STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 13-0839MPI

AMER-CU HOME CARE, INC.,

Respondent.
_____/

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing on August 1, 2013, by videoconference in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Jeffries H. Duvall, Esquire
Assistant General Counsel
Agency for Healthcare Administration
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Tallahassee, Florida 32308

For Respondent: Enrique F. Vazquezbello, Jr.
Qualified Representative
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STATEMENT OF THE ISSUES

The issues are whether Petitioner has overpaid Respondent $9713.34 in reimbursed claims for home health visit services.

If so, additional issues are whether Petitioner is entitled to impose a fine of $1942.67 and assess costs of $254.70.

PRELIMINARY STATEMENT

By Final Audit Report dated January 2, 2013 (FAR), Petitioner advised Respondent that, after an audit of claims for Medicaid reimbursement from July 1, 2007, through March 31, 2011, Petitioner had determined that it had overpaid Respondent $9713.34. The FAR advises that Petitioner is imposing a fine of $1942.67, pursuant to sections 409.913(15)-(17), Florida Statutes, and Florida Administrative Code Rule 59G-9.070, and costs of $254.70, pursuant to section 409.913(23), Florida Statutes.

The FAR explains why the challenged claims do not meet Medicaid requirements. The FAR cites the Florida Medicaid Home Health Services Coverage and Limitations Handbook dated October 2003, page 3-2, for the limitation that home health visits to multiple recipients with individual residences at the same address are reimbursed at the established rate for the first recipient and 50 percent of the established rate for additional recipients. The FAR cites an identical limitations in the Florida Medicaid Home Health Services Coverage and Limitations Handbook dated July 2007 and July 2008, both at page 3-2.

Respondent timely requested a hearing.

At the hearing, Petitioner called three witnesses and offered into evidence 11 exhibits: Petitioner Exhibits 1-11. Respondent called two witnesses and offered into evidence one exhibit: Respondent Exhibit 1. All exhibits were admitted.

The court reporter filed the transcript on August 27, 2013. Petitioner filed its proposed recommended order on September 26, 2013.

FINDINGS OF FACT

1. Respondent has been a Medicaid provider since 2005, and the record discloses no prior violations of Medicaid law. Respondent provides home health visit services to Medicaid recipients in their homes, which may be group homes or private homes. The five recipients at issue in this case reside in private homes.

2. As identified in the FAR, the recipients are M. O., who is Recipient 1; A. del. P., who is Recipient 2; J. R., who is Recipient 3; N. M. de O., who is Recipient 4; and B. C. C., who is Recipient 5. (The Preliminary Audit Report dated November 8, 2011 (PAR), identifies these recipients by the numbers, respectively, of 1, 4, 7, 9, and 10, but this recommended order will refer to the recipients by the numbers assigned to them in the FAR.)

3. Respondent stipulates that the Florida Medicaid Home Health Services Coverage and Limitations Handbooks applicable to

the years in question authorize a full reimbursement for home health visit services provided to a single recipient at a specific address and a reduced reimbursement of one-half for home health visit services provided on the same date to subsequent recipients at the same address. This provision, which has been in Medicaid handbooks for about ten years, occurs on page 3-2 in Petitioner Exhibit 5.

4. As for the dates of service at issue in this case, Respondent concedes that, at the time of receiving home health visit services, Recipients 1-4 each resided with another recipient, who also received home health visit services from Respondent on the same dates. Respondent concedes that it has received full reimbursements for the services that it provided to these coresident recipients. Respondent contends that it is entitled to full reimbursements for the services that it provided to Recipients 1-4 because Petitioner's Medicaid billing program did not allow Respondent to enter the necessary information to halve these reimbursements.

5. Respondent contends that Recipient 5 did not reside with another recipient receiving home health visit services from Respondent for any date of service occurring from May 6, 2009, through September 1, 2009. Alternatively, Respondent would contend that, if this contention failed to prevail, it is

entitled to a full reimbursement for Recipient 5 on the same ground as it is for Recipients 1-4.

6. There is no merit to Respondent's contention as to Recipients 1-4. First, reimbursement rates are set by the home health services coverage and limitations handbooks, not a Medicaid billing program maintained by Petitioner for use by providers. Second, Petitioner has proved that Respondent could have entered on its submitted claims halved reimbursement amounts for Recipients 1-4.

7. Third, Petitioner gave Respondent a chance to correct its claims for Recipients 1-4 without any penalty. The Amended Preliminary Audit Report dated October 31, 2012 (APAR), which reduced the claimed overpayment to $9713.34, provides: "If the identified overpayment is paid within 15 days of receipt of this letter, amnesty will be granted in regard to the application of sanctions and the assessment of costs for this audit."

8. As one of Petitioner's witnesses testified, all Respondent had to do within 15 days was to contact Petitioner and arrange for a repayment schedule. But Respondent did not avail itself of this opportunity, clinging instead to its argument that some flaw in the online billing program entitles Respondent to full reimbursements for all coresidents to whom it provided home health visit services. Assuming, strictly for the sake of discussion, that something was wrong with the online

billing program, the amnesty offer constitutes the repair of the program and the restoration of Respondent to the point of submission (or resubmission) of the subject reimbursement claims. By not accepting the offer, Respondent essentially refuses to use the repaired program and unreasonably repeats its demand that it be relieved from a longstanding limitation on Medicaid reimbursement of home health visit services.

9. As for Recipient 5, the dispute is whether this recipient coresided with another recipient receiving home health visit services from Respondent. The PAR found a problem with four recipients, including Recipient 5, but, after examining documentation provided by Respondent, Petitioner dropped the overpayment claims arising out of the other three recipients, but not Recipient 5.

10. Relying on information contained in the Florida Medicaid database, which is known as FLMMIS, Petitioner determined that Recipient 5 coresided with another recipient. Although each recipient is required to provide updated residential information when appropriate, it is possible that Recipient 5 may not have timely done so. For its part, though, Respondent did not have documentation showing where the home health visit services were provided. Respondent instead relied on Recipient 5's Plan of Care, which is typically completed by the physician and presumably focuses more on the treatment plan

than the recipient's place of residence. The record does not reveal the date of the Plan of Care on which Respondent relied, nor how often these plans are updated.

11. Petitioner's staff tried to verify the address in Recipient 5's Plan of Care, but were unable to do so. On these facts, the addresses on FLMMIS control. It is unclear what role a recipient's address plays in a plan of care, but a recipient's address in FLMMIS is crucial because it is used to establish and maintain the recipient's Medicaid eligibility. A service log contemporaneously documenting the location that a provider visited to provide home health visit services probably would have sufficed to overcome the evidentiary force of the FLMMIS and FAR, which, as noted below, is evidence of the overpayment, but a mere plan of care cannot overcome this evidence.

12. Having determined that Petitioner has proved that Recipient 5 coresided with another recipient of home health visit services from Respondent on the dates in question, Respondent's alternative argument, which is the billing argument that it used for Recipients 1-4, is rejected on the same grounds.

13. Lastly, Petitioner has proved all factual grounds for imposing a fine of $1942.67 and assessing investigative costs of $254.70.

CONCLUSIONS OF LAW

14. DOAH has jurisdiction over the subject matter. §§ 120.569, 120.57(1), and 409.913(31), Fla. Stat.

15. Providers presenting reimbursement claims are required to ensure that each claim is "true and accurate and . . . is for goods and services that . . . [a]re provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law." § 409.913(7)(b) and (e).

16. Petitioner is required to "require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished." § 409.913(11). In discharging this duty, Petitioner is required to conduct audits of Medicaid providers to determine if it has overpaid reimbursement claims, § 409.913(2), and to prepare and issue audit reports documenting overpayments. § 409.913(21).

17. 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 regarding the standard of proof is that clear and convincing evidence is

required for fines. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

18. However, the audit report, if accompanied by supporting work papers, is "evidence of the overpayment." § 409.913(22). Although the statute could be clearer, section 409.913(22) provides that the audit report and work papers establish the determined total overpayment, absent contrary evidence.

19. Petitioner has proved that it overpaid Respondent a total of $9713.34. This overpayment has been determined without regard to Petitioner Exhibit 11, to which Respondent's objection is now sustained, post-hearing, under the authority of § 409.913(22).

20. Section 409.913(15) provides:

> (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[.]

21. Section 409.913(16)(c) authorizes Petitioner to impose a fine of up to $5000 per violation. Florida Administrative Code Rule 59G-9.070(7)(e) authorizes a fine of up to $1000 per violation for a first offense. Petitioner has proved the existence of several violations in this case, but Rule 59G-9.070(4)(a) caps the fine at 20 percent of the overpayments. Thus, the fine is $1942.67.

22. Petitioner is authorized to assess costs because it has prevailed in this case. § 409.913(23). The costs total $254.70.

RECOMMENDATION

It is RECOMMENDED that the Agency for Health Care Administration enter a final order finding a total overpayment of $9713.34, imposing a fine of $1942.67, and assessing costs of $254.70.

DONE AND ENTERED this 27th day of September, 2013, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 27th day of September, 2013.

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.