STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 12-2487MPI
SUN STATES SERVICES, INC.,	)	
Respondent.	)	

RECOMMENDED ORDER

A final administrative hearing was held in this case on September 7, 2012, via video teleconference in Sarasota and Tallahassee, Florida, before Lynne A. Quimby-Pennock, an Administrative Law Judge of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Andrew T. Sheeran, Esquire
Agency for Health Care Administration
Fort Knox Building 3, Mail Station 3
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Tallahassee, Florida 32308

For Respondent: Charles F. Johnson, III, Esquire
Blalock Walters, P.A.
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STATEMENT OF THE ISSUES

Whether Respondent, Sun States Services, Inc., a/k/a Always Care Nursing Service, received Medicaid overpayments that

Petitioner, Agency for Health Care Administration (AHCA), is entitled to recoup, and whether a fine should be imposed against Respondent.

PRELIMINARY STATEMENT

Following an audit of Respondent's Medicaid billing for the period of July 1, 2005,[1/] through December 31, 2008, AHCA issued a Final Audit Report (FAR) on August 5, 2010, concluding that Respondent received $15,627.50[2/] in Medicaid overpayments. The FAR informed Respondent that AHCA intended to recoup the overpayments, impose a fine of $1,000.00, and seek recovery of its costs as authorized by statute.

Respondent timely requested an administrative hearing to contest the FAR, and, on July 6, 2011, the case was forwarded to DOAH for the assignment of an Administrative Law Judge to conduct the requested hearing.[3/] The case was initially scheduled to be heard on September 20, 2011; however, a week before the hearing, the parties filed a joint motion to remand and relinquish jurisdiction without prejudice. The parties represented that they were in serious discussions to amicably resolve the case, and they wanted to conserve resources in furtherance of that posture. The September hearing was canceled, and the case was relinquished to AHCA.

On July 10, 2012, AHCA filed a Motion to Re-open Case and [for DOAH to] Assume Jurisdiction (Motion). In the Motion, AHCA

advised that the parties were "unable to resolve this matter." AHCA's counsel was unable to confer with Respondent's counsel prior to filing the Motion. On July 17, a telephone conference was held between the parties and the undersigned. Thereafter, an Order was issued re-opening the case with the above case number.

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

At the final hearing, both parties provided opening statements, but chose to rely on the exhibits offered into evidence to support their respective case. AHCA's Exhibits[4/] 1 through 5 and 9 through 16 were admitted into evidence by stipulation. Official recognition was taken of the relevant sections of the Florida Statutes (2012),[5/] the Florida Administrative Code rules, and those portions of various Medicaid handbooks provided without objection. Respondent's Exhibits[6/] A and B were admitted into evidence by stipulation. Exhibit A is the deposition of AHCA's program administrator, Ruth (Robi) Anne Olmstead.

At the conclusion of the hearing, the parties requested 30 days after the filing of the transcript to submit their proposed recommended orders (PROs). The request was granted. On September 18, 2012, the one-volume Transcript of the final

hearing was filed. Petitioner timely filed its PRO. Respondent's PRO was filed on October 19, 2012.[7/] To date, AHCA has not filed a motion to strike Respondent's PRO, and, therefore, each has been duly considered in the preparation of this Recommended Order.

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 to provide health care services to certain qualified individuals.

2. From January 1, 2005, through December 31, 2008, Respondent was an enrolled Medicaid provider operating under provider number 6815065-96.

3. Beginning in 2003, the State of Florida accepted Lynk Services, Inc. (Lynk), as a waiver support coordinator for Medicaid. Lynk was, at all times material to this matter, an enrolled waiver support coordinator for Medicaid.

4. In January 2004, there were discussions between Lynk and Respondent about the possibility of Respondent providing Medicaid services to a Medicaid recipient identified as B.L. B.L. required insulin injections.

5. In a letter dated January 16, 2004, Lynk's waiver support coordinator supervisor, Thomas Engelke, wrote the following to Respondent (addressed to "To Whom It May Concern"):

> [B.L.] is authorized to receive nursing services from [Respondent] at an accelerated rate of $6.65 per quarter hour. He is to receive 9 quarter hours for a total of $59.85 per visit. The Department of Children and Families has approved this rate on December 22, 2003 by Cindy Totten and Linda Schneider department liaisons.
>
> Per the Service Authorization form that was sent to you on December 22, 2003,[8/] you [Respondent] are to provide service to [B.L.] for the duration of his current support plan year.
>
> Should you have any further concerns or questions please contact Julie Buckner [B.L.'s] support coordinator. . . . (emphasis added).

6. Later on January 22, 2004, Lynk and Respondent exchanged emails. The first email is from Howard Gruensfelder, Respondent's "VP," to Mr. Engelke and Julie Buckner, support coordinator of Lynk. It reads:

> I have a concern that billing 9 units says that the nurse is there for a full hour and forty five minutes administering his injection, when the nurse is not there for a full hour and forty five minutes. I want to make sure that we are not committing any type of fraud by doing this.
>
> This message is to confirm that the negotiated price for LPN insulin injections for [B.L.] is $59.85 per injection under the Skilled Waiver program. To do this, administratively we must bill nine units to achieve this price for service. You have waved [sic] the normal definition of unit (one quarter hour) for us in this case in order to end up with the agreed upon rate. According to your instructions we are to bill for nine units for each injection regardless

> of how much or how little time is required to complete the nursing service visit.
>
> Please confirm our understanding by replying to this message with an affirmative answer.

Less than an hour later, Lynne Ballou, Lynk's president, sent the following response to Mr. Gruensfelder:

> Per the Service Authorization[9/] we sent to you 1/5/04 you can bill 9 quarter hours each visit. The negotiated rate was approved by the Department of Children and Families liaison and liaison's supervisor. Your company stated they needed this amount to provide the service. The actual time spent with the individual is no where [sic] near the 2 hours and 15 minutes that is being charged but the only way you can bill in the system is using the quarter hour. By DCF approving the 9 quarter hours a visit they are waiving the time requirement to be able to have the service provided to the client.

7. Shortly after the letter and emails, Respondent began to provide medical services to B.L. During the audit period, Respondent provided skilled nursing services to B.L., submitted claims to AHCA for services allegedly provided to B.L., and received payment from AHCA on those claims.

8. The claims identified in AHCA's Exhibit 9 represent claims submitted by Respondent for services to B.L. and paid by AHCA.

9. Respondent billed $59.85 "per visit," regardless of the actual time spent by Respondent's employees providing the services.

10. In all but 12 of the claims identified in AHCA's Exhibit 9, Respondent billed AHCA for nine units of service ($59.85), each unit of service representing 15 minutes of time. In the other 12 claims identified in AHCA's Exhibit 9, Respondent billed AHCA for 18 units of service and received a higher reimbursement.

11. The nursing notes, contained in AHCA's Exhibit 15, reflect that Respondent did not spend two hours and 15 minutes performing the services for which it billed nine units of service, nor did it spend four hours and 30 minutes performing the services for which it billed 18 units of service.

12. No evidence was offered or received to define the term "current support plan year." However, common sense dictates that without any other definition, the entities operated on a calendar year of January 1 to December 31 of each year.[10/] Thus, the letter itself (AHCA's Exhibit 10, page 347) reflects that the 2004 current support plan year would have ended on December 31, 2004, six months prior to the audit period.

13. AHCA conducted an audit of the claims submitted by Respondent between July 1, 2005, and December 31, 2008.[11/] AHCA determined that Respondent was overpaid $16,518.60, which figure was later reduced by AHCA based on further review of the claims at issue.

14. All communications regarding services to be provided to B.L. were between Respondent and Lynk.

15. Respondent relied on the January 16, 2004, letter and subsequent email exchange as authorization to bill "per visit," rather than on an hourly basis. However, it is undisputed that the audit period was between July 1, 2005, through December 31, 2008.

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

17. In this instance, in February 2010, AHCA notified Respondent that it was in the process of reviewing claims billed to Medicaid between July 1, 2005, and December 31, 2008. The purpose of the audit was to verify that claims for which Respondent had already been paid by the Medicaid program were for services that were provided, billed, and documented in accordance with Medicaid statutes, rules, and provider handbooks. While Respondent certified with each claim submission that the claim was proper and that all records required to be maintained in support of each claim were in fact maintained, the audit goes

behind that certification by actually reviewing those records. The medical records for B.L. were provided to AHCA for review.

18. AHCA established the amount of overpayment for the claims.

19. No evidence was offered of any additional "authorization letter" (to support a "flat fee" payment for services to B.L.) from AHCA, DCF, or Lynk for any period between July 1, 2005, and December 31, 2008.

20. No credible evidence was offered that AHCA authorized that the Medicaid payment to Respondent would be by a flat "per visit" payment between July 1, 2005, and December 31, 2008.

CONCLUSIONS OF LAW

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

22. The burden of proof is on AHCA to prove the material allegations by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

23. Additionally, AHCA must carry the burden of proof with respect to the imposition of fines by the clear and convincing standard. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

24. Section 409.913 provides in pertinent part:

> The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.
>
> * * *
>
> (1)(e) "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.
>
> * * *
>
> (2) The agency shall conduct, or cause to be conducted by contract or otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report the findings of any overpayments in audit reports as appropriate. At least 5 percent of all audits shall be conducted on a random basis. . . .
>
> * * *
>
> (7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

* * *

(e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

(f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

The agency shall deny payment or require repayment for goods or services that are not presented as required in this subsection.

* * *

(15) 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:

* * *

(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;

* * *

A provider is subject to sanctions for violations of this subsection as the result of actions or inactions of the provider, or actions or inactions of any principal, officer, director, agent, managing employee, or affiliated person of the provider, or any partner or shareholder having an ownership interest in the provider equal to 5 percent or greater, in which the provider participated or acquiesced.

(16) 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):

* * *

(c) Imposition of a fine of up to $5,000 for each violation. . . . Each instance of improper billing of a Medicaid recipient; . . . and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

* * *

(j) Other remedies as permitted by law to effect the recovery of a fine or overpayment.

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.

* * *

> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. . . . Notwithstanding the applicable rules of discovery, all documentation that will be offered as evidence at an administrative hearing on a Medicaid overpayment must be exchanged by all parties at least 14 days before the administrative hearing or must be excluded from consideration.
>
> (23)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.
>
> (b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relation to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability, and needs of the provider, who has the burden of demonstrating such factors.

25. AHCA made a prima facie case as to the overpayments to Respondent by submitting into evidence its audit report. Respondent stipulated to the exhibits. AHCA established that Respondent's billing for B.L.'s care did not comport with applicable billing requirements. Consequently, the payments at issue constitute overpayments.

26. Once AHCA made the prima facie case as outlined by the statute, then it was "incumbent upon the provider to rebut,

impeach, or otherwise undermine AHCA's evidence." See Ag. for Health Care Admin. v. Bagloo, Case No. 08-4921, RO at p. 33 (Fla. DOAH Sept. 10, 2009; Fla. AHCA Nov. 8, 2010).

27. Respondent attempted to undermine AHCA's theory by relying on a 2004 letter issued by a waiver support provider that clearly provided an end point to a particular payment arrangement. Respondent argued that AHCA is estopped to claim the overpayments were not authorized, that there was an expressed agency authorization by Lynk to Respondent, and/or that Lynk was an apparent agent of AHCA. Those arguments are rejected. Any equitable defense should be applied against an agency only in rare instances and in compelling circumstances. State Dep't of Rev. v. Anderson, 403 So. 2d 397, 400 (Fla. 1981). The facts of this case do not constitute a rare instance nor do they constitute compelling circumstances. Respondent relied to its determent on a letter that clearly contained an end time for a payment schedule. Respondent failed to effectively rebut, impeach, or otherwise undermine AHCA's evidence.

28. By presenting prima facie evidence of the overpayment, which was not credibly rebutted by Respondent, Petitioner met its ultimate burden of proving that Respondent has received overpayments in the total amount of $15,627.50, which is subject to recoupment.

29. Section 409.913(16)(c) provided that, at all times material to this case, AHCA "shall impose any of the following sanctions . . . on a provider or a person for any of the acts described in subsection (15): . . . Imposition of a fine of up to $5,000 for each violation."

30. Florida Administrative Code Rule 59G-9.070(7)(e) provides:

> 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.][.]

31. Respondent took the opportunity presented by this case to offer evidence demonstrating why it billed in the manner it did. Respondent relied on an expired waiver and did nothing to ensure it was properly billing after the 2004 current year ended. The record fails to establish that imposing fines within the applicable guidelines in this case would not be in the best interest of the Medicaid program.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration, enter a final order requiring Respondent, Sun States Services, Inc.:

(1) To repay the sum of $15,627.50 for overpayments on claims that did not comply with the requirements of Medicaid laws, rules, and provider handbooks; and

(2) To pay a fine of $1,000.00 for the violations of the requirements of Medicaid laws, rules, and provider handbooks.

DONE AND ENTERED this 1st day of November, 2012, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 1st day of November, 2012.

ENDNOTES

[1/] Although the pre-hearing stipulation reflects January 1, 2005, both parties and all the documentation confirm that AHCA conducted the audit from July 1, 2005, through December 31, 2008.

[2/] The overpayment was initially $16,518.60; however, this amount was subsequently reduced.

[3/] The original DOAH case number was 11-3345MPI.

[4/] After the hearing was concluded and the undersigned was reviewing the admitted exhibits, confidential medical information regarding Patient B.L. (name, social security number, Medicaid identification number, other private information, etc.) was noted

and redacted from Petitioner's Exhibits 1, 2, 3, 4, 9, 10, 12, 13, 14, and 15. Further, other personal information regarding the owners of Lynk Services, Inc. (social security number), was noted and redacted from Petitioner's Exhibit 16. In the future, Petitioner's counsel shall ensure that all confidential information is redacted prior to submission to DOAH.

[5/] Unless otherwise noted, all statutory references are to Florida Statutes (2012).

[6/] Several pages of the exhibits attached to Respondent's Exhibit A contained confidential medical information regarding Patient B.L. That information (name, social security number, Medicaid identification number, and other private information, etc.) has been redacted. In the future, Respondent's counsel shall ensure that all confidential information is redacted prior to submission to DOAH.

[7/] Respondent's PRO does not contain a certificate of service to opposing counsel, and a Notice of Ex-parte Communication was issued. Following the issuance of the Notice of Ex-parte Communication, the undersigned was notified that, at the time of filing of Respondent's PRO, the opposing counsel was, in fact, served.

[8/] This specific Service Authorization is on a Florida Department of Children and Families (DCF) form and is contained in AHCA's Exhibit 12, page 353. It reflects a "Begin Date" of December 23, 2003, and an "End Date" of February 1, 2004. Despite the pre-hearing stipulation that Lynk and Respondent were in discussion in January 2004 for services to be provided to B.L., it appears that Lynk was already providing some type of skilled nursing services to B.L. However, the specific services provided for in this Service Authorization are outside the audit period.

[9/] The Service Authorization referenced was not part of any exhibit provided. AHCA's Exhibit 12 contains two Service Authorizations: one, as listed above in Endnote 8; and the other with the begin and end dates of January 28, 2004, and September 30, 2004, respectively. Both authorization periods are outside the audit period.

[10/] Even if the "current support plan year" ran on the state's fiscal year (i.e., July 1 to June 30), the audit period started on July 1, 2005, and the 2004 waiver would have expired the day before the audit started.

[11/] Respondent's services to B.L. ended in September 2006, at B.L.'s death.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.