STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

A+ THERAPY, INC.,

Respondent.

Case No. 12-0692MPI

RECOMMENDED ORDER

A final hearing was conducted in this case on May 10, 2012, pursuant to sections 120.569 and 120.57(1), Florida Statutes (2011), before Jessica E. Varn, an Administrative Law Judge of the Division of Administrative Hearings (DOAH). The hearing was held by video teleconference at sites in Lauderdale Lakes and Tallahassee, Florida.

APPEARANCES

For Petitioner: Rachic Avanni Wilson, Esquire
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For Respondent: Erin M. Bengele, Esquire
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STATEMENT OF THE ISSUE

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 Respondent's Medicaid billing for the period of January 1, 2009 through December 31, 2009, the Agency for Health Care Administration (AHCA) issued a Final Audit Report (FAR) on January 2, 2012. In the FAR, AHCA concluded that Respondent, A+ Therapy, Inc. (A+ Therapy), received $152,529.46 in Medicaid overpayments. The FAR informed A+ Therapy that AHCA intended to recoup the overpayment, impose a fine of $24,976.91, and seek recovery of its costs as authorized by statute.

A+ Therapy timely requested an administrative hearing to contest the FAR, and on February 17, 2012, this case was forwarded to DOAH for the assignment of an Administrative Law Judge to conduct the requested hearing. The hearing was scheduled for May 10, 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 outset of the final hearing, AHCA announced that the alleged overpayment had been reduced to $119,023.94, and the fine

had been recalculated to be $23,804.79. AHCA presented the testimony of Robi Olmstead, an AHCA administrator in the Bureau of Medicaid Program Integrity (MPI); and Tracy MacDonnell, an AHCA Medical Health Care Program Analyst in the Bureau of Medicaid Program Integrity. AHCA's Exhibits 1-16 were admitted by stipulation. The stipulated exhibits included pertinent sections of Florida Statutes, Florida Administrative Code rules, and Medicaid provider handbooks incorporated by reference in rules, for the year in which the alleged overpayments were made. Official recognition was taken of these submissions, without objection. The parties also agreed to allow AHCA 7 days after the hearing to file its final calculation of costs.

A+ Therapy presented the testimony of Susan Marquez, the owner of A+ Therapy; and Michael Sloan and Jaime Correa, two therapists with A+ Therapy. Respondent's Exhibits 1-7 were admitted by stipulation. The parties agreed to allow 20 days after the filing of the Transcript to file Proposed Recommended Orders (PRO). The two-volume Transcript was filed on May 31, 2012, and both parties timely filed PROs on June 20, 2012. The PROs have been considered in the preparation of this Recommended Order.

Unless otherwise indicated, all statutory references are to the 2009 codification, which was in effect at the time of the alleged overpayment.

FINDINGS OF FACT

1. AHCA is the state agency responsible for administering the Medicaid program in Florida. The Medicaid program is a federal and state partnership that provides health care services to certain qualified individuals.

2. At all times material to this case, A+ Therapy has been a Medicaid provider rendering therapy services, pursuant to a Medicaid Provider Agreement with AHCA. A+ Therapy's Medicaid provider number is 886486100. A+ Therapy provides physical, occupational, and speech therapy to pediatric patients.

3. A+ Therapy is required to retain Medicaid records that support services provided to Medicaid recipients, and to timely provide those records to AHCA upon request.

4. Medicaid policy requires that all services reimbursed by Medicaid must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner (ARNP) or a designated physician assistant (PA), or a designated physician specialist. Services rendered prior to a prescription being received are not reimbursable.

5. Medicaid policy requires that all therapy services reimbursed by Medicaid must have an individualized plan of care developed by the therapist for a recipient. The plan of care must include the elements as described in the Therapy Services Coverages and Limitations Handbook. A plan of care should be

approved by the medical provider prior to services being provided.

6. Medicaid policy requires that therapy services be recorded on a per treatment basis and that therapist rendering the services must record the time period and type of service rendered, the progress achieved and the change in the recipient's status due to treatment. Each entry must be signed and dated by the Medicaid enrolled treating provider contemporaneous to the date the service is rendered.

7. Medicaid policy specifies that to be reimbursable, services must be medically necessary.

8. The audit in the instant case was initiated because in running what is commonly called "time bandits", AHCA discovered that A+ Therapy was billing an unusually high number of services.

9. When AHCA audits a possible overpayment, 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 populations . . . and other generally accepted statistical methods." § 409.913(20), Fla. Stat.

10. AHCA uses a sample cluster program in cases where it is impractical to review all claims for each recipient or all claims for a sample group of recipients. In this case, a two-stage cluster sample first identified a statistically valid random

sample of recipients. Then, a statistically valid random sample of claims billed by the provider during the corresponding audit period was selected.

11. On May 11, 2011, Tracy MacDonell, the AHCA Medical Health Care Program Analyst assigned to investigate this case, sent A+ Therapy a letter, notifying A+ Therapy that an audit was being conducted, and requesting all records for the list of recipients and dates of service that had been randomly selected from the cluster sample program.

12. A+ Therapy collected and sent records to AHCA on May 26, 2011.

13. After a review of all the records sent, Ms. MacDonell prepared a Preliminary Audit Report (PAR) dated October 14, 2011. The PAR gave A+ Therapy the option of providing more records, which A+ Therapy did on November 1, 2011.

14. AHCA reviewed the additional records sent, and made adjustments to the overpayment amount. AHCA issued a FAR on January 4, 2012, after the cluster sample program took the randomly selected claims and extrapolated those claims to the universe of all claims in the audit period and generated a total overpayment amount of $152,529.46. A fine of $24,976.91 was also being imposed, and costs were incurred in the amount of $2,668.00.

15. The parties stipulated that A+ Therapy provided all services billed through Medicaid.

16. AHCA contends, however, that A+ Therapy has: (1) provided therapeutic services without a prescription; (2) provided services without an individualized plan of care; (3) failed to properly record the therapeutic services on a per treatment basis; and (4) as to one recipient, provided services that were not medically necessary.

17. As to the allegation that one recipient, T.F., received services that were not medically necessary, A+ Therapy concedes that the services were not medically necessary.

18. As to the allegation that proper documentation was not kept by A+ Therapy, the undersigned finds that A+ Therapy did comply with Medicaid policy by using two forms for each date of service, and for each treatment provided. For each recipient, A+ Therapy had narrative forms, where the therapist would list each date of service, and provide a S.O.A.P. (S=Subjective, O=Objective, A=Assessment, P=Plan) note for the dates of service. The treating therapist signed and dated each S.O.A.P. note. The second form contained a chart, with each date of service listed, each type of service documented in 15-minute intervals, and the treating therapist's initials were placed on each date of service.

19. The records for all of the recipients that were reviewed for the audit contain proper documentation, in full compliance with Medicaid requirements.

20. As to the allegation that physical therapy services were provided before a prescription was received, A+ Therapy concedes that prescriptions were never received for recipients R.M., A.M., S.G., Y.U., and A.G., despite efforts to acquire the prescriptions from the medical provider. Accordingly, A+ Therapy improperly billed Medicaid for physical therapy for these four recipients.

21. As to the allegation that speech therapy services were provided before a prescription was received, A+ Therapy concedes that a prescription was never received for recipient A.M., despite efforts to acquire the prescription from the medical provider. Accordingly, A+ Therapy improperly billed Medicaid for speech therapy services provided to A.M.

22. As to the allegation that occupational therapy services were provided before a prescription was received, A+ Therapy concedes that a prescription was never received for recipient J.S., despite efforts to acquire the prescription from the medical provider. Accordingly, A+ Therapy improperly billed Medicaid for occupational therapy services provided to J.S.

Contested Overpayments

23. Recipient A.C.: A prescription dated August 25, 2009 was followed by a plan of care that was created on September 1, 2009. It was not signed by the treating medical provider until October 9, 2009. Services were provided on September 8, 11, and 16, 2009. Since the services were provided before the plan of care was signed and approved by the medical provider, these dates of service were improperly billed to Medicaid.

24. Recipient E.C.: The plan of care for physical therapy was signed but not dated; therefore, there is no evidence to establish that the plan of care was approved prior to the dates of service that were audited. Accordingly, A+ Therapy improperly billed Medicaid for the physical therapy services.

25. Recipient Mat. C.: Mat. C. received speech therapy services on June 10 and 15, 2009. The plan of care for speech therapy was not signed by the medical provider until August 25, 2009. Accordingly, A+ Therapy improperly billed Medicaid for the speech therapy services.

26. Recipient F.F.: A valid prescription for physical therapy was dated November 3, 2008, and although the plan of care is signed by the medical provider, it is not dated. Therefore, there is no evidence to establish that the plan of care was approved prior to the physical therapy services being provided. Accordingly, A+ Therapy improperly billed Medicaid for physical

therapy. For occupational therapy services provided to F.F., the prescription is dated November 21, 2008, and the plan of care was signed and dated by the medical provider on November 25, 2008. All of the audited dates of service for occupational therapy are subsequent to the plan of care having been approved; therefore, they do not constitute overpayments.

27. Recipient A.G.: As to occupational therapy, the plan of care is signed by the medical provider, but not dated. Therefore, there is no evidence to establish that the plan of care was approved prior to the treatments. Accordingly, all dates of occupational therapy services were improperly billed to Medicaid. As to the speech therapy provided to A.G., the prescription is dated May 20, 2009, and the only plan of care that is dated and signed by the medical provider is dated November 20, 2009. Occupational therapy services dated prior to that date were improperly billed to Medicaid; occupational therapy services provided after November 20, 2009, do not constitute overpayments.

28. Recipient D.G.: A plan of care for physical therapy was never signed or approved by a medical provider; therefore, the physical therapy services were improperly billed to Medicaid. As to occupational therapy, the plan of care was dated and signed on May 26, 2009, but there is no legible evidence of a prescription for occupational therapy. Accordingly, A+ Therapy

improperly billed for occupational therapy treatments. As to speech therapy, there is no legible evidence of a prescription for speech therapy; therefore, A+ Therapy improperly billed for speech therapy services.

29. Recipient S.G.: As to occupational therapy, the prescription is dated May 20, 2009, and the plan of care was approved by the medical provider on June 17, 2009. All occupational therapy treatments prior to June 17, 2009, were improperly billed to Medicaid; any occupational therapy treatments after June 17, 2009, do not constitute overpayments.

30. Recipient R.L.: As to speech therapy, the plan of care was signed and dated by the medical provider on August 7, 2009. All speech therapy provided on July 20 and 22, 2009, as well as on August 3, 2009, was improperly billed to Medicaid. As to occupational therapy, the plan of care was approved by the medical provider on July 23, 2009. The occupational therapy provided on July 22, 2009, was improperly billed to Medicaid. All occupational therapy provided after July 23, 2009, was properly billed to Medicaid.

31. Recipient J.M.: As to physical therapy, the plan of care was never approved by the medical provider; therefore, all physical therapy services audited were improperly billed to Medicaid. As to occupational therapy, the plan of care was approved by the medical provider on August 25, 2009. All

occupational therapy provided before August 25, 2009, was improperly billed to Medicaid. Occupational therapy provided after that date was properly billed to Medicaid. As to speech therapy, the plan of care is signed by a medical provider, but not dated. Accordingly, there is no evidence to establish when the plan of care was approved. All speech therapy services were improperly billed to Medicaid.

32. Recipient Jo.M.: As to physical and occupational therapy, there is no dated prescription or dated plan of care approved by the medical provider; therefore, all physical and occupational therapy treatments were improperly billed to Medicaid.

33. Recipient I.O.: As to occupational therapy, the plan of care was approved by the medical provider on September 10, 2009. All occupational therapy treatments provided prior to that date were improperly billed to Medicaid; all occupational therapy treatments provided after that date were properly billed to Medicaid. As to speech therapy, the plan of care was approved by the medical provider on August 13, 2009. Speech therapy provided on July 20, 2009, and on August 5, 2009, was improperly billed to Medicaid.

34. Recipient K.P.: As to occupational therapy, the prescription was dated March 5, 2008, and the plan of care approved on January 12, 2009. All occupational therapy provided

prior to January 12, 2009, was improperly billed to Medicaid. Any occupational therapy provided after January 12, 2009, was properly billed to Medicaid. As to physical therapy, the prescription is dated February 21, 2008, the plan of care approved on September 9, 2008. As all the audited dates of service fall in 2009, the physical therapy provided was properly billed to Medicaid.

35. Recipient J.S.: As to physical therapy, the prescription was dated November 11, 2008, but the plan of care was never approved by the medical provider. Therefore, all physical therapy treatments were improperly billed to Medicaid.

36. Recipient Y.U.: As to occupational therapy, the plan of care was approved by the medical provider on January 20, 2009. Any occupational therapy provided prior to that date was improperly billed to Medicaid; any occupational therapy provided after that date was properly billed to Medicaid.

CONCLUSIONS OF LAW

37. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes.

38. AHCA is empowered to "recover overpayments . . . as appropriate." § 409.913, Fla. Stat. 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).

39. Section 409.913(15) provides that AHCA may recoup overpayments and seek any remedy provided by law where:

> (c) The provider has not furnished or had 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;
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> * * *
>
> (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.

40. The Florida Medicaid Provider General Handbook, p. 2-44, states in relevant part:

> Medicaid requires that the provider retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient. Records can be kept on paper, magnetic material, film, or other media including electronic storage, except as otherwise required by law or Medicaid requirements. In order to qualify as a basis for reimbursement, the records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media. Rubber signatures must be initialed.

The records must be accessible, legible and comprehensible.

41. Regarding documentation for therapy services, the Therapy Services Coverage and Limitations Handbook, p.2-4, states:

> Documentation for authorization must include:
>
> * The evaluation and plan of care, reviewed, signed and dated by the primary care provider, ARNP or PA designee, or designated physician specialist and the therapist, and
>
> * A prescription for the therapy service that is in accordance with the prescription requirements in this chapter.

42. Regarding prescription requirements, the Therapy Services Coverage and Limitations Handbook, p 2-3, states:

> To be reimbursed by Medicaid, all therapy services, PT, OT, RT and ALP, must be prescribed by the recipient's primary care provider, an advanced registered nurse practitioner(ARNP) or a designated physician assistant (PA), or a designated physician specialist.
>
> * * *
>
> If the prescription has not been received before the service is rendered, Medicaid will not reimburse for the service.

43. Regarding plan of care requirements, the Therapy Services Coverage and Limitations Handbook, p 2-7, states:

> The plan of care must be reviewed, signed and dated by the therapist and by the primary care provider, ARNP or PA designee, or designated physician specialist who prescribed the therapy. The physician's

> signature indicates approval of the care plan. The physician must review, certify, and re-sign the renewed plan of care every one to six calendar months depending on the approved authorization period. This must be done before the end of the authorization period.

44. With regard to documentation of therapy services, the Therapy Services Coverage and Limitations Handbook, p 2-11, states:

> The therapist must record, on a per treatment basis the time period and type of services rendered, the progress achieved, and the change in the recipient's status due to treatment. Each entry must be signed and dated by the Medicaid enrolled treatment provider on the date the service is provided.

45. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on Petitioner. South Medical Serv., 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).

46. Although AHCA bears the ultimate burden of persuasion and thus must present a prima facie case, section 409.913(21) 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 Pharmaceuticals, Inc. v. Ag.

for Health Care Admin., DOAH Case No. 97-3791, 1998 Fla. Div. Adm. Hear. LEXIS 6245, *6-7 (DOAH March 20, 1998). It is then "incumbent upon the provider to rebut, impeach, or otherwise undermine AHCA's evidence." See Ag. for Health Care Admin. v. Bagloo, DOAH Case No. 08-4921 (DOAH September 10, 2009).

47. AHCA failed to demonstrate that documentation provided by A+ Therapy for its therapy services failed to comply with Medicaid requirements. For each treatment provided, A+ Therapy used two forms. One gave a narrative description of the recipient's status with treatment, the progress achieved, and the plan for future treatments; this form was signed and dated, accounting for all dates of service. The other form was a flow chart that provided a detailed explanation of the exact treatment provided, and the time period for each service provided; this form was also dated and initialed daily by the therapist. These forms, used together, satisfy the Medicaid requirements for documentation for therapy services.

48. AHCA did demonstrate, by a preponderance of the evidence, that A+ Therapy improperly billed Medicaid for some physical, speech, and occupational therapy for certain recipients, before a valid prescription had been received, as detailed in the Findings of Fact. As explained in the Findings of Fact, in some instances, A+ Therapy successfully rebutted

AHCA's prima facie case, and brought forth evidence of proper billing with a valid prescription.

49. AHCA also demonstrated, by a preponderance of the evidence, that A+ Therapy improperly billed Medicaid for therapy services provided prior to having an authorized plan of care in place. These instances are detailed in the Findings of Fact. And, as explained above, in some instances, A+ Therapy successfully rebutted AHCA's prima facie case, and brought forth evidence of proper billing with a valid plan of care.

50. A+ Therapy conceded improper billing in many instances, as detailed in the Findings of Fact.

51. Overpayments owed to AHCA bear interest at the rate of ten percent per annum from the date of determination of the overpayment. § 409.913(25)(c).

52. Fines on overpayments are limited by Florida Administrative Code Rule 59G-9.070 (7)(e) and (4)(a), which state, respectively:

> For failure to comply with the provisions of of the Medicaid laws: For a first offense, $1,000 fine per claim found to be in violation. For a second offense, $2,500 fine per claim found to be in violation. For a third or subsequent offense, $5,000 fine per claim found to be in violation.
>
> . . .
>
> Where a sanction is applied for violations of Medicaid laws . . . and the violations are a "first offense" as set forth in this rule, if

> the cumulative amount of the fine to be imposed as a result of the violations giving rise to that overpayment exceeds twenty-percent of the overpayment, the fine shall be adjusted to twenty-percent of the amount of the overpayment.

53. As to costs, section 409.913(23)(a) allows AHCA to recover its investigative, legal, and expert witness costs. AHCA filed a Notice of Filing Costs after the date of the hearing; that amount was not contested by A+ Therapy.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that AHCA issue a final order and note therein that:

1. A+ Therapy properly documented all therapy services provided to all recipients, in full compliance with Medicaid requirements;

2. AHCA should recalculate, using generally accepted statistical methods, the total overpayment determination to reflect that A+ Therapy was not overpaid for certain services provided to certain recipients, as set forth in the Findings of Fact;

3. A+ Therapy was overpaid for all other services identified in the FAR and AHCA is entitled to recoup the overpayments as set forth in the Findings of Fact;

4. AHCA is entitled to statutory interest on the overpayment;

5. AHCA is entitled to recover its costs in this matter; and

6. AHCA is entitled to impose against A+ Therapy an administrative fine as set forth in Florida Administrative Code Rule 59G-9.070 (7)(e) and (4)(a).

DONE AND ENTERED this 18th day of July, 2012, 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
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this 18th day of July, 2012.

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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.