STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. JAIRO'S MEDICAL EQUIPMENT, INC., Respondent.	)	Case No. 11-2897MPI

RECOMMENDED ORDER

A hearing was conducted in this case pursuant to sections 120.569 and 120.57(1), Florida Statutes[1] before Administrative Law Judge Jessica Varn of the Division of Administrative Hearings (DOAH). The hearing was held on August 10, 2011, by video teleconference at sites in Miami and Tallahassee, Florida.

APPEARANCES

For Petitioner: Kristina Schlieter, Esquire
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For Respondent: Alain Rosello, Qualified Representative
15205 Southwest 13th Terrace
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Emilsa Lopez, President
Jairo's Medical Equipment, Inc.
1823 Ponce De Leon Boulevard
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STATEMENT OF THE ISSUE

Whether Respondent violated section 409.913, Florida Statutes, by failing to retain required Medicaid records and by failing to provide the required training prior to setting up medical equipment, thereby incurring a $7,000 fine according to Florida Administrative Code Rule 59G-9.070(7)(e).

PRELIMINARY STATEMENT

By letter dated May 3, 2010, the Agency advised Respondent of its intent to apply sanctions for violations of federal and state laws, including the failure on five occasions to retain separate pulse oximetry testing results, either through copies of physicians' office notes documenting pulse oximetry test results or through pulse oximetry test results obtained from a laboratory. The Agency also intended to apply a sanction for the failure, on one occasion, to retain a copy of a Certificate of Medical Necessity (CMN) that contained pulse oximetry test results that are dated, at the most, thirty days before the prescribing physician's dated signature on the CMN. Lastly, the Agency intended to apply a sanction for the failure, on one occasion, to have a licensed professional supervise the

placement and set up of oxygen equipment in the recipient's residence. The letter directed Respondent to pay a $7,000 fine for the alleged violations.

On or about May 25, 2011, Respondent requested a hearing on the Agency's imposition of the sanction. The matter was referred to DOAH on June 9, 2011, for the assignment of an administrative law judge to conduct a formal hearing and to submit a recommended order to the Agency.

Pursuant to notice, the final hearing in this case was conducted on August 10, 2011. At the hearing, the Agency presented the testimony of Gina Selwitz; Agency's Exhibits 1-5, 7, 10-15, and composite exhibits 6, 8, and 9 were offered and received into evidence. The Respondent presented the testimony of Emilsa Lopez; Respondent's Exhibits 2-8[2], and composite exhibit 1 were offered and admitted into evidence[3].

The Transcript of the proceedings was filed with DOAH on September 14, 2011. The parties timely filed Proposed Findings of Fact and Conclusions of Law, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. Jairo's Medical Equipment is a durable medical equipment provider. One function of the company is to provide and maintain oxygen equipment to Medicaid recipients.

Mrs. Lopez (Lopez) is the owner and manager of Jairo's Medical Equipment.

2. On March 31, 2011, the Agency conducted an unannounced on-site inspection of the medical records retained by Respondent. Ms. Gina Selwitz, along with two other investigators, conducted this investigation. The investigators requested a list of documents, including licensing documents, insurance records, and medical records for ten different Medicaid recipients.

3. Lopez immediately provided licensing and insurance records, but needed more time to copy the medical files requested. The investigators gave Lopez a few days to copy and provide the requested medical files for ten Medicaid recipients.

4. Complete medical records on each patient, including pulse oximetry test results, were provided on the day of collection.

5. On at least three separate occasions after the initial production of records, the Agency called Lopez to ask for maintenance and repair records, licensing information, and FBI background information records. These records had been listed in the initial demand for records, but the Agency could not find them in the records that Respondent had already provided. The Agency did not indicate that the required pulse oximetry test results were missing from the medical records. Lopez promptly

faxed the maintenance and repair records, licensing information, as well as the FBI information.

6. There was conflicting testimony as to whether the pulse oximetry test results for five patients were included in the medical records collected during the investigation. Ms. Selwitz testified that she did not receive the pulse oximetry test results until after the sanction letter was sent to Respondent. This testimony is unpersuasive because, the undersigned infers, had the pulse oximetry test results been missing in the medical records, the Agency would have requested them again, which it never did. In contrast, Lopez testified that she did provide the pulse oximetry test results in the initial records production. The undersigned credits Lopez's testimony, which is both credible and consistent with the fact that the Agency requested, after the investigation, other documents that could not be located in the records that Respondent had produced.

7. At the hearing, Ms. Selwitz testified that Lopez signed a "Completeness of Records" form at the conclusion of the investigation, but no such form was admitted into evidence.

8. As a result of this inspection, the Agency found seven violations of Medicaid policies. On five occasions, Respondent was charged with failing to retain separate pulse oximetry testing results, either through copies of physician's office notes or through separate results obtained from a laboratory.

9. As to the sets of records for five Medicaid recipients[4], the undersigned finds that each medical file contains pulse oximetry test results from either a physician or a laboratory. Respondent did retain the necessary pulse oximetry test results in the medical files of those five patients.

10. The Agency also charged Respondent with a failure to retain a copy of a Certificate of Medical Necessity (CMN) that contained pulse oximetry test results dated no more than 30 days from the prescribing physician's dated signature on the CMN.

11. The records for patient S.R. indicate that the CMN was dated July 26, 2010, but the pulse oximetry test result was dated May 19, 2010. This span of time is beyond the 30-day maximum amount of days allowed between the date of the CMN and the date of the pulse oximetry test.

12. Lastly, Respondent was charged with failing to have a licensed professional supervise the placement and set up of oxygen equipment in a recipient's residence.

13. The records for patient V.P. reveal that Lopez delivered oxygen equipment to the patient's home on September 10, 2010, set up the equipment, and signed a form indicating that she had trained the patient on how to use the equipment. Lopez is not certified to do such training. Lopez did not, however, train the patient on how to use the equipment. Because the patient was admitted to the hospital, the equipment

was not actually used until October 31, 2010. At that point, the patient did receive training from a certified professional. Respondent billed Medicaid for this oxygen equipment for the months of September and October, even though the equipment was not used, and the patient had not been trained on how to use the equipment.

14. Of the seven counts against Respondent, only two are supported by the evidence. Respondent provided copies of the pulse oximetry test results for the five patients in question; therefore, counts 1-5 are baseless. There is evidence, however, that Respondent failed to retain a copy of a CMN dated, at most, thirty days after the pulse oximetry testing results. There is also evidence that Respondent billed Medicaid for two months of oxygen equipment use when the proper training had not been completed.

CONCLUSIONS OF LAW

15. DOAH has jurisdiction over the subject matter of this proceeding and of the parties hereto pursuant to chapter 120, Florida Statutes.

16. AHCA is statutorily charged with the responsibility of operating 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.

17. Section 409.913(9), Florida Statutes, requires Medicaid providers to retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid. Florida Administrative Code Rule 59G-9.070(7)(e) provides that the Agency may sanction a provider with a $1,000 fine per claim found to be in violation of the Medicaid rules, if it is a first offense. It may do so, however, only if the violation is proven by clear and convincing evidence. See Dep't of Banking & Fin., Div. of Sec. & Inv. Prot. v. Osborne Stern and Co., 670 So. 2d 932, 935 (Fla. 1996).

18. The Medicaid DME and Medical Supply Services Coverage and Limitations Handbook, at page 2-68, requires that oxygen equipment providers retain pulse oximetry test results for each Medicaid patient, in each patient's medical files. It also requires that the time span between the CMN or prescription date and the oxygen testing results be no more than thirty days.

19. The Handbook, at page 2-62, requires that prior to a patient using oxygen equipment, the patient must receive training from a licensed professional (either a CRT, RN, RCP, or RT) in how to properly use the equipment. On page 2-64, the

Handbook states that claiming Medicaid reimbursement for the unsupervised set up of oxygen equipment is not allowed.

20. Respondent properly retained the pulse oximetry test results for the five patients in question; thus, the first five counts against Respondent are groundless.

21. One medical file did, however, contain a CMN dated more than 30 days from the date of the oxygen test results for the patient.

22. And in one other medical file, Respondent improperly sought Medicaid reimbursement for two months of oxygen equipment use when the proper training had not been provided to the patient.

23. Accordingly, two of the seven counts against Respondent were proven by clear and convincing evidence.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby RECOMMENDED that pursuant to Florida Administrative Code Rule 59G-9.070(7)(e), Respondent be fined $2,000 for two first offense counts of failure to comply with the Medicaid rules.

DONE AND ENTERED this 7th day of October, 2011, in Tallahassee, Leon County, Florida.

JESSICA E. VARN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of October, 2011.

ENDNOTES

[1]/ Unless otherwise noted, all references in this Recommended Order to Florida Statutes are to Florida Statutes (2010).

[2]/ Respondent's exhibits 7 and 8 were filed after the hearing without objection, and were marked for identification as Respondent's Exhibits 7 and 8. In the Transcript, however, they were incorrectly labeled as "Respondent’s Exhibits 1 and 2." Respondent's exhibits 1-6 were incorrectly identified in the Transcript as "Respondent’s Exhibit 3."

[3]/ The Transcript of this proceeding incorrectly identifies the Agency's exhibits 1-14 as "Petitioner’s Exhibit 1" and Agency Exhibit 15 as "Petitioner’s Exhibit 2".

[4]/ Those patients are: M.A., J.G., M.I., R.M., and S.R.

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.