signs, acceptable oxygen saturation levels, no wheezing, and a chest x-ray that showed no acute abnormalities. The weight of persuasive evidence supports the finding that a level of care of observation, and not inpatient, was the correct level Respondent should have billed for this patient. The patient had no medical acuity to support a one-day inpatient stay. AHCA is entitled to recover the overpayment in the amount of $1,358.09.

22. AHCA no longer disputes Adventist-FL-154 claim. Consequently, the overpayment associated with the audit must be reduced by $3,856.68. It is determined Respondent accurately billed for this claim.

23. Similarly, Respondent no longer disputes claims Adventist-FL-155-156. These claims should have been billed as observation, not inpatient stays. Accordingly, Petitioner is entitled to recover the overpayment associated with these claims in the amount of $2,672.98.

24. The patient associated with Adventist-FL-180 claim was a 53-year-old female with a history of breast cancer and

metastatic disease. On the date of her admission, she had had radiation therapy. She suffered nausea and vomiting and presented to the ER. She received an IV of fluids and IV Zofran, felt better, and left the hospital against medical advice. In total, the patient was in the hospital approximately three hours or less. The claim billed her admission as inpatient. This claim should have been billed as observation. Accordingly, the weight of persuasive evidence supports that an overpayment occurred with regard to this claim. Petitioner is entitled to recover the difference between inpatient and observation for this patient. The amount of the overpayment is unknown.

25. With regard to Adventist-FL-230 claim, this patient was a 58-year-old male complaining of shortness of breath with a history of atrial fibrillation. The patient was admitted for a five-day inpatient admission. Respondent was paid for a four-day inpatient stay because that length of stay was approved by KePro. Petitioner disputes that an inpatient stay was required. The weight of persuasive evidence supports an inpatient stay of three days. The patient had stabilized, testing had been completed, and there was no significant medical basis for an inpatient stay beyond that point. The amount of the overpayment is unknown as the audit sought reimbursement at an observation rate. Although not entitled to the four days of inpatient as billed for this patient, Respondent has established it was entitled to a three-

day inpatient compensation based upon the medical necessity established for this patient.

26. Respondent, and other providers may adjust Medicaid billings after-the-fact to conform to medical necessity for any claim filed. In this case, Respondent did not review its claims once KePro approval had been secured. That is to say, if the KePro approval was documented, Respondent did not question the claim for medical necessity once treatment was given. Billings were adjusted to conform to KePro approval, but were not questioned or re-visited as to whether the appropriate level of acuity was documented.

27. Petitioner asserts that Respondent failed to submit the complete medical records for Adventist-FL-98 claim until after the audit was issued. Respondent's response that it provided all medical records timely to the auditor, BAH, is accepted. It is unlikely the records of one claim would have been omitted from the hundreds of pages of records given to the auditor. BAH conducted their audit over an extensive period of time. The Interim Audit Report was issued on October 4, 2010. The overpayment at that time was alleged to be $42,848.29. That amount was also noted in the FAR dated November 16, 2010. Concurrent with the FAR, Petitioner announced its intention to impose sanctions against FHO. The July 20, 2011, audit report reduced the overpayment to $38,790.68, but again claimed

Petitioner was entitled to impose sanctions. The June 12, 2012, audit report further reduced the overpayment to $38,500.78. Subsequent to the hearing, Petitioner acknowledged that the overpayment should be reduced another $3,856.68 to $34,644.10.

28. Petitioner incurred investigative and legal costs in connection with this case in the amount of $7,635.27. Respondent has not challenged the reasonableness of that amount.

29. Petitioner seeks sanctions against Respondent in the amount of $2,000.00.

30. Respondent submitted records to BAH for 285 claims that had to be reviewed. Of that total, only those claims addressed above remain at issue. Ninety-four percent of the claims reviewed/audited by BAH were resolved without dispute.

CONCLUSIONS OF LAW

31. DOAH has jurisdiction over the parties to and the subject matter of these proceedings. § 120.57(1), Fla. Stat.

32. All provisions of Florida law applicable to this case have essentially remained the same for the period 2006-2012. The parties have not challenged the provisions of law that would have been in effect at the time of the claims, the audit, or the final hearing in this cause. While the numbering of some provisions may have changed, the verbiage has remained the same. The citations to law noted herein are consistent with those cited by the parties.

33. Pursuant to chapter 409, Florida Statutes, Petitioner is responsible for administering the Medicaid Program in Florida.

34. As the party asserting the overpayment, Petitioner bears the burden of proof to establish the alleged overpayment by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106 (Fla. 1st DCA 1992). AHCA has failed, in part, to meet its burden.

35. Section 409.913, Florida Statutes, 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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> * * *
>
> (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.
>
> * * *
>
> (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.

36. In this case, Petitioner seeks reimbursement of overpayments based upon the lack of medical necessity for the disputed claims. Section 409.913(1)(d), Florida Statutes, provides:

> (d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

37. In this case, although the audit supports the overpayment claimed, it must be adjusted in light of the totality of the evidence presented in this cause. Petitioner acknowledged subsequent to hearing that Adventist-FL-154 was correct thereby reducing Respondent's overpayment by $3,856.68. Respondent acknowledged Adventist-FL-155, 156 claims were overpayments. More important, Respondent presented substantial, credible evidence to establish medical necessity for portions of the remaining disputed claims. The findings set forth above chronicle the medical necessity for the patients treated claim by claim. The overpayment claimed by Petitioner must be adjusted to conform to the findings reached in this case.

38. With regard to sanctions, Petitioner maintains Respondent should be required to remit $2,000.00 in sanctions for failure to submit complete records or failure to accurately bill Medicaid as required by law. It is concluded Respondent did not fail to submit complete records. Respondent's contention that it timely submitted records as required by BAH is accepted.

39. As to the inaccuracy of its billings, Respondent has attempted to explain and has successfully defended its Medicaid billing related to several of the disputed claims. This case demonstrated on more than one claim that reasonable medical minds may differ as to the prudent course of treatment for a patient. Respondent erred in providing a higher level of care than was

medically necessary based upon the acuity of the patient. While commendable from a social standpoint, Medicaid provisions do not allow reimbursement on that basis. Even so, the inaccurate records would not support a sanction in the amount sought. Petitioner should recover a sanction in the amount of $500.00 not $2,000.00 as charged.

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 adjusting the recoupment for the Medicaid overpayment as indicated in the foregoing findings of fact, imposing a sanction in the amount of $500.00, and recovering its costs in the amount of $7,635.27.

DONE AND ENTERED this 4th day of September, 2013, in Tallahassee, Leon County, Florida.

J. D. PARRISH
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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this 4th day of September, 2013.

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.