STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

IDEAL PUGH, SR., d/b/a SERVICES ON TIME, LLC,

Respondent.

Case No. 11-1671MPI

RECOMMENDED ORDER

An administrative hearing was conducted in this case on February 1, 2012, by video teleconference in Jacksonville and Tallahassee, Florida, before James H. Peterson, III, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Dwight O. Slater, Esquire
Agency for Health Care Administration
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For Respondent: Sheldon J. Vann, Esquire
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STATEMENT OF THE ISSUE

Whether the Agency for Health Care Administration (Agency or Petitioner) is entitled to recover from Ideal Pugh, Sr., d/b/a Services on Time, LLC (Respondent), alleged Medicaid overpayments, administrative fines, and investigative, legal, and expert witness costs.

PRELIMINARY STATEMENT

On August 16, 2010, the Agency issued a letter and final audit report (Final Audit Report) advising Respondent of its intention to seek reimbursement of $600,536.89 in alleged Medicaid overpayments, $521.52 in audit costs, and a $2,500 administrative fine from Respondent based upon an audit of Respondent's records for Medicaid claims Respondent made from January 1, 2007 through December 31, 2008 (the audit period). The Final Audit Report also notified Respondent that he had the right to request an administrative hearing within 21 days from his receipt of the notice.

Respondent timely requested an administrative hearing under section 120.57(2), Florida Statutes. Thereafter, following Respondent's unopposed motion to change his request for a hearing under section 120.57(1), the Agency's informal hearing officer issued an Order Relinquishing Jurisdiction dated November 3, 2010, as well as an order granting the parties'

request for a period of abeyance prior to its referral to the Division of Administrative Hearings (DOAH).

Following abeyance, on April 4, 2011, the Agency referred the case to DOAH. Upon referral, this case was originally scheduled for a hearing to begin July 27, 2011, but, by Order granting Respondent's unopposed motion for continuance, was rescheduled for hearing to begin October 27, 2011.

The hearing was convened as scheduled on October 27, 2011, at which time Petitioner's pending Motion for Official Recognition filed October 18, 2011, was granted. In granting the motion, the undersigned took official recognition of certain provisions of chapters 393, 408, and 409 of the 2007 and 2008 Florida Statutes; sections of Florida Administrative Code Rule 59G; several chapters from the Florida Medicaid Provider General Handbook from January 2007 and July 2008 (Medicaid Handbook); enumerated chapters and appendices from the June 23, 2005, June 2007, and December 3, 2008, Developmental Disabilities Waiver Services Coverage and Limitations Handbook (DD Handbook); and the case of Agency for Health Care Administration v. Custom Mobility, Inc., 995 So. 2d 984 (Fla. 1st DCA 2008), cert. denied, 3 So. 3d 1246 (Fla. 2009), as more particularly listed in the Agency's Motion for Official Recognition.

Following the granting of Respondent's Motion for Official Recognition and discussion of preliminary matters, including the

fact that the parties were in disagreement as to the pertinent issues in this case and had failed to enter into a prehearing stipulation, the final hearing convened on October 27, 2011, was continued in order to give the parties additional time to agree on the disputed issues and to prepare a joint prehearing stipulation. The case was rescheduled and reconvened by video teleconference on February 1, 2012.

At the hearing, the Agency presented the testimony of Magdalena Olsson, an investigator with the Agency's Medicaid Program Integrity Bureau; Robi Olmstead, an Agency administrator with the Medicaid Program Integrity Bureau's waiver unit; Kristen Koelle, a medical health care program analyst with the Agency's Medicaid Program Integrity Bureau; and Dr. Fred W. Huffer, Ph.D., a professor in mathematics at Florida State University. The Agency offered 21 exhibits which were received into evidence as Exhibits P-1 through P-21, without objection.

Respondent testified on his own behalf and presented the testimony of Ms. Olsson. During the hearing, Respondent described a letter dated July 22, 2008, from the Agency for Persons with Disabilities, a non-party. Respondent had not previously shared a copy of the letter with the Agency's counsel, and a copy was not otherwise available for review during the hearing. Respondent was given time to proffer a copy of the letter within ten days after the end of the hearing, but

failed to do so. Respondent did not submit any exhibits into evidence.

By permission, the Agency filed post-hearing submittals updating Exhibits P-6 and P-10 to reflect the most recent submissions by Respondent in support of his Medicaid claims at issue. These updates resulted in further reduction of the amount of overpayments claimed by the Agency.

At the close of the hearing, the parties were given 30 days from the filing of the transcript within which to file their respective proposed recommended orders. The two-volume Transcript of these proceedings was filed March 1, 2012. By two separate Orders granting motions for extension of time, the parties were given additional time within which to file their proposed recommended orders. Thereafter, the parties timely filed their respective Proposed Recommended Orders, which have been taken into consideration in preparing this Recommended Order.

FINDING OF FACTS

1. The Agency is the state agency responsible for administering the Florida Medicaid Program ("Medicaid"). Medicaid is a federally funded state-administered program that provides health care services to certain qualified individuals.

2. Respondent, Ideal Pugh, Sr., is an individual doing business as a limited-liability corporation called Services on

Time, LLC, and was enrolled as a provider in the Florida Medicaid program at all material times. By enrolling in the Medicaid program, Respondent agreed to fully comply with all state and federal laws, policies, procedures, and handbooks pertaining to the Medicaid program.

3. Respondent submitted bills to Medicaid while he was enrolled and these bills were processed and paid to Respondent through the Florida Medicaid automated payment system. Claimed services for which Respondent submitted bills and was paid by Medicaid include transportation, in-home support, respite care, companion, homemaker, self-care/home management training, non-residential supports, and personal care assistance.

4. The Agency is authorized to recover Medicaid overpayments, as appropriate. § 409.913(1)(e), Fla. Stat.[1/]

5. One method the Agency uses to discover Medicaid overpayments is by auditing billing and payment records of Medicaid providers. Such audits are performed by staff in the Agency's Bureau of Medicaid Program Integrity (MPI).

6. Providers are identified as potential candidates for auditing either randomly, or through data collection and analysis performed by MPI staff.

7. In 2009, Investigator Magdalena Olsson identified Respondent as a potential audit candidate when his name appeared

as an additional service provider for clients of a different provider that she was investigating.

8. During her investigation, Ms. Olsson reviewed the Delmarva quality assurance inspection summaries for Respondent, available on the Agency for Persons with Disabilities' (ADP) website. Delmarva is an organization under contract with the Agency to review providers that render services through APD and the Development Disabilities Waiver Program ("DD Waiver"). Based upon her review of Delmarva inspection summaries indicating that Respondent had "poor" results, specifically with respect to records or service documentation, Ms. Olsson decided that further investigation of Respondent was warranted.

9. First, Ms. Olsson conducted an unannounced site visit of Respondent's facility, but Respondent was not there, so she left Respondent a letter requesting that he contact her.

10. When she did not hear from him, Ms. Olsson sent Respondent a "demand letter" requesting documentation for claims billed during the three-month period beginning October 1, 2008, and ending December 31, 2008. After Respondent failed to respond, the Agency imposed a $1,000 sanction against Respondent for failure to timely submit the requested records. Thereafter, Respondent paid the sanction and contacted Ms. Olsson and made arrangements to bring the requested documents to her office.

11. Instead of submitting copies according to Agency policy, Respondent delivered original records to Ms. Olsson. Ms. Olsson reviewed the records and found significant deficiencies in the documentation ranging from no documentation whatsoever to insufficient supporting documentation for the claimed services. Ms. Olsen was "disturbed by seeing so many documents that were not signed, [or] that did not have the times when the services were provided."

12. Ms. Olsson decided to give Respondent another opportunity to provide the records, so she arranged another visit to Respondent's facility. During the site visit, however, Respondent still did not produce sufficient documentation. As a result, Ms. Olsson referred Respondent to Agency Administrator Robi Olmstead and recommended a full audit.

13. Ms. Olmstead reviewed Ms. Olsson's referral and agreed that an audit of Respondent's billing and payment records was appropriate. She opened a case on Respondent and assigned it to Ms. Kristen Koelle for a full audit.

14. Ms. Koelle completed the first steps of the audit process according to established protocols. She reviewed Respondent's provider information and billing to determine what types of services he provided, what types of claims he had submitted, and how much had been paid by Medicaid. She reviewed Respondent's Delmarva inspection summaries, and selected

January 1, 2007 through December 31, 2008, as the audit period. During that audit period, Respondent submitted 13,119 claims for 62 recipients allegedly served by Respondent.

15. When the Agency audits a Medicaid provider for possible overpayments it "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 . . . and other generally accepted statistical methods." § 409.913(20), Fla. Stat.

16. The audit method used by the Agency depends on the characteristics of the provider and of the claims. For example, where a provider serves thousands of Medicaid recipients during the audit period, but there are not many claims for each recipient, then the Agency may use a single-stage cluster sampling methodology. Under this approach, a random sample of recipients is selected, and then all claims are examined for the recipient sample group.

17. Alternatively, where there are so many claims per recipient that it would be impractical to review all claims for each recipient or all claims for a sample group of recipients, a two-stage cluster sample methodology may be used, whereby a random sample of recipients is first selected, followed by a

random selection of sample claims for the recipients in the sample.

18. As a general target, the Agency considers samples of between five and 15 claims, per recipient, to be reasonable sample sizes for the second stage of two-stage cluster sampling. However, if a given recipient has fewer than 15 claims, a smaller number of claims for that recipient will be selected.

19. Because of the high volume of claims generated by Respondent during the audit period in this case, Ms. Koelle determined with her supervisor that a two-stage cluster sampling methodology would be used. In other words, it was not feasible to review all 13,119 claims generated by the 62 recipients claimed to have been served by Respondent during the audit period.

20. Using a computer program to carry out the random sampling, the Agency's two-stage cluster sampling software selected a random sample of 30 recipients from the population of 62 recipients served by Respondent. It then selected a random sample of from 5 to 15 claims for each recipient from Respondent’s paid-claims data in the Agency’s data warehouse for the two-year audit period. A total of 347 sample claims were randomly selected from that portion of the 13,119 claims submitted by Respondent for the 30 sample recipients during the audit period.

21. Thereafter, Ms. Koelle prepared a letter to send to Respondent that served to notify him that an audit had been initiated, and to request that he provide all Medicaid-related records for the random sample of 30 recipients generated by the cluster sampling program, as well as the employment/personnel records or files for any of Respondent's staff that provided services to Medicaid recipients during the audit period. The letter gave Respondent the standard 21-day period to submit the requested records.

22. Ms. Olmstead reviewed and signed the letter and it was mailed, along with a "Provider Questionnaire" and "Certification of Completeness of Records," to Respondent on April 27, 2010.

23. Ms. Koelle received the first set of records from Respondent in late May or early June 2010. Respondent also returned the Provider Questionnaire and a signed Certification of Completeness of Records .certifying the accuracy, truthfulness, and completeness of the records submitted.

24. Persons who provide Medicaid services must meet certain minimum qualifications and obtain certain trainings, otherwise the person is deemed "ineligible" or "disqualified" and Medicaid cannot reimburse for services provided by such persons. All persons who provide services directly to Medicaid recipients must also pass a Level 2 background screening. Training and screening requirements for staff of Medicaid

providers during the audit period are set forth in the Medicaid Handbook and DD Handbook.

25. Upon receiving records sent by Respondent in response to the Agency's April 27, 2010 letter, Ms. Koelle first reviewed Respondent's staff files to determine whether each staff member met requirements necessary to be able to provide Medicaid or Medicaid waiver services. After discovering that Respondent had only submitted files for three staff members, she contacted Respondent and asked for additional staff records. After receiving additional records from Respondent, Inspector Koelle reviewed Respondent's submissions and recorded her findings.

26. Ms. Koelle reviewed the documentation Respondent submitted for each recipient against the 347 claims in the random sample and recorded her findings on worksheets along with her descriptions of any deficiencies or noted violations of Medicaid law. Claims that she found to be supported by documentation, in full compliance with Medicaid rules, were marked on the worksheet next to the "allow" option, thus indicating that no overpayment was found.

27. Claims that Inspector Koelle determined were not in compliance with Medicaid rules were marked on the worksheet next to the "adjust" or "deny" option. If she found that no portion of the claim complied with Medicaid law, she checked "deny" and the entire amount paid was written in the worksheet space marked

“dis-amt,” shorthand for “disallowed amount,” indicating an alleged overpayment.

28. If Inspector Koelle found that some, but not all, of a given claim complied with Medicaid law, she marked the “adjust” option on the worksheet and only a portion of the amount paid was written in the space marked “dis-amt.”

29. Ms. Koelle completed her review and entered all amounts that she found to be disallowed into the computer program. The program added the figures together to find the overpayment amount for the sample, and then extended the overpayment to the entire universe of recipients, according to an established statistical methodology, which yielded the total overpayment amount. The computer program generated a printout showing the exact overpayment amount for each of the 347 claims in the sample, and the total overpayment extended to the population. The figures on the printout correspond to the figures on the worksheets.

30. Utilizing this methodology, Ms. Koelle determined that Respondent had been overpaid by an amount of $632,264.51. Thereafter, she prepared the Preliminary Audit Report (Preliminary Audit), describing the methodology applied to determine overpayment and the deficiencies that led to that determination. She attached to the Preliminary Audit the printout, copies of her worksheets, and a copy of the

spreadsheet with staff findings. A provision in the Preliminary Audit explains that Respondent may submit additional documentation to support the sample claims, although such submission may be deemed evidence of previous non-compliance.

31. Ms. Olmstead reviewed, approved, and signed the Preliminary Audit, which was mailed with attachments to Respondent on June 7, 2010.

32. After receiving the Preliminary Audit, Respondent submitted additional records in an effort to further support the sample claims.

33. In preparation of the Final Audit Report, Ms. Koelle, in consultation with Ms. Olmstead, reviewed Respondent's documentation and found that there were incorrect, illegible, or insufficient documents to support 319 of the 347 claims (91.93 percent of the claims) in the sample. The deficiencies included incomplete or missing staff files, lack of documentation of services, no service authorization, no trip logs or trip logs that did not meet Medicaid handbook requirements, no monthly summary, and indications that unqualified staff members were providing services.

34. The documents, or lack thereof, demonstrated that Respondent overbilled, leading to overpayment, because the number of service units billed were not supported by documented activities, and that Respondent billed and was paid for services

and activities beyond the scope of services authorized in the recipients' support plan or service authorization.

35. The Agency's review of Respondent's billing against documentation submitted by Respondent also revealed overbilling based upon the fact that Respondent billed and was paid for services performed by staff members who did not meet Level 2 background screening requirements.

36. In addition, Respondent's billings and records showed that many claims for services were performed by staff members that were not trained in accordance with Medicaid requirements for the services performed.

37. As before, Ms. Koelle recorded her findings on spreadsheets. She documented all the records received for each staff member regarding minimum qualifications and trainings. The spreadsheets also set forth the documentation that remained outstanding.

38. Ms. Koelle also reviewed all recipient records submitted by Respondent against the claims in the random sample and against the requirements of Medicaid law, including all applicable handbook provisions. As in the Preliminary Audit, Ms. Koelle detailed her findings on worksheets, making notes to describe deficiencies in the records or other violations of Medicaid law. Claims that were found to be supported by documentation, in full compliance with Medicaid rules, were

marked on the worksheet with a check mark next to the "allow" option. The remaining claims were either "adjusted" or "denied."

39. Ms. Koelle recorded her findings in a spreadsheet. The spreadsheet, organized by recipient numbered 1 through 30, contains the following information for each of the 347 claims in the sample: Date of service (DOS), procedure code, procedure description, unit of service (UOS), cost per unit of service, amount paid to Respondent, claim determination (Allow, Adjust, or Deny), review determination, whether there was a document deficiency (Doc. Def.), an overbilling issue, or a background screening (Bkgrd. Screen) issue; and the amount of the overpayment for the claim (O/P).

40. Next, Ms. Koelle entered the disallowed amounts into the computer program, which then added the amounts together, found the overpayment amount for the sample, and extended the overpayment to the entire population of 13,119 claims.

41. Ultimately, Ms. Koelle prepared the Final Audit Report which Ms. Olmstead signed and sent to Respondent on August 16, 2010. Because some records submitted by Respondent since the Preliminary Audit supported previously unsubstantiated claims, Ms. Koelle adjusted the overpayment to $600,536.89.

42. The Final Audit Report notified Respondent of the adjusted total overpayment, described the types of non-

compliance found in the sample claims, and explained the methodology employed to select the claims for review and extend the sample overpayment to arrive at the total overpayment.

43. The Final Audit Report also advised Respondent that the Agency intended to recover a $2,500.00 fine and $521.52 for audit costs. Copies of the worksheets, as well as the two spreadsheets detailing the staff review findings, were attached.

44. Respondent elected to dispute the Final Audit Report and the Agency referred the matter to DOAH.

45. Over the course of the proceedings, on at least three separate occasions, Respondent submitted additional records. Many of them were duplicative. Nevertheless, Ms. Koelle accepted and reviewed all of the additional documentation, considered all explanations given, and, to the extent warranted, revised the audit determinations. She updated the spreadsheets containing the audit findings and the staff findings to reflect the most recent information, including post-hearing filings of updated versions of Exhibits P-6 and P-10.

46. The subsequent submissions resulted in downward adjustments to the total overpayment amount, so that the final overpayment, not including fines or costs, was calculated to be $563,073.76.

47. The findings of the Preliminary Audit and Final Audit Report were substantiated at the final hearing through the testimony of both Ms. Koelle and Ms. Olmsted.

48. At the final hearing, Respondent contended that he had submitted original documents substantiating his claims to the Agency Investigator Olsson early on in the process and that the Agency lost the records. Respondent, however, did not retain copies of the records. According to Ms. Olsson, the documents were returned to Respondent.

49. Under the facts and circumstances, including the fact that Respondent submitted originals against Agency policy, failed to keep copies, and otherwise failed to substantiate over 90 percent of the sample claims, it is found that Respondent's testimony that the Agency lost his records is unpersuasive. It is otherwise found that Ms. Olsson's recollection is accurate, and that the Agency did not lose any of Respondent's documents submitted in support of his claims that are the subject of the Final Audit Report.

50. Respondent further argued in Respondent's Proposed Recommended Order that the Agency "neither alleged nor presented evidence that services were not provided." Respondent's Proposed Recommended Order (PRO), ¶ 2. In the same paragraph, however, Respondent admits, "[a]ll deficiencies were due to incorrect, illegible or insufficient documentation."

51. While suggesting that "Respondent shall repay [the Agency] $23,824.48 due to overpaid claims [derived from unsubstantiated claims in the sample], Respondent further argues that "[b]ecause [the Agency] did not properly implement the 'Two-Stage Cluster Sampling Method,' the projected extension of sample results to the population is statistically invalid and cannot be used to assess an enlarged overpayment amount." Respondent's PRO, ¶¶ 3-4. Respondent, however, did not produce evidence, by expert testimony or otherwise, that the two-stage cluster sampling utilized by the Agency was invalid or unreliable.

52. On the other hand, the methodology and description of two-stage cluster sampling were explained and confirmed at the final hearing by the Agency's expert witness, Professor Fred Huffer, Ph.D., who is an expert on statistical sampling. In addition, the methodology comports with established law. See § 409.913, Fla. Stat. et seq.; Ag. for Health Care Admin. v. Custom Mobility, Inc., 995 So. 2d 984 (Fla. 1st DCA 2008), cert. denied, 3 So. 3d 1246 (Fla. 2009).

53. Fred Huffer, Ph.D., is a professor of statistics at Florida State University, with a Bachelor of Science degree in mathematics from the Massachusetts Institute of Technology and a Ph.D. in Statistics from Stanford University. He has taught and

researched statistics for more than 30 years in various institutions of higher learning.

54. Dr. Huffer was familiar with the case at hand and with the science of random sampling of populations and the analysis of samples, including extension of results to the universe of objects.

55. Dr. Huffer analyzed the sampling method utilized by the Agency in this case with repeated random simulation that recreated the audit circumstances, randomly, many thousands of times, and found them to be accurate in this case.

56. Because the sampled recipients in this case are only 30 out of 62 recipients in the entire universe, the software multiplied by 62/30 to "scale up" the number from the 30 recipients that were sampled to the entire population size. Every recipient in the sample was weighted according their number of claims. And, the Agency's software corrected for the variability within each cluster, within each recipient.

57. The software utilized by the Agency determined the amount of overpayments at a 95 percent confidence level. As explained by Dr. Huffer, if the entire procedure is repeated "many, many times, typically it's around 95% of the time that the number you arrived at will be less than the true amount" of the overpayment.

58. In other words, the amount the Agency has asked Respondent to repay is most likely lower than the actual overpayment. According to Dr. Huffer's calculations, the overpayment in this case is 64.6 percent of the "point estimate," which is already only 86 percent of the total overpayment.

59. Dr. Huffer testified that he has "no doubts" about the calculations the Agency made in this case or the efficacy of the statistical sampling method employed. According to Dr. Huffer's testimony, "You can think of it as a random discount . . . . It's undeniable that there was an overpayment."

60. In sum, Dr. Huffer credibly explained that the Agency's cluster sampling method is appropriate and that it that comports with the technical meaning of random sample and generally accepted statistical methods.

61. Instead of presenting contradictory expert testimony, Respondent attempted to undermine Dr. Huffer's opinions through cross-examination and argument. Respondent, however, was not effective in this regard.

62. Dr. Huffer's opinions that the audit in this case utilized a correct and reasonable application of two-stage cluster sampling, and that the sampling method used in this case was reasonable and comported with generally accepted statistical methods, are accepted as credible and accurate.

CONCLUSIONS OF LAW

63. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat.

64. The Agency is required to 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 to report the findings of any overpayments in audit reports as appropriate. § 409.913(2), Fla. Stat.

65. The audit process that led to the claim for overpayments in this case was properly initiated by the Agency in accordance with section 409.913.

66. An "overpayment" includes "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud abuse or mistake." § 409.913(1)(e), Fla. Stat.

67. The statutes and rules in effect during the period for which the services were provided, including the Medicaid Handbook and DD Handbook which are promulgated as rules, govern the outcome of this dispute. Toma v. Ag. for Health Care Admin., Case No. 95-2419, RO at ¶ 213 (Fla. DOAH July 26, 1996; Fla. AHCA Sept. 24, 1996).

68. The 2007 version of section 409.913(15), Florida Statutes, in effect at the end of the audit period in this case, specifically authorizes the Agency to recoup overpayments 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;
>
> * * *
>
> (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;

69. Pertinent portions from the Medicaid Handbook and DD Handbook of which official recognition was taken in this proceeding include, but are not limited to, the following excerpts:

> 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 support the provision of a service to a recipient. [DD Handbook, p. 2-5, June 23, 2005 (documentation requirements)(Ex. P-13 at 621)]

> Documentation is a written record that supports the fact that a service has been rendered . . . . All documentation must be dated and signed by the individual rendering the service. [Id.]
>
> Incomplete records are records that lack documentation that all requirements or conditions for services have been met. Medicaid may recover payment for services or goods when the provider has incomplete records or cannot locate the records. [Medicaid Handbook, p. 5-8, Jan. 2007 (recovery of costs)(Ex. P-13 at 594)]
>
> Records must be retained for a period of at least 5 years from the date of service.
>
> * * *
>
> The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives of request of [the Agency]. [Medicaid Handbook, p. 2-51, Jan. 2007 (Record Keeping)(Ex. P-13 at 592)]
>
> 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 Handbook, p. 2-57, July 2008 (Record Keeping)(Ex. P-13 at 599)]
>
> Medicaid payments for services that lack required documentation or appropriate signatures will be recouped. [Id.]

70. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on the Agency. S. Med. Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v.

Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992). The burden of proof with respect to the imposition of fines or sanctions is by clear and convincing evidence. Dep't of Banking and Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

71. Although the Agency bears the ultimate burden of persuasion and thus must present a prima facie case, section 409.913(22) provides that "[t]he audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Further, section 409.913(20), Florida Statutes, provides that "[i]n meeting its burden of proof . . ., the agency may introduce the results of [accepted and valid] statistical methods as evidence of overpayment."

72. The Agency made out its prima facie case of overpayment through the introduction into evidence of the Preliminary Audit and Final Audit Report, as well as the supporting work papers. In addition, it is concluded that the Agency's overpayment calculation was based upon an accepted and valid statistical method of cluster sampling which was properly applied to determine the amount of overpayments.

73. Respondent did not overcome the Agency's prima facie case and was otherwise ineffective in attempting to discredit

the statistical sampling method used by the Agency to determine the total amount of overpayments.

74. Further, the Agency demonstrated, by a preponderance of the evidence, that documentation provided by Respondent to the Agency was insufficient to support the services for which he billed Medicaid. A preponderance of evidence also demonstrated that Respondent was not in compliance with the Medicaid documentation and record retention policies for most of his claims submitted during the audit period, that many services were rendered by untrained or unqualified individuals, and that, as a result, over 90 percent of amounts claimed by Respondent during the audit period resulted in overpayments.

75. In accordance with the Findings of Fact and Conclusions of Law, above, it is found that the Agency established, by a preponderance of evidence, that Respondent received payment for multiple Medicaid claims that, in whole or in part, did not comply with applicable law and rules for Medicaid reimbursement purposes and, that, as a result, Respondent was overpaid at least $563,073.76, which amount the Agency is entitled to recover from Respondent.

76. Overpayments owed to the Agency bear interest at the rate of 10 percent per annum from the date of determination of the overpayment. § 409.913(25)(c).

77. In addition to recovery of overpayments set forth above, section 409.913(16) provides that “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) . . . [including] imposition of a fine of up to $5,000 for each violation."

78. The acts described in subsection (15) include, inter alia:

> (b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government.
>
> (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; . . .

§ 409.913(15), Fla. Stat.

79. The first page of the Final Audit Report states:

> Be advised of the following:

> (1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (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 $1,000 for violations of Rule Section 59G-9.070(7)(c), F.A.C.
>
> - A fine of $1,500 for violation(s) of Rule Section 59G-9.070(7)(e), F.A.C.
>
> (2) Pursuant to Section 409.913(23)(a), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

80. Florida Administrative Code Rule 59G-9.070, promulgated in 2005, provided notice as how the Agency would normally exercise its sanction authority.

81. Rule 59G-9.070(7)(c) and (e) recited in the Final Audit Report correspond to subsections 409.913(15)(c) and (e), Florida Statutes. The rules state:

> (7) SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction . . . 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 of authorized representative. [Section 409.913(15)(e), F.S.]

82. The fines recited in the Final Audit Report are consistent with guidelines for sanctions in the version of rule 59G-9.070(10) in effect at the time Respondent committed the acts[2/] described in subsections 409.913(15)(c) and (e), Florida Statutes, and corresponding rules.

83. The Agency showed by clear and convincing evidence that Respondent failed to furnish all Medicaid-related records within the timeframe requested by the Agency as required by section 409.913(15)(c). Thus, a $1,000 fine pursuant to the 2008 version of 59G-9.070(10) was warranted.

84. Moreover, the clear and convincing evidence showed that Respondent was not in compliance with the Medicaid documentation and record retention policies for most of the claims he submitted during the audit period, and that many of the services for which Respondent made claims were rendered by

untrained or unqualified individuals. The version of the guidelines rule 59G-9.070(10) in effect at the time of these claims-based violations was the version amended in April 2006. That version provides for first offenders a fine of $1,000 per violation, not to exceed $3,000 per agency action for a "pattern" of acts.

85. A "pattern" is defined in rule 59G-9.070(2)(s)2.a., as when the number of individual claims found to be in violation is greater than 6.25 percent of the total claims reviewed. The evidence submitted by the Agency in this case clearly and convincingly showed that substantially more than 6.25 percent of the claims reviewed did not comply with the Medicaid laws, rules, and provider handbooks. Therefore, under the facts and the law, imposition of the $1,500 fine sought by the Agency for violation of section 409.913(7)(e), Florida Statutes, and corresponding rule was appropriate.

86. As to costs, section 409.913(23)(a), Florida Statutes, provides:

> In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

87. In support of the Agency's claim for costs, the Agency attached to its Proposed Recommended Order "Appendix A" detailing investigative costs for Investigator Koelle and expert witness costs for Dr. Huffer.

88. The Agency, however, presented no evidence of costs at the final hearing and a procedure for a recommendation on the award of costs was not discussed. Moreover, Respondent has not been given the opportunity to contest the amount of costs requested in the Agency's post-hearing submittal.

89. While the Agency may ultimately prevail by the entry of a final order consistent with this Recommended Order, a determination of costs at this stage of the proceedings, under the circumstances, is premature.

90. If the Agency ultimately prevails, it may recover its costs pursuant to section 490.913(23)(a).

91. Should a disputed issue of material fact arise as to the appropriate amount of those costs, the Agency may refer the matter to DOAH for further recommendation limited to the issue of allowable costs pursuant to subsection 409.913(23)(a).

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration, enter a final order requiring Respondent, Ideal Pugh, Sr., d/b/a Services on Time, LLC:

(1) To repay the sum of $563,073.76, for overpayments on claims that did not comply with the requirements of Medicaid laws, rules, and provider handbooks;

(2) To pay interest on the sum of $563,073.76 at the rate of ten percent per annum from the date of the overpayment determination;

(3) To pay a fine of $1,000 for failure to furnish all Medicaid-related records within the requested timeframe;

(3) To pay a fine of $1,500 for violations of the requirements of Medicaid laws, rules, and provider handbooks; and

(4) To pay allowable costs pursuant to subsection 409.913(23)(a), Florida Statutes. If a disputed issue of material fact arises regarding the appropriate amount of those costs, the matter may be referred back to DOAH for a further recommendation regarding costs.

DONE AND ENTERED this 31st day of May, 2012, in Tallahassee, Leon County, Florida.

JAMES H. PETERSON, III
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
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Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of May, 2012.

ENDNOTES

[1/] Unless otherwise noted, all references to the Florida Statutes are to the 2007 version in effect at the end of the audit period at issue in this case.

[2/] Rule 59G-9.70 was amended effective October 29, 2008, to increase the amounts of fines in the guidelines. Since many of Respondent's claims at issue were in 2007, before that 2008 effective date, the rule version amended April 26, 2006, is applicable to claims-based violations under section 409.913(15)(e). However, the 2008 rule amendment is applicable to determine fines for Respondent's failure in 2010 to provide all Medicaid-related records within the requested timeframe in violation of section 409.913(15)(c).

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.