STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. SHARING FACILITY GROUP HOME, Respondent.	)	Case Nos. 12-1664MPI 12-1841MPI

RECOMMENDED ORDER

Pursuant to notice, a hearing was conducted in these consolidated cases pursuant to sections 120.569 and 120.57(1), Florida Statutes,[1/] before Stuart M. Lerner, a duly-designated administrative law judge of the Division of Administrative Hearings (DOAH), on October 12, 2012, by video teleconference at sites in Port St. Lucie and Tallahassee, Florida.

APPEARANCES

For Petitioner: Rachic A. Wilson, Esquire
Agency for Health Care Administration
Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308

For Respondent: Curtis Randolph, Esquire
2801 Orange Avenue, Suite B
Fort Pierce, Florida 34947

STATEMENT OF THE ISSUES

Whether Respondent engaged in sanctionable conduct in violation of Medicaid laws, as alleged in the April 9, 2012, sanction letters the Agency for Health Care Administration (ACHA) sent to Respondent in the above-styled cases, and, if so, what sanction(s) should be imposed.

PRELIMINARY STATEMENT

By letter dated April 9, 2012, ACHA, in connection with its review of claims that Respondent had submitted to the Florida Medicaid program from June 1, 2011, through December 1, 2011, under Provider No. 679849796 as a provider of Developmental Disabilities Home and Community-Based Medicaid Waiver services, advised Respondent of the following:

> In accordance with Section 409.913, Florida Statutes (F.S.) and Rule 59G-9.070,, Florida Administrative Code (F.A.C.), the Agency for Health Care Administration (Agency) shall apply sanctions for violations of federal and state laws, including failure to provide proof of current Infection Control and Zero Tolerance training for employee DS,
>
> - A fine of $1,000.00 for violation(s) of 7(e) under Rule Section 59G-9.070, F.A.C.
>
> *   *   *
>
> You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. . . . .

On May 3, 2012, Respondent, through counsel, filed a Petition

for Formal Hearing on the matter. Respondent's hearing request was referred to DOAH on May 11, 2012. The case was docketed as DOAH Case No. 12-1664MPI.

By separate letter dated April 9, 2012, AHCA, in connection with its review of claims that Respondent had submitted to the Florida Medicaid program from January 1, 2011, through November 30, 2011, under Provider No. 142150600 as a provider of assistive care services, advised Respondent of the following:

> In accordance with Section 409.913, Florida Statutes (F.S.) and Rule 59G-9.070,, Florida Administrative Code (F.A.C.), the Agency for Health Care Administration (Agency) shall apply sanctions for violations for violations of federal and state laws, including [f]ailure to maintain a current Health Assessment for consumers FB, WW, FW & LS. This letter shall serve as notice of the following sanction(s):
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> - A fine of $4,000.00 for violation(s) of 7(e) under Rule Section 59G-9.070, F.A.C.
>
> *   *   *
>
> You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. . . . .

On May 3, 2012, Respondent, through counsel, filed a Petition for Formal Hearing on the matter. Respondent's hearing request was referred to DOAH on May 18, 2012. The case was docketed as DOAH Case No. 12-1841MPI.

On July 2, 2012, AHCA filed an unopposed motion to consolidate DOAH Case Nos. 12-1664MPI and 12-1841MPI. By Order

issued July 10, 2012, the motion was granted and the cases were consolidated.

As noted above, the final hearing in these consolidated cases was held on October 12, 2012.[2/] Two witnesses testified at the hearing: Victor Rivera (on behalf of AHCA) and Angel Cox (on behalf of Respondent). In addition to the testimony of these two witnesses, the following exhibits were offered and received into evidence: AHCA's Exhibits A through I and Respondent's Exhibits A through D in DOAH Case No. 12-1664MPI; and AHCA's Exhibits A through I and Respondent's Exhibits A through F in DOAH Case No. 12-1841MPI. The evidentiary record was left open for purposes of ACHA's submitting its Exhibit J (to be used in both DOAH Case No. 12-1664MPI and DOAH Case No. 12-1841MPI) and Respondent's submitting its Exhibit G in DOAH Case No. 12-1841MPI. These two exhibits were timely filed with DOAH on November 5, 2012, and on October 25, 2012, respectively. By Order issued November 7, 2012, they were received into evidence, and the evidentiary record was closed.

The proposed recommended order filing deadline was originally set at 30 days from the date of the filing the hearing transcript with DOAH. The hearing Transcript (consisting of one volume) was filed with DOAH on November 14, 2012. Upon the joint request of the parties, the proposed

recommended order filing deadline was thereafter twice extended--the final time to February 8, 2012. On February 8, 2012, both parties timely filed their Proposed Recommended Orders.

FINDINGS OF FACT

1. AHCA is the state agency charged with administering and overseeing the Medicaid program in Florida. Housed within AHCA is the Bureau of Medicaid Program Integrity (MPI). Among MPI's responsibilities is to conduct audits and investigations to ensure that the state's Medicaid providers are in compliance with programmatic requirements.

2. At all times material to the instant cases, Respondent was enrolled in the Florida Medicaid program under two separate provider numbers (Provider No. 679849796, as a provider of Developmental Disabilities Home and Community-Based Medicaid Waiver services, and Provider No. 142150600, as a provider of assistive care services) and subject to the terms of Medicaid Provider Agreements,[3/] which contained the following provisions, among others:

> (5) Provider Responsibilities: The Medicaid provider shall:
>
> * * *
>
> (b) Keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records as AHCA requires for a period of at least five (5) years.

*   *   *

> (d) Send, at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records;

and, in connection with Provider No. 679849796, it was also subject to the terms of a Medicaid Waiver Services Agreement with the Florida Agency for Persons with Disabilities (APD),[4/] in which it had agreed, among other things, to do the following:

> To permit persons duly authorized by APD, the Agency for Health Care Administration (AHCA), or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records, (including electronic storage media), papers, documents, facilities, goods and services of the Provider, which are relevant to this Agreement . . . .
>
> *   *   *
>
> 2. Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period . . . .

3. At all times material to DOAH Case No. 12-1664MPI Respondent, as an enrolled Medicaid provider of Developmental Disabilities Home and Community-Based Medicaid Waiver services, was bound by the following provisions of the Developmental

Disabilities Waiver Services Coverage and Limitations Handbook dealing with employee training and recordkeeping requirements, which handbook provisions were incorporated by reference (along with the other provisions of the handbook) in Florida Administrative Code 59G-13.083:

> Companion Provider Requirements
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> *   *   *
>
> Training Requirements
>
> Proof of training in the areas of Cardiopulmonary Resuscitation (CPR), HIV/AIDS and infection control is required within 30 days of initially providing companion services. Proof of annual or required updated training shall be maintained on file for review. The provider is responsible for all training requirements outlined in the Core Assurances.
>
> Note: Refer to the Core Assurances in Appendix A for the provider training requirements. . . .
>
> *   *   *
>
> Appendix A: Core Assurances for Providers of Developmental Disabilities Home and Community-Based Waiver Services Program
>
> *   *   *
>
> 2.1 Required Training
>
> The provider and its employees will ensure they receive the specific training required to successfully serve each recipient including the following topics:
>
> *   *   *

H. All direct service providers hired after 90 days from the effective date of this rule are required to complete the Agency for Persons with Disabilities developed Zero Tolerance Training course prior to rendering direct care services (as a pre-service training activity). Said training may only be completed via APD's web-based instruction or classroom-led instruction (using APD's approved classroom curriculum presented either by APD staff or an individual who has been trained and approved by APD to conduct such classroom trainings). In addition, all direct service providers shall be required to complete the APD developed Zero Tolerance training course at least once every three years. The provider shall maintain on file for review, adequate and complete documentation to verify its participation, and the participation of its employees, in the required training sessions.

The documentation for the above listed training shall, at a minimum, include the training topic(s), length of training session, date and location of training, name and signature of trainer, name and signature of person(s) in attendance. Proof of training shall be on file and available for monitoring and review.

4. At all times material to DOAH Case No. 12-1841MPI, Respondent, as an enrolled Medicaid provider of assistive care services, was bound by the following provisions of the Assistive Care Services Coverage and Limitations Handbook dealing with health assessments, which handbook provisions were incorporated by reference (along with the other provisions of the handbook) in Florida Administrative Code Rule 59G-4.025:

> Recipients receiving Assistive Care Services must have a complete assessment at least annually by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) or sooner if a significant change in the recipient's condition occurs (see below for a definition of a significant change). An annual assessment must be completed no more than one year plus fifteen days after the last assessment. An assessment triggered by a significant change must be completed no more than fifteen days after the significant change.
>
> > -The assessment for a resident of a ALF or AFCH must be completed by a physician or other licensed practitioner of the healing arts (Physician Assistant, Advanced Registered Nurse Practitioner, Registered Nurse) acting within the scope of practice under state law, physician assistant or advanced registered practitioner.
> >
> > -The assessment for a resident of a RTF must be completed by a physician or licensed mental health professional. The assessment must document the need for at least two of the four ACS components. The assessment for ALF residents must be recorded on the Resident Health Assessment for Assisted Living Facilities, AHCA Form 1823.

5. At all times material to both DOAH Case No. 12-1664MPI and DOAH Case No. 12-1841MPI, Respondent was also bound by the following provisions of the Florida Medicaid Provider General Handbook, which were incorporated by reference in Florida Administrative Code Rule 59G-5.020 and applied to all enrolled Medicaid providers, including providers of Developmental

Disabilities Home and Community-Based Medicaid Waiver services and providers of assistive care services:

> Record Keeping Requirement
>
> Medicaid requires that the provider retain all business records as defined in 59G-1.010(30) F.A.C., medical-related records as defined in 59G-1.010(154) F.A.C., and medical records as defined in 59G-1.010(160) F.A.C. on all services provided to a Medicaid recipient.[[5/]]
>
> 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 stamped signatures must be initialed.
>
> The records must be accessible, legible and comprehensible.
>
> * * *
>
> Record Retention
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> Records must be retained for a period of at least five years from the date of service.
>
> * * *
>
> Right to Review Records
>
> Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies

> to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records.
>
> The provider must send, at his expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives upon request of AHCA.
>
> At the time of the request, all records must be provided regardless of the media format on which the original records are retained by the provider. All medical records must be reproduced onto paper copies.
>
> * * *
>
> Incomplete Records
>
> Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments.
>
> Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.
>
> Note: See Chapter 5 in this handbook for information on administrative sanctions and Medicaid payment recoupment

6. The foregoing contractual and handbook provisions supplemented section 409.913(9), Florida Statutes, which then provided (as it still does) as follows:

> A Medicaid provider shall retain medical, professional, financial, and business

> records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

7. On or about December 6, 2011, MPI investigators visited Respondent's facility to review Respondent's Medicaid-related records, but left before completing their review.

8. Approximately a month later, MPI sent Respondent a letter, dated January 5, 2012, concerning claims that Respondent had filed under its Provider No. 679849796 as a provider of Developmental Disabilities Home and Community-Based Medicaid Waiver services (January 5 Letter). The letter read as follows:

> The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity is in the process of completing a review of claims billed to Medicaid during the period June 01, 2011, through December 01, 2011, to determine whether the claims were billed and paid in accordance with Medicaid policy.
>
> Pursuant to Section 409.913, Florida Statutes (F.S.), this is official notice that the Agency requests the documentation for services paid by the Florida Medicaid

> provider to the above provider number [679849796]. The Medicaid-related records to substantiate billing for the [four] recipients identified on the enclosed printout are due within fifteen (15) calendar days of your receipt of this notification. Please submit the documentation and the attached Certification of Completeness of Records to the Agency within this timeframe, or other mutually agreed upon timeframe.
>
> Correspondence and requested records should be sent to the following address:
>
> Victor Rivera, Investigator
> Agency for Health Care Administration
> Medicaid Program Integrity
> 400 West Robinson Street, Suite S309
> South Tower, Hurston Building
> Orlando, Florida 32801
>
> In accordance with Section 409.913, F.S., and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. Pursuant to the aforementioned provisions, failure to provide all Medicaid-related records in compliance with this request will result in the application of sanctions, which include, but are not limited to, fines, suspension and termination. The Medicaid-related records associated with this review should be retained until [the review is] completed.
>
> If you have any questions, please contact Victor Rivera, Investigator, at (407)420-2524.

The Certification of Completeness of Records form enclosed with the letter was to be completed by the provider's "official

custodian of records," and it contained the following verification and certification:

> I hereby verify that I have searched the Medicaid-related records maintained by the Provider and have determined that the attached records consisting of (# of pages) are true and correct copies of the Medicaid-related records requested by the Agency for Health Care Administration, Office of the Inspector General, Bureau of Medicaid Program Integrity.
>
> I further certify that these are all of the Medicaid-related records that were made at or near the time that the services were rendered by, or from information transmitted by, the Provider; are kept in the course of the regularly conducted business of the Provider; and that it is the regular practice of the Provider to keep such records.

Also accompanying the letter was a printout providing information concerning "documentation organization." Among other things, it advised that the "employee documentation" that needed to be submitted included "[c]opies of all required AHCA training certificates," and it contained the further advisement that "[f]ailure to follow the aforementioned guidelines and/or failure to provide the [sic] ALL of the requested documentation for ALL staff members who provided services to Medicaid Recipients during the predetermined audit period w[ould] result in the [a]application of sanctions," including "fines."

9. The January 5 Letter and accompanying documents were received by Respondent on January 9, 2012.

10. Ten days later, MPI sent Respondent a second letter, dated January 19, 2012 (January 19 Letter). This letter concerned claims that Respondent had filed under its Provider No. 142150600 as a provider of assistive care services, and it provided as follows:

> The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity is in the process of completing a review of claims billed to Medicaid during the period January 1, 2011, through November 30, 2011, to determine whether the claims were billed and paid in accordance with Medicaid policy.
>
> Pursuant to Section 409.913, Florida Statutes (F.S.), this is official notice that the Agency requests the documentation for services paid by the Florida Medicaid provider to the above provider number [143150600]. The Medicaid-related records to substantiate billing for the [four] recipients identified on the enclosed printout are due within fifteen (15) calendar days of your receipt of this notification. Please submit copies of the Medicaid-related records and the attached Certification of Completeness of Records to the Agency within this timeframe, or other mutually agreed upon timeframe.
>
> Correspondence and requested records should be sent to the following address:
>
> Victor Rivera, Investigator
> Agency for Health Care Administration
> Medicaid Program Integrity
> 400 West Robinson Street, Suite 309
> South Tower, Hurston Building
> Orlando, Florida 32801
>
> In accordance with Section 409.913, F.S., and Rule 59G-9.070, Florida Administrative

> Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy.
>
> Pursuant to the aforementioned provisions, failure to provide all Medicaid-related records in compliance with this request will result in the application of sanctions, which include, but are not limited to, fines, suspension and termination. The Medicaid-related records associated with this review should be retained until [the review is] completed.
>
> If you have any questions, please contact Victor Rivera, Investigator, at (407)420-2524.

At the bottom of the "enclosed printout" referenced in the letter was the following cautionary advisement:

> Please refer to your Assistive Care Services handbook, July 2009, for information on the required documentation for recipient files.

The Certification of Completeness of Records form enclosed with the letter was identical to the Certification of Completeness of Records form that had accompanied the January 5 Letter.

11. The January 19 Letter and accompanying documents were received by Respondent on January 21, 2012.

12. Respondent, through its owner/administrator Angel Cox, responded to the records requests made in the January 5 and January 19 Letters by providing MPI with copies of numerous documents, along with two completed, signed, and dated Certifications of Completeness of Records (one for each records

request), on January 24, 2012.[6/] Ms. Cox supplemented this response by faxing additional copies to MPI on February 7, 2012.

13. Victor Rivera, the MPI investigator to whom Respondent had been directed to send its responses to MPI's January 5, 2012, and January 19, 2012, records requests, reviewed the documentation that Ms. Cox had submitted and determined that the following Medicaid-related records that Respondent had been requested to produce in the January 5 and January 19 Letters were missing (hereinafter referred to collectively as the "Further Required Documentation"): written proof that D. S., an employee of Respondent's who had helped deliver services for which Respondent had billed the Florida Medicaid program from June 1, 2011, through December 1, 2011, under its Developmental Disabilities Home and Community-Based Medicaid Waiver services provider number, had completed the infection control and zero tolerance training required by the Developmental Disabilities Waiver Services Coverage and Limitations Handbook; and the annual health assessments required by the Assistive Care Services Coverage and Limitations Handbook for the four recipients of the services for which Respondent had billed the Florida Medicaid program from January 1, 2011, through November 30, 2011, under its assistive care services provider number.

14. At all times material to the instant cases, Respondent had the Further Required Documentation in its possession,[7/] however, Ms. Cox had inadvertently failed to include these documents in the submissions she made (on behalf of Respondent) in response to MPI's January 5 and January 19 Letters.

15. Ms. Cox first learned that the Further Required Documentation was missing during a telephone conversation she had with Mr. Rivera at the end of March 2012, when he advised her of the omission and told her that she needed to get these documents to him "as soon as possible."[8/]

16. On April 1 or 2, 2012, no more than three or four days after this telephone conversation, Ms. Cox provided Mr. Rivera, by fax, with copies of the following: a certificate of completion issued by APD to employee D. S. on April 28, 2010, for "Zero Tolerance Training"; a certificate of completion issued by All Metro Health Care to employee D. S. for "Infection Control Guidelines" training completed on February 12, 2011; and a completed March 2011 annual health assessment recorded on AHCA Form 1823 (2011 Health Assessment Form) for each of the four recipients identified in the printout accompanying the January 19 Letter. Respondent also had in its possession the previous year's completed AHCA Form 1823 (2010 Health Assessment Form) for each of these recipients, but Ms. Cox did not fax copies of these forms[9/] to Mr. Rivera because she reasonably believed that

Mr. Rivera had asked only for the 2011 Health Assessment Forms.[10/]

17. MPI tries to "work with the [Medicaid] providers." If a provider is asked by MPI to provide, "as soon as possible," a specified document or documents previously requested but not produced and the provider, in response to such a follow-up request, produces the document(s) in question within a matter of days, it is MPI's practice to not impose any sanctions on the provider and, instead, to "move on to the next case."[11/] In the instant cases, however, in an unexplained departure from that practice, MPI chose to issue the April 9, 2012, sanction letters set out above. It is these sanction letters that frame the issues to be resolved in these cases.

CONCLUSIONS OF LAW

18. DOAH has jurisdiction over the subject matter of this proceeding and of the parties hereto pursuant to chapter 120.

19. ACHA is seeking to impose sanctions on Respondent in the form of fines of $1,000.00 (in DOAH Case No. 12-1664MPI) and $4,000.00 (in DOAH Case No. 12-1841MPI) pursuant to section 409.913(15)(e) and (16)(c), Florida Statutes, and Florida Administrative Code 59G-9.070(7)(e), which at all times material to the instant cases have provided, in pertinent part, as follows:

§ 409.913(15)(e), Fla. Stat.

The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:

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; . . . .

§ 409.913(16)(c), Fla. Stat.

The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):

Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. . . .[[12/]]

Florida Administrative Code 59G-9.070(7)(e)

SANCTIONS: In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S.,[[13/]] sanctions shall be imposed as follows:

For failure to comply with the provisions 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. [Section 409.913(15)(e), F.S.].

Because they are penal in nature, these statutory and rule provisions must be strictly construed, with any ambiguities being resolved in favor of Respondent. See Dyer v. Dep't of Ins., 585 So. 2d 1009 (Fla. 1st DCA 1991)(court "[a]ppl[ied] the principle of statutory construction that penal statutes must be strictly construed in favor of the party to be penalized").

20. In order to fine a provider for a violation of "Medicaid laws," ACHA must establish the provider's guilt of the violation by clear and convincing evidence. See Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996)("[A]n administrative fine deprives the person fined of substantial rights in property. Administrative fines . . . are generally punitive in nature. . . . Because the imposition of administrative fines . . . [is] penal in nature and implicate[s] significant property rights, the extension of the clear and convincing evidence standard to justify the imposition of such a fine is warranted."); Diaz de la Portilla v. Fla. Elect. Comm'n, 857 So. 2d 913, 917 (Fla. 3d DCA 2003)("We agree with the administrative law judge that the standard of proof in a case seeking fines under chapter 106 is clear and convincing evidence."); and § 120.57(1)(j) ("Findings of fact shall be

based on a preponderance of the evidence, except in penal or licensure disciplinary proceedings . . . .").

21. Clear and convincing evidence is an "intermediate standard," "requir[ing] more proof than a 'preponderance of the evidence' but less than 'beyond and to the exclusion of a reasonable doubt.'" In re Graziano, 696 So. 2d 744, 753 (Fla. 1997). For proof to be considered "'clear and convincing' . . . the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." In re Davey, 645 So. 2d 398, 404 (Fla. 1994)(quoting with approval Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)); see also In re Adoption of Baby E. A. W., 658 So. 2d 961, 967 (Fla. 1995)("The evidence [in order to be clear and convincing] must be sufficient to convince the trier of fact without hesitancy."). "Although this standard of proof may be met where the evidence is in conflict, . . . it seems to preclude evidence that is ambiguous." Westinghouse Electric Corp., Inc. v. Shuler Bros., Inc., 590 So. 2d 986, 989 (Fla. 1st DCA 1991).

22. In determining whether AHCA has met its burden of proof, it is necessary to evaluate its evidentiary presentation in light of the specific allegations of wrongdoing made in the charging instrument provided to the alleged "Medicaid laws" violator. Due process prohibits an agency from taking penal action based on matters (either factual or legal) not specifically alleged, unless those matters have been tried by consent. See Trevisani v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005)("A physician may not be disciplined for an offense not charged in the complaint."); Marcelin v. Dep't of Bus. & Prof'l Reg., 753 So. 2d 745, 746-747 (Fla. 3d DCA 2000)("Marcelin first contends that the administrative law judge found that he had committed three violations which were not alleged in the administrative complaint. This point is well taken. . . . We strike these violations because they are outside the administrative complaint."); and Delk v. Dep't of Prof'l Reg., 595 So. 2d 966, 967 (Fla. 5th DCA 1992)("[T]he conduct proved must legally fall within the statute or rule claimed [in the administrative complaint] to have been violated.").

23. The charging instruments in the instant case, AHCA's April 9, 2012, sanction letters to Respondent, allege (in DOAH Case No. 12-1664MPI) that Respondent "fail[ed] to provide [required] proof of current Infection Control and Zero Tolerance

training for employee D[.] S[.]" and (in DOAH Case No. 12-1841MPI) that Respondent "[f]ail[ed] to maintain a current Health Assessment" for the four recipients referenced in the January 19 Letter.

24. With respect to the latter allegation, the record evidence affirmatively establishes that, while Respondent may not have produced the "Health Assessments" in question within the "15 day period" specified in the January 19 Letter, it did have in its possession and "maintain" these "Health Assessments" at all times material to DOAH Case No. 12-1841MPI.[14/] Accordingly, given AHCA's failure to meet its burden of proving the allegation made in the charging instrument in that case, that allegation must be dismissed.

25. With respect to the "failure to provide" allegation made in DOAH Case No. 12-1664MPI, the record evidence clearly and convincingly establishes that Respondent did provide to MPI the "Infection Control and Zero Tolerance training" documents referenced in the sanction letter, just not "within fifteen (15) calendar days of [Respondent's] receipt" of the January 5 Letter, which was the deadline set forth in the letter for Respondent's responding to the letter's production request. Although Respondent did not meet this deadline, the record evidence establishes that at no time during this 15-day response period, or thereafter, did Respondent knowingly or intentionally

refuse (as opposed to merely inadvertently fail) to provide MPI with these documents (which at all material times existed and were maintained by Respondent), and it further establishes that, once Respondent was advised by MPI that these particular documents were not, but should have been, included in Respondent's initial submissions in response to the general "all Medicaid records" production request made in the January 5 Letter[15/] and that Respondent needed to provide these missing documents to MPI "as soon as possible," it was only a matter of days before Respondent supplemented its prior submissions to MPI with the required documents. It has been the practice of AHCA (through MPI), when faced with similar provider behavior, to find no sanctionable conduct under section 409.913(15)(e) and (16)(c) and Florida Administrative Code 59G-9.070(7)(e). AHCA has not offered, nor does the undersigned find, any justification for deviating from this agency practice in Respondent's case. Accordingly, consistent with this practice, the "failure to provide" allegation made in DOAH Case No. 12-1664MPI should be dismissed. See Pagan v. Sarasota Cnty. Pub. Hosp. Bd., 884 So. 2d 257, 266 (Fla. 2d DCA 2004)(Canady, J., concurring specially)("Denying precedential effect to the decision of this case in future cases presenting similar facts and issues would, however, be inconsistent with the fundamental principle that like cases should be treated alike."); Nordheim

v. Dep't of Envtl. Prot., 719 So. 2d 1212, 1214 (Fla. 3d DCA 1998)("PERC abused its discretion in failing to consider the rule in Jackson. Refusing to do so was an exercise of agency discretion that was 'inconsistent with officially stated agency policy or a prior agency practice' not explained by the agency."); Gessler v. Dep't of Bus. & Prof'l Reg., 627 So. 2d 501, 504 (Fla. 4th DCA 1993)("The concept of stare decisis, by treating like cases alike and following decisions rendered previously involving similar circumstances, is a core principle of our system of justice. . . . While it is apparent that agencies, with their significant policy-making roles, may not be bound to follow prior decisions to the extent that the courts are bound by precedent, it is nevertheless apparent the legislature intends there be a principle of administrative stare decisis in Florida."); Martin Mem'l Hosp. Ass'n v. Dep't of HRS, 584 So. 2d 39, 40 (Fla. 4th DCA 1991)("[A]gency action which yields inconsistent results based upon similar facts, without reasonable explanation, is improper."); Ag. for Health Care Admin. v. Beth Shalom Corp., Case No. 2011004055, 2012 Fla. Div. Adm. Hear. LEXIS 84 **4-7 (ACHA Feb. 13, 2012)("[W]hile Petitioner is correct in stating that '[t]he determination of each case must be done by applying the facts of that case to the statutory definition of the classification of a deficiency as found in section 408.813(2)(a),' past agency precedent must also

guide that determination. When an agency departs from its prior precedent, it must give an explanation for the departure. When asked why the Agency departed from its precedent of citing PEG violations as Class II violations, Petitioner's witness simply answered 'lack of leadership.' The Agency's witness gave no further explanation for the departure from prior Agency precedent. Thus, the Agency's classification of the violations alleged in this case as Class I violations could not withstand judicial review."); and § 120.68(7)(e)3 ("The court shall remand a case to the agency for further proceedings consistent with the court's decision or set aside agency action, as appropriate, when it finds that: [t]he agency's exercise of discretion was: [i]nconsistent with officially stated agency policy or a prior agency practice, if deviation therefrom is not explained by the agency.").

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby

RECOMMENDED that the Agency for Health Care Administration dismiss the allegations made against Respondent in the April 9, 2012, sanction letters issued in these cases and it not impose any sanctions against Respondent for the conduct alleged in these letters.

DONE AND ENTERED this 21st day of February, 2013, in Tallahassee, Leon County, Florida.

____
STUART M. LERNER
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Filed with the Clerk of the
Division of Administrative Hearings
this 21st day of February, 2013.

ENDNOTES

1/ Unless otherwise noted, all references in this Recommended Order to Florida Statutes are to that version of Florida Statutes in effect at the time of the occurrence of the particular event or action being discussed.

2/ The hearing was originally scheduled to commence in July 2012, but was continued/postponed four times.

3/ "The statutory framework applicable to Florida's Medicaid program conditions the receipt of funds from the AHCA on the existence of a Provider Agreement." Diaz v. State, 65 So. 3d 78, 80 (Fla. 3d DCA 2011).

4/ As was explained in Diaz, 65 So. 3d at 79-80:

> The AHCA is the Medicaid agent for Florida provided by federal law. However, the AHCA has delegated the duty to perform daily operations to the APD. In essence, the APD ensures that waiver program providers comply

> with applicable rules and regulations, while the AHCA pays qualified providers for services rendered to program recipients. A qualified provider must possess a facilities license and enter into a Provider Agreement with the APD. Qualified providers receive a Medicaid number enabling the receipt of payment from the AHCA.

[5/] At all times material to both DOAH Case No. 12-1664MPI and DOAH Case No. 12-1841MPI, Florida Administrative Code Rule 59G-1.010(30), (154), and (160) provided as follows:

> The following definitions are applicable to all sections of Chapter 59G, F.A.C., unless specifically stated otherwise in one (1) of those sections. These definitions do not apply to any Agency for Health Care Administration (Agency), Medicaid program rules other than those in Chapter 59G, F.A.C.:
>
> (30) "Business records" are those documents related to the administrative or commercial activities of a provider, as contrasted with medical or professional activities. Business records made available to Medicaid must be dated and legible. Business records include, as applicable, admission, accident, appointment, assignment, billing, contract, eligibility, financial, insurance, legal, medical release, patient activity, peer review, personnel, procurement, registration, signature authorization, tax, third party correspondence, utilization review documents, all administrative or commercial records that are customarily prepared or acquired and are customarily retained by the provider, and administrative or commercial records that are required by statute or rule to be prepared or acquired and retained by the provider. Records may be on paper, magnetic material, film or other media. Also see "Medical records" and "Medicaid related records."

(154) "Medicaid-related records" means records that relate to the provider's business or profession and to a Medicaid recipient. Medicaid-related records include records related to non-Medicaid customers, clients, or patients, to the extent that the documentation is shown by the department to be necessary to determine a provider's entitlement to payments under the Medicaid program. Also see "Business records" and "Medical records."

(160) "Medical records" means those documents corresponding to medical or allied care, goods, or services furnished in any place of service. The records may be on paper, magnetic material, film, or other media. In order to qualify as a basis for reimbursement, the medical records must be dated, signed or otherwise attested to, as appropriate to the media, and legible.

(a) Medical records will include, as applicable:

1. Date of service on each visit, and time spent with patient on each visit;

2. Place of service;

3. Patient's name and date of birth;

4. Caregiver's signature (not stamp or facsimile), and name and title of person performing the service. When the caregiver is the billing practitioner, the name and title must appear on the claim form;

5. Referring physician;

6. Chief complaint on or purpose of each visit;

7. Medical history;

8. Findings on examination;

9. Medications administered, prescribed or dispensed;

10. Description of treatment, when applicable;

11. Daily progress notes, physician's orders, prescriptions, and recommendations for additional treatments or consultations;

12. Laboratory reports, X-ray and other image records, and other tests and results;

13. Documentation related to medical equipment and supplies ordered or prescribed; and

14. All other records that are customarily prepared or acquired, and are customarily retained by the provider and all records that are required by statute or rule to be prepared or acquired and retained by the provider.

(b) Also see "Business records" and "Medicaid-related records."

6/ These items were mailed by Ms. Cox on January 23, 2012, and received by MPI the following day.

7/ In fact, this documentation could have been made available to MPI investigators during their December 6, 2011, visit to Respondent's facility had the investigators not decided to cut the visit short.

8/ Mr. Rivera had not previously communicated with Ms. Cox, either verbally or in writing, regarding the matter.

9/ The 2010 Health Assessment Forms (which were not faxed to Mr. Rivera) covered that portion of the January 1, 2011, through November 30, 2011, billing period referenced in the January 19 Letter not covered by the 2011 Health Assessment Forms (which were faxed to Mr. Rivera).

[10/] The 2010 Health Assessment Forms were offered and received into evidence as Respondent's Exhibit G in DOAH Case No. 12-1841MPI.

[11/] Mr. Rivera so testified--credibly, in the opinion of the undersigned--as reflected on page 58 of the hearing Transcript.

[12/] The "left flush" language at the end of section 409.913(16) makes the imposition of such a fine discretionary. It provides 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.

[13/] As noted above, it is the "left flush" language at the end of section 409.913(16), not section 409.913(16)(j), which gives the Secretary such discretion.

[14/] Unlike the sanction letter in DOAH Case No. 12-1664MPI, the sanction letter in DOAH Case No. 12-1841MPI alleges a "[f]ailure to maintain," not a "failure to provide."

[15/] The request made by MPI in its letter placed the burden on Respondent to determine exactly what specific documents in its possession it needed to produce to comply with the request.

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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.