STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 11-4242MPI
JUANA RODRIGUEZ, d/b/a ACCESS ROAD, INC.,	)	
Respondent.	)	

RECOMMENDED ORDER

A final administrative hearing was held in this case on January 3, 2012, in Tallahassee, Florida, before Administrative Law Judge Elizabeth W. McArthur of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: L. William Porter, II, Esquire
Beverly H. Smith, Esquire[1/]
Agency for Health Care Administration
Fort Knox Building, Building 3
2727 Mahan Drive
Tallahassee, Florida 32308-5403

For Respondent: Nancy P. Campiglia, Esquire
Keating and Schlitt, P.A.
250 East Colonial Drive, Suite 300
Orlando, Florida 32801-1231

STATEMENT OF THE ISSUES

The issues in this case are whether Respondent received Medicaid overpayments that Petitioner is entitled to recoup, and whether fines should be imposed against Respondent.

PRELIMINARY STATEMENT

Following an audit of 2007 and 2008 Medicaid claims, the Agency for Health Care Administration (AHCA or Petitioner) issued a Final Audit Report (FAR) on August 10, 2010, concluding that Respondent, Juana Rodriguez, d/b/a Access Road Inc. (Access Road or Respondent), received $159,741.86 in Medicaid overpayments. The FAR informed Respondent that AHCA intended to recoup the overpayments, impose a fine of $3,500.00, and seek recovery of its costs as authorized by statute.

Respondent timely requested an administrative hearing to contest the FAR, and on August 19, 2011, this case was forwarded to the Division of Administrative Hearings (DOAH) for the assignment of an Administrative Law Judge to conduct the requested hearing.[2/] The initially-scheduled hearing was continued once on the parties' joint motion and was rescheduled for January 3, 2012.

Before the final hearing, the parties submitted a joint Pre-Hearing Stipulation, in which they stipulated to a number of facts. These agreed facts are incorporated into the Findings of Fact below, to the extent relevant.

At the final hearing, Petitioner presented the testimony of Robi Olmstead, an AHCA administrator in the Bureau of Medicaid Program Integrity (MPI); Kristin Koelle, an MPI investigator; and Fred Huffer, Ph.D., a professor at Florida State University in the statistics department, tendered and accepted as an expert in Medicaid statistical formula evaluation of claims. Petitioner's Exhibits A through Q were admitted in evidence by stipulation. Included in the stipulated exhibits were pertinent sections of Florida Statutes, Florida Administrative Code rules, and Medicaid provider handbooks incorporated by reference in rules, all for the years in which the alleged overpayments were made. Official recognition was taken of these submissions, without objection. In addition, Petitioner's Exhibit R, a demonstrative exhibit created by Dr. Huffer at the hearing to illustrate his testimony was admitted in evidence without objection.

Respondent presented no witnesses and no evidence. Instead, Respondent relied on cross-examination of Petitioner's witnesses and argument in its Proposed Recommended Order (PRO).

The record was left open at AHCA's request to receive an update of the exhibit of AHCA's costs admitted in evidence to reflect additional costs incurred through the final hearing. AHCA timely filed its updated cost exhibit on January 7, 2012. Respondent was initially allowed seven days to submit a response or objection to AHCA's updated cost exhibit. Respondent moved

for a brief extension, which was granted, and Respondent timely filed a response by the extended deadline. Although timely filed, as will be discussed below, Respondent's submission did not dispute the accuracy or reasonableness of AHCA's updated costs. Instead, Respondent took the opportunity to belatedly request a discovery sanction as an offset to any statutory award of costs to AHCA.

At Respondent's request, the parties were allowed 30 days after the filing of the Transcript to submit their PROs. The two-volume Transcript of the final hearing was filed on January 17, 2012. AHCA filed its PRO on January 26, 2012. On February 15, 2012, Respondent requested a short extension of the PRO deadline due to unforeseen circumstances, which was granted without objection. Respondent timely filed its PRO by the extended deadline of February 24, 2012. Both PROs have been duly considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. AHCA is the single state agency responsible for administering the Medicaid program in Florida. The Medicaid program is a federal and state partnership to cover the costs of providing health care and related services to persons meeting certain criteria, such as persons with very low income or persons with certain developmental disabilities.

2. For persons with developmental disabilities, Florida developed a program designed to identify those who could receive needed services in their homes and communities, instead of in institutional settings. To use the state-federal Medicaid funds for home and community-based services, instead of institutional care, Florida was required to obtain a waiver from the federal government by demonstrating that its program presented a less-costly and more-effective alternative to institutionalization. This program, approved for certain developmentally disabled Medicaid recipients, is known as the Home and Community-Based Waiver (HCB waiver).

3. Under the HCB waiver, services are planned for each developmentally disabled recipient according to the recipient's particular needs and described in a detailed support plan. The support plan articulates the goals for each type of needed service and is updated annually. A service authorization is developed from each support plan to specify the amount, by time and dollars, approved for each type of service. The support plan and service authorization documents also identify which Medicaid-contracted providers will be providing each of the approved services.

4. At all times material to this case, Access Road has been a provider of HCB waiver services to Medicaid recipients,

pursuant to a Medicaid provider contract with AHCA. Access Road's Medicaid provider number is 681213996.

5. Between January 1, 2007, and December 31, 2008, Access Road provided HCB waiver services to a total of 16 Medicaid recipients. Fourteen recipients received services throughout the two-year period. Two recipients received services for only a short period of time near the end of the two-year period.

6. During this two-year time period, Access Road provided four types of HCB waiver services: personal care assistance; companion care; respite care; and non-residential support. Each of these services is billed in quarter-hour units of service provided on a single day so that a claim for 16 units of service would represent that the service was provided for four hours that day.

7. For the two-year period at issue, Access Road submitted a total of 12,927 claims for reimbursement for services provided to the 16 Medicaid recipients. For those claims, Access Road billed Medicaid and was reimbursed a total of $809,374.42.

8. By entering into Medicaid provider agreements with AHCA, providers such as Respondent agree to "maintain and make available in a systematic and orderly manner," as AHCA requires, all Medicaid-related records for a period of at least five years. In addition, providers agree to send "at the provider's expense, legible copies of all Medicaid-related information" to authorized

state and federal employees. These contractual agreements are also requirements of Florida's Medicaid laws and rules, including the Medicaid provider handbooks that are promulgated as rules.

9. AHCA is responsible for conducting investigations and audits to determine possible fraud, abuse, overpayment, or neglect, and must report any findings of overpayment in audit reports. AHCA need not have any particular reason or cause for initiating investigations and audits of Medicaid providers. AHCA is not only authorized to conduct random audits; AHCA is required to conduct at least five percent of its audits on a random basis.

10. In this instance, in early 2010, some question about Respondent's billings arose from a cursory review by the AHCA field office in Respondent's area. The nature of the field office's review or question about Respondent's billings was not established, but is not material, as it is only germane as background explanation of how this matter arose. The result of the area office's question about Access Road's billings was that the MPI Bureau decided to conduct an audit investigation of Respondent, as it is authorized to do, and a referral was made to MPI investigator Kristin Koelle.

11. The purpose of the Medicaid audit was to verify that claims for which Respondent has already been paid by the Medicaid program were for services that were provided, billed, and documented in accordance with Medicaid statutes, rules, and

provider handbooks. While Respondent certifies with each claim submission that the claim is proper and that all records required to be maintained in support of each claim are in fact being maintained, the audit goes behind that certification by actually reviewing those records.

12. In setting the audit period, AHCA has up to a four-year range. The end point is set by going back at least one year, since providers have one year to submit and adjust claims. The beginning point is set no more than five years back, which is the record retention period. In this case, within the allowable four-year range, AHCA chose two years, January 1, 2007, through December 31, 2008.

13. The next step in the audit process is to determine the population of recipients and claims for which records will be requested for review. When AHCA 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. (2007).[3/]

14. The audit methods used depend 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 for each recipient, there are not many claims, such as might be the case for a hospital provider, then AHCA 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.

15. Alternatively, where there are too many claims to review all of the claims for each recipient or to review 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 and then random samples of the claims for the sample group of recipients are selected.

16. Because of the extremely high volume of claims generated by Respondent during the audit period, Ms. Koelle determined with her supervisor that a two-stage cluster sampling methodology would be used. AHCA utilizes a computer program to carry out the random sampling selection once the method is chosen, so Ms. Koelle was able to select the two-stage cluster sampling method and, with the provider number and audit period, the computer drew from the claims database to make the random selection of the samples to be reviewed.

17. As a general target, AHCA considers 30 recipients to be a reasonable sample size for the first stage of two-stage cluster sampling. This target sample size assumes that there are many more than 30 recipients. Since Access Road only served 16

recipients over two years, the computer selected all 16 recipients for review.

18. AHCA's expert credibly explained that while a selection of all recipients is an unusual application of the concept of random sampling, it is an appropriate result that comports with the technical meaning of random sample: a sample chosen whereby all possible samples of the same size are equally likely to have been chosen. Thus, AHCA's expert opined that this audit involved an entirely correct and reasonable, albeit atypical, application of two-stage cluster sampling.[4/] Given that AHCA's standard rule of thumb is to include 30 recipients in the "sample" group, it is apparent that what is atypical here is that the provider served only 16 Medicaid recipients over the audit period. Given the small number of recipients served, review of all 16 recipients was feasible and could only increase the reliability of AHCA's review, as AHCA's expert confirmed.[5/]

19. It was not feasible, however, to review all 12,927 claims generated by those 16 recipients, nor, presumably, would Access Road want to have been burdened with producing all records to support its 12,927 claims. As a general target, AHCA considers samples of between five and 15 claims, per recipient, to be reasonable sample sizes for the second stage of two-stage cluster sampling. Accordingly, the computer selected 219 claims,

representing between five and 15 claims for each recipient in accordance with AHCA's standard.

20. AHCA's expert opined that the sampling method used in this case was reasonable and comported with generally accepted statistical methods. His opinions and explanation were credible, were unrebutted, and are accepted. Respondent's attempt to undermine the expert's opinions, through cross-examination and argument in Respondent's PRO, was ineffective and lacked the support of contradictory expert testimony regarding generally accepted statistical methods.

21. By letter to Access Road dated May 11, 2010, AHCA requested copies of all documentation supporting the 219 claims that were the sample group of claims for the 16 recipients. Access Road also was asked to produce specified staff records, to document that the individuals providing the services represented by the 219 claims were qualified to do so and had met background screening requirements. With its production, Access Road was required to execute a certificate of completeness attesting that all supporting documentation for the 219 claims had been produced.

22. The May 11, 2010, letter stated that the documentation was due within 21 days from the letter's receipt, but added that Access Road should submit the documentation and certificate of

completeness "within the requested timeframe, or other mutually agreed upon timeframe."

23. Respondent did not request a different deadline. Instead, Respondent sought clarification of the documentation that had to be produced and then sent a package with documentation and a certificate of completeness, by which Respondent certified to AHCA that all documentation to support the specified billings was included.

24. Ms. Koelle contacted Access Road after reviewing the documentation, because she was unable to determine from what was submitted that all staff were qualified or had undergone background screening. Ms. Koelle allowed Access Road additional time to submit any further documentation to address the omissions she had identified.

25. After the additional time for staff-related documentation, Ms. Koelle conducted her audit of the 219 claims. Ms. Koelle assessed the documentation for each claim by reference to the requirements in Medicaid provider handbooks, as well as the specific service authorizations and support plan goals for each recipient. Each of the 219 claims was either allowed, denied, or adjusted to reduce the amount of the claim for reasons set forth in detailed audit work papers.

26. Ms. Koelle input the audit results on the 219 claims--approved, denied, or adjusted--into the computer that was

programmed to carry out the two-stage cluster sampling methodology by extending the results of the claims sample reviewed to the entire claims population. The result was a preliminary audit determination that Respondent had been overpaid $219,810.12.

27. The results of Ms. Koelle's review were summarized in a Preliminary Audit Report (PAR). The reasons for the denied and adjusted claims were grouped in two broad categories: (1) incorrect, illegible, or insufficient documentation; and (2) overbilling leading to overpayment. The first category included claims for services provided by ineligible or unqualified staff, claims for services with no documentation, and claims for services for which no activities were documented on a service log. The second category included claims for which the number of units of service billed was not supported by the documented activities, claims that billed for more units of service than were documented, and claims for services and activities beyond the scope of services authorized in the recipient's support plan or service authorization.

28. The PAR and the audit work papers were sent to Respondent on June 22, 2010. Respondent was advised that additional documentation could be submitted by a specified deadline in support of claims identified as overpayments. However, in bold print, the PAR warned Respondent that while any

additional submittals would be reviewed and could change the treatment of claims, "additional documentation may be deemed evidence of non-compliance with the Agency's initial request for documentation in which [Respondent was] required to provide all Medicaid-related records. Sanctions for this non-compliance will be imposed."

29. Respondent submitted additional documentation by the specified deadline. Ms. Koelle repeated the process of reviewing the new submittals, and in some instances, approving claims that were preliminarily denied. Ms. Koelle repeated the process of inputting the revised determinations into the computer, which repeated the extension of the overpayments within the sampled claims to the entire claims population for the 16 recipients. The result was a reduced overpayment determination, which was set forth in the FAR, of $159,741.86.

30. The reasons for the denied and adjusted claims were grouped in the same two categories and included the same problem areas that had been summarized in the PAR. The FAR determined that a total of 55 claims, representing 25.11 percent of the sample group of claims, were denied, in whole or in part, for documentation deficiency reasons (the first category); and an additional 16 claims, representing 7.31 percent of the sample claims reviewed, were denied, in whole or in part, due to overbilling (the second category). In total, nearly one-third--

71 of the 219 claims reviewed--were found in the FAR to involve overpayments.

31. As Respondent was warned, the production of additional documentation after the PAR resulted in the FAR's imposition of a $1,000 fine for failing to provide all Medicaid-related records within the timeframe requested in the May 10, 2010, records request. The FAR also imposed a fine of $2,500 for Respondent's failure to follow Medicaid laws, rules, and provider handbooks.

32. Petitioner submitted in evidence the FAR and the audit work papers standing behind the FAR's determinations, including Ms. Koelle's worksheets stating the reasons for denying or adjusting specific claims and the provider documentation that was submitted and available for review of the claims that were adjusted or denied.

33. At hearing, Respondent did not offer any evidence or testimony to refute or impeach the audit findings or to supplement the documentation relevant to the denied or adjusted claims beyond what was provided in Petitioner's audit work paper exhibits.

34. In its PRO, Respondent presented argument disputing the findings on 15 claims for eight recipients. Thus, Respondent presented no evidence and no argument to refute AHCA's overpayment determinations for 56 of the 219 claims reviewed.

The disputed claims, audit findings, and Respondent's argument are summarized below.

35. Recipient No. 1, Claim 5: This claim was for 20 units of service (5 hours) for personal care assistance on December 10, 2007. The claim was denied based on insufficient documentation, "no activities documented on service log." Respondent's PRO argues that the audit work papers only include a service log for the week that included December 10, 2008, whereas the documentation for this claim would have been on a different service log for December 10, 2007. However, Respondent failed to offer in evidence a service log covering December 10, 2007, which Respondent claims would have documented that personal care assistance was provided on December 10, 2007, as would be necessary to rebut Petitioner's audit findings of insufficient documentation. It is possible that the service log in the audit work papers was dated incorrectly, or it may be that there was no other service log with an entry for December 10, 2007. Regardless, there is no evidence of sufficient documentation for this claim.

36. Recipient No. 1, Claim 6: This claim was for four units of respite care service on January 7, 2008. The claim was denied because there was no service log. Ironically (juxtaposed with the last challenge), Respondent asserts that a service log in the audit work papers for the week ending January 13, 2007, is

the correct service log, but that it was dated incorrectly. Even if Respondent's assertion (not supported by any testimony or evidence) is correct, Respondent overlooks the fact that the misdated service log would support Petitioner's denial of Claim 6, because that service log has no respite care entry on January 7, 2007. Therefore, either because there is no service log at all for January 7, 2008, or because the service log for January 7, 2007, contains no respite care hours, Claim 6 was properly denied.

37. Recipient No. 1, Claim 7: Claim 7 was for four units of respite care service on January 25, 2008. The claim was denied, again because there was no service log. A service log in the work papers for the week including January 25, 2008, shows zero hours of respite care on January 25, 2008, but four hours of respite care each on January 26 and 27, 2008, which was all the respite care authorized for the week. Respondent claims in its PRO, with no supporting documentation or testimony, that there was a clerical error. According to Respondent's PRO assertion, respite care was provided to Recipient No. 1 on Friday, January 25, 2008, as billed, but was incorrectly recorded on January 26, 2008. But Respondent's PRO assertion is not evidence and cannot be the basis for a finding of fact. The fact remains that Respondent billed Medicaid for respite care services provided on January 25, 2008, and was paid for those services,

but there is no documentation that the services were provided. Moreover, no evidence was offered to show that Respondent was not paid for all of the documented respite care hours on January 26, 2008, which Respondent now claims were not all provided that day.

38. Recipient No. 2, Claim 8: Respondent billed Medicaid for 28 units (seven hours) of companion care services on February 10, 2008. The claim was adjusted by disallowing 14 units of service, based on the finding that the documentation does not support the number of units of service billed. The only documentation describing the companion care services provided was the following statement signed by the provider: "Today we went to the Library. She was very happy looking at different magazines and to [sic] different books. She was seating [sic] for a while watching the books." Respondent argues in its PRO that Petitioner arbitrarily reduced the claimed units, because the documentation is sufficient to establish the activity, even if all things done at the library were not listed. However, AHCA reasonably found excessive a claim for seven hours at a library to look at magazines and books, absent more detail and more information, which Respondent failed to provide by way of testimony or documentary evidence. Respondent's arguments that the documentation was "sufficient to establish the activity" and the reduction was "arbitrary," are not evidence to refute the contrary finding that the units billed were excessive.

39. Recipient No. 2, Claim 15: This claim was for eight units of personal care assistance on October 16, 2008. The claim was denied due to lack of a service log. Respondent points out that there is a service log, showing two hours (eight units) of personal care assistance on October 16, 2008. However, there is an unexplained anomaly on this service log. The service log is filled out, in part, by typewriting and, in part, by handwriting. Typewritten in the blank for the total number of personal care assistance hours for the week was ten hours, but in handwriting, the "0" was changed to a "2," changing the total to 12 hours. The daily entries, all typewritten, add up to 12 hours. Therefore, AHCA could reasonably question this claim, without explanation of the service log anomaly. If the total hours of personal care assistance that week was actually ten, it may be that the entry of two hours for October 16, 2008, was not done contemporaneously with the service, but, rather, at the end of the week when the document was signed, and it became apparent that there was a shortage of personal care assistance hours that week. While bad motives are not attributed to Respondent or to the individual caregiver who completed the form, the anomaly on the form is sufficient to support Petitioner's audit finding, and Respondent has failed to rebut that finding with evidence explaining the anomaly in the documentation.

40. Recipient No. 3, Claim 12: This claim was for 20 units (five hours) of respite care service on June 20, 2008. The claim was denied based on a finding of no documentation to support the billing. The service log for that week shows zero hours of respite care on June 20, 2008, a Friday. Five hours of respite care was provided on each weekend day, for a total of ten hours, which was all that was authorized. Respondent argued in its PRO that this was another clerical error, and the amount billed is documented under June 21 and June 22, 2008. Once again, however, Respondent provided no testimony or evidence to support this assertion. Once again, the fact remains that Respondent billed Medicaid for respite care services provided on June 20, 2008, and was paid for those services, but there is no documentation that they were provided. And once again, Respondent failed to prove that it was not reimbursed for the claimed respite care on the days on which Respondent now claims the service was not actually provided.

41. Recipient No. 6, Claim 5: Respondent billed Medicaid for four units of companion care service on May 15, 2008. This claim was denied because the documented activities billed under companion care--meal preparation and washing dishes--were unauthorized by the support plan for companion care services. Respondent argued in its PRO that teaching a recipient meal preparation is a "meaningful activity." However, the issue is

not whether it is "meaningful," but whether it is an authorized activity as part of the companion care service authorization. According to the support plan, the recipient was also authorized to receive personal care assistance. Personal care assistance was authorized to maintain the recipient's hygiene and help with his personal care needs. Companion care was authorized to give the recipient meaningful days to visit places and make new friends. Meal preparation and washing dishes fall within the personal care assistance category and not within the authorized companion care, as described in the support plan. This claim was properly denied.

42. Recipient No. 9, Claim 12: This claim was for 24 units of companion care service on May 14, 2008. The claim was adjusted, allowing three hours instead of the six hours claimed, based on a finding that the documentation did not support the number of units billed. The only documentation describing what was done in this six-hour period was "parks," with no additional detail or information to justify the amount of time claimed. With the absence of detail, AHCA reasonably found that a six-hour claim for "parks" was excessive. Respondent argued in its PRO that the activity is appropriate, and the number of units billed is in line with the service. Respondent presented no evidence to establish the facts or opinions argued in its PRO. Respondent's

unsupported assertions are not evidence to refute the contrary finding that the claim was excessive.

43. Recipient No. 14, Claim 1: This claim was for 16 units of non-residential support services on January 2, 2007. The claim was denied on the basis of insufficient documentation, as there was no daily progress note. Respondent argues that the weekly service log is sufficient documentation. The service log for the week including January 2, 2007, shows that non-residential support services were provided from 8:00 a.m. to 12 noon on three consecutive days--January 1, 2, and 3, 2007. No information is provided regarding the activities done each day. Instead, a single-block description is provided, presumably of all activities done over the three-day, 12-hour period. The description was:

a. Get in order all of his money
b. Get in order gift certificates
c. [Illegible]ing money

The support plan goals for non-residential support services for this recipient were to help the recipient learn the value of money, learn to make purchases, and pay for them. Respondent argues in its PRO that the activities summarized above for the three-day period are "geared toward the recipient's stated goals[.]" While that is apparently true, the summary is inadequate to justify the claim for four hours each day for a three-day period. As Petitioner notes in the audit, there should

be daily progress notes specifying what was done each day. Indeed, daily progress notes are required by the Developmental Disability Waiver Services Coverage and Limitations Handbook (Waiver Handbook). See Waiver Handbook, Ch. 2-55, Non-Residential Support Services, Documentation Requirements, No. 5 ("Daily progress notes for each day services were provided.").

44. Recipient No. 15, Claim 9: Respondent billed Medicaid for 32 units (eight hours) of companion care services on May 10, 2008. AHCA adjusted the claim to allow 14 units of service. AHCA denied 16 units of service because the documentation did not support the amount billed. Two units of service were denied for time spent doing laundry, an unauthorized activity for companion care. The service log showed that on May 10, 2008, companion care was recorded from 11 a.m. until 7 p.m., a total of eight hours. In addition, another four hours were logged for personal care services, described as shampoo, bathroom cleaning, bedroom cleaning, and laundry. The description of the companion care services for that day was "restaurant" and "laundry."

45. Respondent argued in its PRO that the claim was directly connected to the goals for recipient no. 15, which include activities to reduce depression and avoid suicidal tendencies. However, Respondent failed to address the points made in the audit--that the documentation does not support the number of units of service claimed and that laundry is an

authorized activity for personal care assistance, not companion care. Petitioner's auditor reasonably found that eight hours for "restaurant and laundry" were excessive, and, indeed, Petitioner was generous in allowing three and one-half hours for "restaurant," while disallowing only one-half hour billed as companion care for doing laundry. The claim was properly adjusted; Respondent offered no evidence or argument to the contrary.

46. Recipient No. 16, Claims 3, 4, 5, 7, and 8: These claims were each for 12 units of companion care services on different days. Each of these claims was adjusted by subtracting one unit of service from the 12 units claimed, because the documentation showed that an unauthorized activity--feeding--was included. The applicable support plan authorized companion care services for the following goals: "Wants to have meaningful days and socialize as well as buy things of his interests; Wants to go to the library to get videos." The recipient was also authorized for personal care assistance provided by a different provider (not Respondent) to meet the following goal: "Wants to be helped with his personal care needs." Respondent argued in its PRO that the recipient needs to be fed through a bag and learn how to perform personal care, so these are activities for which he needs assistance. Respondent's argument, unsupported by any testimony or documentary evidence, misses the point. The recipient was

indeed authorized to receive "help with his personal care needs," but the authorized service for that activity was personal care assistance, not companion care, to be provided by a different provider, not Respondent. Respondent failed to refute the finding that the claims included an unauthorized activity. Petitioner reasonably adjusted these claims by deducting one unit of service from each claim.

Petitioner's Costs

47. Petitioner presented an exhibit at hearing, updated after the hearing, setting forth its investigative and expert witness costs. Respondent did not object to or dispute the reasonableness of Petitioner's documented costs. Through the final hearing, Petitioner's total investigative and expert witness costs were $4,087.19.

48. Respondent took the opportunity offered to respond or object to Petitioner's updated cost submittal, but Respondent's response did not actually respond or object to Petitioner's updated costs. Instead, Respondent asserted that an offset should be applied to reduce any award of Petitioner's costs by what would be, in effect, a discovery sanction.

49. Respondent's request for an offset is based on the apparent fact that in pre-hearing discovery, counsel for Petitioner agreed to make AHCA's expert witness available for deposition in Tallahassee. Although the expert witness appeared

for his deposition, he had not yet reviewed the case material because the file had not yet made its way into his hands. Counsel for Respondent traveled to Tallahassee for the deposition and for business of other clients. After the deposition, counsel for AHCA expressed his apologies, and although he could not commit, he stated he would attempt to get some cost reimbursement for Respondent. Apparently, that never happened.

50. Respondent now seeks recovery of costs for attending a deposition that had to be rescheduled after AHCA's expert witness was better prepared. Even if Respondent had timely filed a motion shortly after this occurrence for costs imposed as a discovery sanction, Respondent offers no authority for ordering reimbursement of costs under these circumstances. Respondent could have subpoenaed the expert and the necessary documents for deposition; Respondent could have asked for entry of an order of pre-hearing instructions to impose requirements on expert witness discovery; Respondent took none of these steps. No subpoena was violated; no pre-hearing order was violated; no rule of civil procedure for discovery was violated.

CONCLUSIONS OF LAW

51. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2011).

52. The statutes and rules in effect during the period for which services were provided govern 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). This includes the provider handbooks pertinent to this case: the Medicaid Provider General Handbook, and the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, which are promulgated as rules.

53. AHCA is empowered to "recover overpayments . . . as appropriate." § 409.913. 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).

54. Payments are not "authorized to be paid by the Medicaid program" when the provider has not complied with section 409.913(7), which at all times material to this case provided, in pertinent part, as follows:

> 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.
>
> (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.

55. Recoupment of overpayments is one remedy that AHCA is authorized to seek to remediate proven charges under what, in 2007, was section 409.913(15). Colonnade Med. Ctr., Inc. v. Ag. for Health Care Admin., 847 So. 2d 540 (Fla. 4th DCA 2003)(confirming AHCA's authority to recover overpayments to remediate proven charges under what was then section 409.913(14)). Section 409.913(15) provided, in pertinent part, as follows:

> The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections (13) and (16) and s. 812.035, 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.

56. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on Petitioner. 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 is by clear and convincing evidence. Dep't of Banking and Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

57. Although AHCA bears the ultimate burden of persuasion and, thus, must present a prima facie case, section 409.913(20) provides that "[i]n meeting its burden of proof . . ., the agency may introduce the results of [generally accepted] statistical methods as evidence of overpayment." In addition, section

409.913(22) provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, AHCA can make a prima facie case by proffering a properly-supported audit report, which must be received in evidence. See Maz Pharm., Inc. v. Ag. for Health Care Admin., Case No. 97-3791 (Fla. DOAH Mar. 20, 1998; Fla. AHCA June 26, 1998); see also Full Health Care, Inc. v. Ag. for Health Care Admin., Case No. 00-4441 (Fla. DOAH June 25, 2001; Fla. AHCA Sept. 28, 2001).

58. If AHCA makes a prima facie case as outlined by the statute, then it is "incumbent upon the provider to rebut, impeach, or otherwise undermine AHCA's evidence." Ag. for Health Care Admin. v. Bagloo, Case No. 08-4921, RO at p. 33 (Fla. DOAH Sept. 10, 2009; Fla. AHCA Nov. 8, 2010).

59. For the reasons set forth in the Findings of Fact above, the undersigned concludes that AHCA made a prima facie case by presenting its properly-supported audit report, including work papers. AHCA's overpayment calculation was based on generally accepted statistical methods, properly applied to this provider.

60. The kind of cluster sampling method used in this case was approved as a means to carry out the requirements of section 409.913(20) in Agency for Health Care Administration v. Custom Mobility, Inc., 995 So. 2d 984, 986-987 (Fla. 1st DCA 2008). The

court described the types of statistical sampling methodologies contemplated by that statute as follows:

> Statistical sampling methodologies are used to permit the auditors to analyze a random sample from the population of Medicaid recipients and/or claims, determine the findings in the sample, and extend the sample findings to the population of recipients and/or claims. (emphasis added).

Id. at 985.

61. Respondent improperly attempted to undermine AHCA's evidence with facts not supported by any testimony or documentary evidence, but, rather, only with assertions in Respondent's PRO. For the reasons set forth in the Findings of Fact, Respondent failed to effectively rebut, impeach, or otherwise undermine AHCA's evidence.

62. By presenting prima facie evidence of the overpayment, which was not rebutted by Respondent, Petitioner met its ultimate burden of proving that Respondent has received overpayments in the total amount of $159,741.86, which is subject to recoupment. Pursuant to section 409.913(25)(c), the overpayment bears interest at the rate of ten percent per annum from the date of determination of the overpayment.

63. Section 409.913(16)(c) provided at all times material to this case, that AHCA "shall impose any of the following sanctions . . . on a provider or a person for any of the acts

described in subsection (15): . . . Imposition of a fine of up to $5,000 for each violation."

64. Rule 59G-9.070 was promulgated in 2005 to provide notice regarding how AHCA would normally exercise its sanction authority and to set forth guidelines for imposition of sanction types and amounts.

65. The FAR imposed a fine of $1,000 pursuant to rule 59G-9.070(7)(c) based on the act described in section 409.913(15)(c) (failure to furnish all Medicaid-related records within the timeframe requested by the Agency or other mutually agreed-upon timeframe). Respondent was warned in the PAR that such a fine would be imposed if additional documents were submitted after Respondent had certified that all documents had been provided.

66. The guidelines for sanctions in the version of rule 59G-9.070(10), in effect at the time Respondent committed the act described in section 409.913(15)(c), provided for imposition of a fine of $1,000 per record request for a provider's first violation. There is no question that Respondent failed to furnish all Medicaid-related records within the timeframe requested by AHCA in its initial records request, because Respondent provided additional records in response to the PAR.

67. The FAR also imposed a fine of $2,500 pursuant to rule 59G-9.070(7)(e), for the acts described in section

409.913(15)(e)(failure to comply with Medicaid laws, rules, and handbooks). The version of the guidelines rule in effect when most of the claims were submitted[6/] provided, in the case of first offenders, for imposition of a fine of $1,000 per violation, not to exceed $3,000 per agency action for a "pattern" of acts.

68. A "pattern" is defined in the applicable rule as when the number of individual claims found to be in violation is greater than 6.25 percent of the total claims that were reviewed to support the agency action. Fla. Admin. Code R. 59G-9.070(2)(s)2.a.

69. Petitioner clearly and convincingly established that substantially more than 6.25 percent of the 219 claims reviewed did not comply with requirements of Medicaid laws, rules, and provider handbooks. Numerous requirements were not followed, as detailed in the FAR, ranging from documentation of services to authorization for services, to qualifications of staff providing services, to eligibility of staff based on background screening. Respondent did not attempt to dispute the findings on 56 of the 219 claims reviewed, which alone is over 25 percent. Petitioner's proposed fine of $2,500 is within the permissible range for Respondent's patterned failure to comply with Medicaid laws, rules, and provider handbooks.

70. The sanctions statute and rule both acknowledge that the AHCA Secretary "may make a determination that imposition of a

sanction or disincentive is not in the best interest of the Medicaid program, in which case a sanction or disincentive shall not be imposed." The AHCA Secretary did not make such a determination prior to issuance of the FAR.

71. Respondent complains that there is no procedure established for the AHCA Secretary to review audit reports to make such a determination. However, the statute does not require a procedure for the agency head to review audit reports, nor would such an undertaking be possible.

72. Respondent could have taken the opportunity presented by this case to offer evidence demonstrating why and how imposition of fines would not be in the best interest of the Medicaid program, but Respondent offered no such evidence. The record fails to establish that imposing fines within the applicable guidelines in this case would not be in the best interest of the Medicaid program. Hence, this record does not support the AHCA Secretary's exercise of discretion to waive the fines.

73. Based on the recommendations herein, AHCA would be considered to have ultimately prevailed in this dispute, and, as such, is entitled to recover its costs, which were found to be $4,087.19. § 409.913(23)(a). Respondent is not entitled to any offset, having failed to show any legal basis to award what would be, in effect, a discovery sanction as an offset to statutory

costs and having failed to establish any acts or omissions that would warrant sanctions.

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 Juana Rodriguez, d/b/a Access Road, Inc.:

(1) To repay the sum of $159,741.86, 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 $159,741.86 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;

(4) To pay a fine of $2,500 for the patterned violations of the requirements of Medicaid laws, rules, and provider handbooks; and

(5) To pay $4,087.19 to reimburse Petitioner for its costs.

DONE AND ENTERED this 26th day of March, 2012, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of March, 2012.

ENDNOTES

[1/] Mr. Porter's retirement from AHCA coincided with his early submission of AHCA's Proposed Recommended Order in this case on January 26, 2012. Thereafter, Ms. Smith entered her appearance in substitution for Mr. Porter.

[2/] No record explanation was given for the delay in transmitting this case to DOAH. However, according to Respondent's preliminary statement in its Proposed Recommended Order, the procedural background of this case included the following: this matter previously had been transmitted to DOAH where a case was initially opened; thereafter, jurisdiction was relinquished to AHCA; and AHCA later determined to re-transmit the matter to DOAH when this case was opened. Neither party presented any evidence regarding, or requested official recognition of, that first DOAH case, and, therefore, no findings of fact can be made regarding the first DOAH case.

[3/] Unless otherwise stated, all statutory references herein are to the Florida Statutes (2007), the law in effect at the time of the services and claims at issue. It is noted that section 409.913 was not amended in 2007 and only paragraph (36), which is not material to this case, was amended in 2008. Therefore, the

2007 statute reflects in all material respects the law in effect for all of 2007 and 2008.

[4/] Dr. Huffer explained that the atypical application of the two-stage cluster sample methodology in this audit--where the random sample of recipients in the first stage ended up being all of the recipients--made this methodology "exactly equivalent to" a stratified random sampling method. In a stratified analysis, sampling is selected from all of the strata, so if the 16 recipients are thought of as strata, then the technique used in this case is "exactly the same as stratified random analysis." Dr. Huffer's testimony, and demonstrative exhibit illustrating his testimony, established that the "atypical" application of two-stage cluster sampling is actually the equivalent of stratified random analysis and both are generally accepted statistical methods. Respondent acknowledged in its PRO that stratified random sampling would be a proper methodology to use in this case. Respondent argued that this technique was not used and relied on one statement by Dr. Huffer, which in context was plainly a misstatement on his part, that the technique applied in this case is "atypical of stratified random sampling." Considering Dr. Huffer's testimony as a whole, it is clear that Dr. Huffer misspoke in this single instance, when he meant to say "atypical of two-stage cluster sampling." Other than that one statement, Dr. Huffer consistently testified, and illustrated in formulaic fashion, that while the application of two-stage cluster sampling in this case was atypical (but reasonable), it was "exactly equivalent to," "exactly the same as," "[i]t is stratified random sample." (emphasis added).

[5/] Respondent argued in its PRO that the selection of all 16 recipients was improper, because the "rule for choosing sample size is: not less than five and not more than fifteen." However, Respondent was confused with the rule of thumb for selecting the sample size of claims to review, which Dr. Huffer testified was between five and 15. A different rule of thumb applies to selecting the recipient sample size: 30 recipients. Relying on the wrong rule of thumb, Respondent argued that by using a larger than typical sample size of recipients, the result would be overstating the overpayment. Not only is the premise of Respondent's argument wrong, but, also, no evidence was presented to establish the claimed result even if the premise had been correct. Neither part of this two-part argument was established.

[6/] Rule 59G-9.070 was amended effective October 29, 2008, to increase the amounts of fines in the guidelines. Since most of the claims in 2007 and 2008 were before the effective date, the

rule version preceding that amendment has been applied to the claims-based violations. However, the 2008 rule amendment was applied to the fine for Respondent's failure in 2010 to provide all Medicaid-related records within the requested timeframe.

COPIES FURNISHED:

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
Fort Knox Building, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308

William H. Roberts, Acting General Counsel
Agency for Health Care Administration
Fort Knox Building, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308

Nancy Pico Campiglia, Esquire
Keating and Schlitt, P.A.
250 East Colonial Drive, Suite 300
Orlando, Florida 32801-1231

Beverly H. Smith, Esquire
Agency for Health Care Administration
Fort Knox Building, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308-5403

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.