STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

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2012 NOV -5 A 10: 14

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

v.

NURSING QUALITY SERVICES,

Respondent.
______________________________/

DOAH CASE NO. 12-1253MPI
AUDIT NO. C.I. 12-1172-000
RENDITION NO.: AHCA-12-1055-FOF-MDO

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), Claude B. Arrington, issued a Recommended Order after conducting a formal hearing. At issue in this proceeding is whether Respondent was overpaid by the Florida Medicaid program for services provided between July 1, 2007 and March 31, 2011; and whether sanctions and costs should be imposed against Respondent. The Recommended Order dated September 13, 2012, is attached to this Final Order and incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

The parties did not file any exceptions to the Recommended Order.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except with regard to Paragraph 34 of the Recommended Order wherein the ALJ recommends that the Secretary of the Agency exercise the discretion afforded her in § 409.913(16), Fla. Stat., to not

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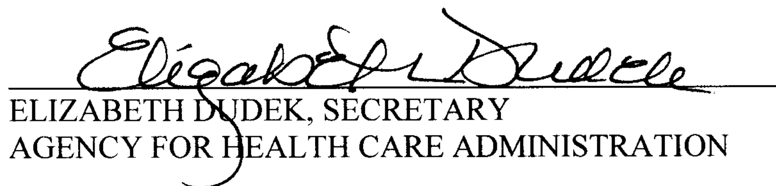
impose an administrative fine on the Respondent based on his conclusion that the Agency's Home Health Services Coverage and Limitations Handbook is misleading. The Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 34 of the Recommended Order since it is the single state agency in charge of administering Florida's Medicaid program, and that it can substitute conclusions of law as or more reasonable than those of the ALJ. Contrary to the ALJ's assertion, the Agency's Home Health Services Coverage and Limitations Handbook is quite clear. Respondent failed to comply with the Handbook when billing for services. Thus, Respondent is subject to sanctions. Therefore, Agency rejects the ALJ's conclusions of law and recommendation in Paragraph 34 of the Recommended Order because it would not be in the best interest of the Medicaid program not to impose an administrative fine in this matter.

IT IS THEREFORE ADJUDGED THAT:

Respondent is required to repay $8,154.02 in Medicaid overpayments, plus interest at a rate of ten (10) percent per annum as required by § 409.913(25)(c), Fla. Stat., to the Agency for paid claims covering the period from July 1, 2007 through March 31, 2011. $1,500 fine and costs in the amount of $43.94 are also imposed against Respondent.

Respondent shall make full payment of the overpayment and fine to the Agency for Health Care Administration within 30 days of the rendition of this Final Order unless other payment arrangements have been agreed to by the parties. Respondent shall pay by check payable to the Agency for Health Care Administration and mailed to the Agency for Health Care Administration, Office of Finance and Accounting, 2727 Mahan Drive, Fort Knox Building 2, Mail Stop 14, Tallahassee, Florida 32308.

DONE and ORDERED this 5 day of November, 2012, in Tallahassee, Florida.



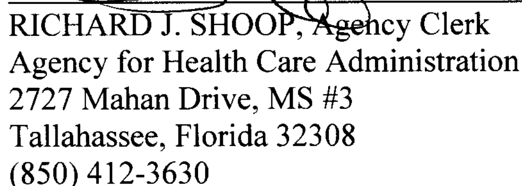
ELIZABETH DUDEK, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY ALONG WITH THE FILING FEE PRESCRIBED BY LAW WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or interoffice mail to the persons named below on this 5 day of November, 2012.



RICHARD J. SHOOP, Agency Clerk
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Finance & Accounting

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	Case No. 12-1253MPI
vs.	)	
NURSING QUALITY SERVICES,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice, a hearing was conducted in this case on July 13, 2012, by telephone conference call at sites in Miami and Tallahassee, Florida, before Administrative Law Judge (ALJ) Claude B. Arrington of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Jeffries H. Duvall, Esquire
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For Respondent: Dagmar Llaudy, Esquire
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STATEMENT OF THE ISSUE

Whether Nursing Quality Services, Inc. (Respondent), a Medicaid provider, was overpaid by the Florida Medicaid Program in the amount of $8,154.02, and, if so, whether Respondent must pay to the Agency for Health Care Administration (Petitioner) the amount of the alleged overpayment, a penalty in the amount of $1,630.80, costs in the amount of $43.94, and any applicable interest.

PRELIMINARY STATEMENT

The audit period at issue is between July 1, 2007, and March 31, 2011. During that time, Respondent was (and still is) enrolled in the Florida Medicaid Program as a home health services provider. As part of a routine audit, Petitioner determined that certain Medicaid units of service, which will be discussed below, were billed by the provider at too high a rate, thereby generating an overpayment.

Petitioner generated a Preliminary Audit Report (PAR) which was sent to Respondent by Federal Express. The PAR advised Respondent of the overpayment and provided Respondent an opportunity to provide documentation to refute that an overpayment had been made. Respondent did not respond to the PAR because Respondent did not receive the PAR.

Thereafter, Petitioner generated a Final Audit Report (FAR) which assessed against Respondent the amount of the alleged overpayment together with the fine and costs set forth above.

Among other topics, the FAR advised Respondent of its right to request an administrative hearing pursuant to the provisions of chapter 120. Thereafter, Respondent requested a formal administrative hearing, the matter was referred to DOAH, and this proceeding followed.

At the final hearing, Petitioner presented the testimony of Pamela Fante (a program administrator for Petitioner's Office of the Inspector General, Medicaid Program Integrity) and Sheri Creel (an analyst in the unit supervised by Ms. Fante). Petitioner offered five sequentially-numbered exhibits, each of which was admitted into evidence without objection. At Petitioner's request, official recognition was taken of the relevant handbooks, rules, and statutes, which are set forth in Petitioner's exhibit book under tabs 6, 7, and 8.

Respondent presented the testimony Simon Fernandez, the owner and president of Respondent. Respondent offered no exhibits.

A Transcript of the hearing, consisting of one volume, was filed August 6, 2012. Both parties timely filed a Proposed Recommended Order, which have been duly considered by the undersigned in the preparation of this Recommended Order.

Unless otherwise noted, all statutory references are to Florida Statutes (2012).

FINDINGS OF FACT

1. At all times relevant to this proceeding, Respondent has been a provider with the Florida Medicaid Program and has had a valid Medicaid Provider Agreement with Petitioner. Relevant to this proceeding, Respondent is a home health services provider, providing nursing services to residents of assisted living facilities (ALFs).

2. Petitioner is the agency of the State of Florida charged with the responsibility of administering the Florida Medicaid Program.

3. At all times relevant to this proceeding, Respondent was subject to all applicable federal and state laws, regulations, rules, and Medicaid Handbooks.

4. Respondent is required to comply with the Florida Medicaid Provider General Handbook. Respondent is also required to comply with the Home Health Services Coverage and Limitations Handbook (Coverage Handbook).

5. Home health services are billed in units of service. Each unit of service has a billing code that generates a specified Medicare payment to the provider. The two billing codes at issue in this proceeding are T1030 and T1031. A billable unit of service is generated under these codes when

either a registered nurse or a licensed practical nurse goes to an ALF and provides a qualified service to a resident of the ALF.

6. Tab 6 in Petitioner's exhibit book contains relevant excerpts of the Coverage Handbook, which was last revised in July 2008. Relevant to this proceeding, the Coverage Handbook reflects the following reimbursement information under the bulletin heading "Home Health Visits for Multiple Recipients at One Location" with emphasis added by the undersigned:

> Home health visit services provided to two or more recipients <u>with individual residences</u> at a single location are reimbursed as one visit for each individual receiving a home health service at that location (<u>for example, visits at an assisted living facility</u>).
>
> Home health visit services provided to two or more recipients sharing a residence at a single location (for example, visits at a group home) are reimbursed as follows:
>
> - For the first recipient, Medicaid reimburses the service at the established Medicaid visit rate;
> - For the second recipient, Medicaid reimburses the service at 50 percent of the established Medicaid visit rate; and
> - For any additional recipients, Medicaid reimburses the services at 50 percent of the established Medicaid visit rate.

7. The Bureau of Medicaid Program Integrity (MPI) has generated a memorandum that reflects its understanding of the coverage and limitations set forth in the Coverage Handbook. Key to this proceeding, the memorandum states the following as to services provided to a resident of an ALF with emphasis added by the undersigned:

> MPI further understands that residence in an assisted living facility would not justify an automatic authorization for a 100 percent reimbursement of the established Medicaid reimbursement rated for home health services. Providers will be given the opportunity to submit documentation demonstrating individual residence at a single location for MPI review and subsequent decision-making as to applicable reimbursement policy. Should the documentation substantiate an individual residence at a single location for the recipient(s) in question, the reimbursement for home health services would be allowed at 100 percent of the established Medicaid reimbursement rate appropriate for the date of service.

8. As part of a larger audit of Medicaid providers, Petitioner audited Respondent based on billings submitted by Respondent and paid by Petitioner. Taking information reflected by Respondent's billings, Petitioner prepared a PAR, which was dated January 23, 2012, and signed by Ms. Fante. The PAR cited the Coverage Handbook, statues, and rules Petitioner relied upon and attached a detailed audit report reflecting that Respondent was overpaid $8,154.02.

9. All of the services at issue in this proceeding were billed and paid at 100 percent of the established Medicaid visit rate for identical units of service (either T1030 or T1031) generated at the same facility location on the same date whether or not it was the first recipient (the so-called anchor recipient), a second recipient, or an additional recipient.

10. Respondent's billings provided the respective address for each of the three ALFs at which these recipients resided, but the billings do not document that each recipient maintained an individual residence in that ALF. Consequently, after payment for the anchor recipient at 100 percent of the Medicaid reimbursement rate, Respondent should have been paid at 50 percent of the reimbursement rate for identical units of service to the other recipients at the same address on the same day.

11. The payments at 100 percent of the billing rate for units of service that should have been reduced to 50 percent of the billing rate constituted overpayments. Petitioner established that the amount of the overpayment totaled $8,154.02.

12. The PAR was not final agency action. Respondent was advised of the following options:

> 1) Pay the identified overpayment in this notice within 15 days of the receipt of this letter. Under this option, amnesty will be granted, sanctions will not be applied and costs will not be assessed.

2) If you wish to submit further documentation in support of the claims identified as overpayments, you must do so within 15 days of receipt of this letter. Any additional documentation received will be taken under consideration and you will be notified of the results of the audit in a final audit report. Under this option, a final audit report will be issued and will include application of sanctions, the assessment of costs, and hearing rights.

3) If you chose not to respond, wait for the issuance of the final audit report. Under this option, a final audit report will include the application of sanctions, the assessment of costs, and inform you of any hearing rights that you may wish to exercise.

13. The PAR was sent to Respondent via Federal Express using the following address: 8300 SW 8 Street, Suite 107, Miami, FL 33144. Ms. Creel testified, credibly, that the foregoing was the address of record for Respondent at the time the PAR was sent to Respondent. The Federal Express receipt reflects that the PAR was delivered on January 25, 2012 at 9:41 a.m., and signed for by someone named "M. Mejia." The receipt reflects that the PAR had been delivered to "Receptionist/Front Desk."

14. Mr. Fernandez testified, credibly, that he never received the PAR because Respondent had moved its offices from Suite 107 to Suite 103 in the same building. While that evidence is accepted, Ms. Creel established that Respondent's

office of record with Petitioner had not been updated at the time the PAR was sent to Respondent.

15. Respondent did not respond to the PAR.

16. Petitioner prepared a "Final Audit Report" (FAR), which was dated March 2, 2012, and signed by Ms. Fante. The FAR asserted that Respondent owed $8,154.02 as the overpayment, a fine in the amount of $1,630.80, and costs in the amount of $43.94, for a total of $9,828.76, plus applicable interest.

17. The FAR was sent to Respondent by Federal Express at the same addressed that had been used for the PAR. The Federal Express receipt reflects that the FAR was delivered on March 8 at 9:28 a.m. and signed for by "M. Mejia." The receipt reflects that the PAR had been delivered to "Receptionist/Front Desk."

18. The FAR advised as follows:

> Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory

> repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program. Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

19. The FAR provided Respondent an explanation of its right to request an administrative hearing pursuant to the provisions of chapter 120.

20. Mr. Fernandez received the FAR. Promptly thereafter, Mr. Fernandez called Ms. Creel to discuss the assessed overpayment, fine, and costs. Mr. Fernandez told her that he had not receive the PAR, and asserted that there was no overpayment because each recipient of the payments at issue lived in an ALF. Ms. Creel answered his questions as to the type documentation Respondent could submit to document there was no overpayment, but she explained to him that she had no authority to extend any of the deadlines set forth in the FAR.

21. Respondent thereafter requested a formal administrative hearing, the matter was referred to DOAH, and this proceeding followed. As noted above in the Preliminary Section, Respondent offered no exhibits at the formal hearing.

22. While Mr. Fernandez had visited each of the three ALFs at issue in this proceeding, he knew nothing about the living quarters of any of the recipients. The term "individual residence" is not defined in the Coverage Handbook, by rule, or by statute. Consequently, the plain meaning of the phrase is used in finding that there was no evidence that any of the recipients maintained an individual residence at the location of his or her ALF.

CONCLUSIONS OF LAW

23. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding pursuant to sections 120.569, 120.57(1), and 409.913(31).

24. Section 409.913(1)(d) defines the term "overpayment" to "include 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."

25. The overpayments at issue are the result of Respondent's misinterpretation of the Coverage Handbook relating to multiple visits to the same location. No fraud or abuse is involved in this proceeding.

26. Section 409.913(7)(e) provides that a Medicaid provider is obligated to present claims that are "true and

accurate" and reflect services that are provided in accordance with all Medicaid "rules, regulations, handbooks, and policies and in accordance with federal, state, and local law."

27. Section 409.913(2) requires Petitioner to conduct audits to detect overpayments. Section 409.913(11) requires Petitioner to require repayment of "inappropriate" goods or services.

28. The burden of proof is on Petitioner to prove the material allegations by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of Health & Rehab. Servs., 596 So. 2d 106, 109 (Fla. 1st DCA 1992). The sole exception is that the standard of proof is clear and convincing evidence for the fine that Petitioner seeks to impose. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

29. Section 409.913(21) provides that Petitioner shall prepare and issue audit reports when determining overpayments. Section 409.913(22) provides that the "audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Petitioner presented such evidence at the formal hearing. Respondent did not refute that evidence.

30. That Respondent did not actually receive the PAR is not dispositive of any issue involved in this proceeding. Section 409.913(6) provides as follows:

> (6) Any notice required to be given to a provider under this section is presumed to be sufficient notice if sent to the address last shown on the provider enrollment file. It is the responsibility of the provider to furnish and keep the agency informed of the provider's current address. United States Postal Service proof of mailing or certified or registered mailing of such notice to the provider at the address shown on the provider enrollment file constitutes sufficient proof of notice . . . .

31. Section 429.02(5) defines the term assisted living facility as:

> (5) "Assisted living facility" means any building or buildings, section or distinct part of a building, private home, boarding home, home for the aged, or other residential facility, whether operated for profit or not, which undertakes through its ownership or management to provide housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.

32. There is nothing in the term assisted living facility that requires the facility to have an individual residence for each residence.

33. Petitioner has the authority to impose an administrative fine against Respondent based on the provisions of subsections 409.913(15), (16), and (17) and Florida Administrative Code Rule 59G-9.070(7)(e). Petitioner seeks to impose an administrative fine in the amount of $1,630.80, which is 20 percent of the overpayment. The amount sought is less

than the maximum permitted amount as set forth in Florida Administrative Code Rule 59G-9.070(4)(b).

34. The undersigned recommends that no administrative fine be imposed pursuant to the discretion afforded by section 409.913(16)(j)[1] because the use of visits at an assisted living facility as an example of units of service that could be billed at the full billing rate is misleading. The following language in the Coverage Handbook was quoted in the Findings of Fact and is repeated here for clarity:

> Home health visit services provided to two or more recipients with individual residences at a single location are reimbursed as one visit for each individual receiving a home health service at that location (for example, visits at an assisted living facility).

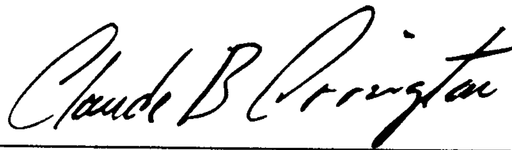
35. Section 409.913(23)(a) authorizes Petitioner to recover investigative costs if Petitioner prevails in this proceeding. Petitioner prevailed and is entitled to these costs in the amount of $43.94.

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Nursing Quality Services, Inc., was overpaid by the Florida Medicaid Program in the principal amount of $8,154.02. It is further recommended that the final order require Nursing Quality Services, Inc., to

repay the Florida Medicaid the amount of $8,154.02, together with applicable interest and cost in the amount of $43.94. It is further recommended that no administrative fine be imposed.

DONE AND ENTERED this 13th day of September 2012, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 13th day of September, 2012.

ENDNOTE

[1] Section 409.913(16)(j) provides, in relevant part as follows:

> The Secretary of Health Care Administration 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.

COPIES FURNISHED:

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Richard Shoop, Agency Clerk
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Tallahassee, Florida 32308

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.