

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2014 MAR 26 A 9:12

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

GULFSIDE REGIONAL HOSPICE, INC.,

Respondent.

CASE NO.: 13-1571MPI

C.I. NO.: 13-0812-000

PROVIDER No.: 087570800

LICENSE No.: 5005096


NPI: 1144328881

RENDITION NO.: AHCA-14-0254-S-MDO

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a settlement agreement, which is attached and incorporated by reference. The parties are directed to comply with the terms of the attached settlement agreement. Based on the foregoing, this file is hereby **CLOSED**.

DONE AND ORDERED on this 25th day of March, 2014, in Tallahassee, Florida.


Elizabeth Dudek, Secretary
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS 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 RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Karl D. Acuff, Esquire
1615 Village Square Boulevard, Suite 2
Tallahassee, Florida 32309-2770
Telephone: (850) 671-2644
Fax: (850) 671-2732
Email: kd_acuff@floridacourts.com
(Via Electronic Mail)

Richard Zenuch, Chief
Medicaid Program Integrity
2727 Mahan Drive
Building 2, Mail Station 6
Tallahassee, Florida 32308
(Via Electronic Mail)

Tracie L. Hardin, Esquire
Agency for Health Care Administration
2727 Mahan Drive
Building 3, Mail Station 3
Tallahassee, Florida 32308
(Via Electronic Mail)

Eric W. Miller, Inspector General
Medicaid Program Integrity
2727 Mahan Drive
Building 3, Mail Station 4
Tallahassee, Florida 32308
(Via Electronic Mail)

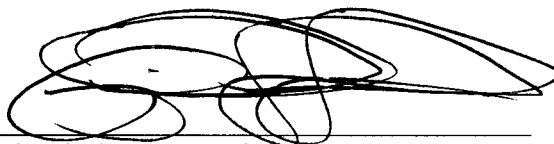
Agency for Health Care Administration
Bureau of Financial Services
2727 Mahan Drive
Building 2, Mail Station 14
Tallahassee, Florida 32308
(Via Electronic Mail)

Division of Administrative Hearings
The Desoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(Via Electronic Mail)

Bureau of Health Quality Assurance
2727 Mahan Drive, Mail Stop 9
Tallahassee, Florida 32308
(Via Electronic Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by Electronic Mail, or the method designated, on this the 26th day of March, 2014.



Richard Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, Building #3
Tallahassee, Florida 32308-5403
(850) 412-3630

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION**

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,**

Petitioner,

vs.

Case No.: 13-1571MPI

C.I. No.: 13-0812-000

Provider No.: 087570800

License No.: 5005096

NPI No.: 1144328881

GULFSIDE REGIONAL HOSPICE, INC.,

Respondent.

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**, (“AHCA” or “Agency” or “Petitioner”), and Respondent, **GULFSIDE REGIONAL HOSPICE, INC.**, (“PROVIDER”), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties enter into this agreement for the purpose of memorializing the resolution to this matter.

2. PROVIDER is a Medicaid provider in the State of Florida, provider number 087570800, and was a provider during the audit period.

3. In its Final Audit Report, dated March 18, 2013, the Agency notified PROVIDER that a review of Medicaid claims performed by Medicaid Program Integrity (“MPI”), Office of the AHCA Inspector General, during the period of January 1, 2008, through December 31, 2011, indicated that certain claims, in whole or in part, were inappropriately paid by Medicaid. The

Agency sought repayment of this overpayment, in the amount of forty-four thousand, eight hundred seventy dollars and thirty-five cents (\$44,870.35). Additionally, the Agency applied sanctions in accordance with Sections 409.913(15), (16), and (17) Florida Statutes, and Rule 59G-9.070(7)(e) Florida Administrative Code. Specifically, the Agency assessed the following sanctions against PROVIDER: a fine in the amount of eight thousand, nine hundred seventy-four dollars and seven cents (\$8,974.07) and costs in the amount of fifty-four dollars and sixteen cents (\$54.16). The total amount due was fifty-three thousand, eight hundred ninety-eight dollars and fifty-eight cents (\$53,898.58).

4. In response to the audit report dated March 18, 2013, PROVIDER filed a *Petition for Formal Administrative Hearing*.

5. Subsequent to the original audit that took place in this matter, the Agency agreed to relinquish the fine. The overpayment remains in the amount of forty-four thousand, eight hundred seventy dollars and thirty-five cents (\$44,870.35). Additionally, the Agency assessed the following against the PROVIDER: costs in the amount of fifty-four dollars and sixteen cents (\$54.16) pursuant to Section 409.913(23)(a), Florida Statutes. The total amount due is forty-four thousand, nine hundred twenty-four dollars and fifty-one cents (\$44,924.51).

6. In order to resolve this matter without further administrative proceedings, PROVIDER and AHCA agree as follows:

- (1) AHCA agrees to accept the payment set forth herein in settlement of the overpayment, fine, and costs arising from the above-referenced audit.

- (2) Within thirty (30) days from the date of the execution of a Final Order adopting this Settlement Agreement, PROVIDER agrees to pay the Agency the sum of forty-four thousand, nine hundred twenty-four dollars and fifty-one cents (\$44,924.51).
- (3) The amount due will be offset by any amount already received by the Agency in this matter.
- (4) PROVIDER and AHCA agree that such payment as set forth above will resolve and settle this case completely and release both parties from all liabilities arising from the findings relating to the claims determined to have been overpaid in the audit referenced as C.I. Number **13-0812-000**.
- (5) PROVIDER agrees that it will not rebill the Medicaid Program in any manner for claims that were not covered by Medicaid, which are the subject of the audit in this case.

Payment shall be made to:

**AGENCY FOR HEALTH CARE ADMINISTRATION
Medicaid Accounts Receivable
2727 Mahan Drive M.S. #14
Tallahassee, Florida 32308-5403**

7. Payment shall clearly indicate it is pursuant to a settlement agreement and shall reference the audit number.

8. Overpayments owed to the Agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the Agency; and payment arrangements must be made at the conclusion of legal proceedings, pursuant to Section 409.913(25)(c), Florida Statutes.

9. PROVIDER agrees that failure to pay any monies due and owing under the terms of this Agreement shall constitute PROVIDER'S authorization for the Agency, without further notice, to withhold the total remaining amount due under the terms of this agreement from any monies due and owing to PROVIDER for any Medicaid claims.

10. AHCA reserves the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

11. This settlement does not constitute an admission of wrongdoing or error by either party with respect to this case or any other matter.

12. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

13. This Settlement Agreement shall be construed in accordance with the provisions of the laws of Florida.

14. Venue for any action arising from this Settlement Agreement shall be in Leon County, Florida.

15. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with or employed by them, concerning all matters and supersedes any prior discussions, agreements or understandings; there are no promises, representations or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

16. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information and contentions, as to facts and law, and with each party compromising and settling any potential correctness or

incorrectness of its understandings, information and contentions as to facts and law, so that no misunderstanding or misinformation shall be a ground for rescission hereof.

17. PROVIDER expressly waives in this matter its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes, the making of findings of fact and conclusions of law by the Agency, and all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this proceeding and any and all issues raised herein. PROVIDER further agrees that it shall not challenge or contest any Final Order entered in this matter which is consistent with the terms of this settlement agreement in any forum now or in the future available to it, including the right to any administrative proceeding, circuit or federal court action or any appeal.

18. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses and expenses, of any and every nature whatsoever, arising out of or in any way related to this matter, AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this agreement.

19. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

20. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement.

21. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.


22. All times stated herein are of the essence of this Agreement.

23. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

24. The parties agree to bear their own attorney's fees and costs, if any.

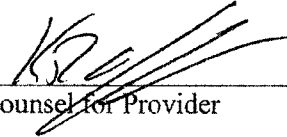
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GULFSIDE REGIONAL HOSPICE, INC.



Provider's Representative

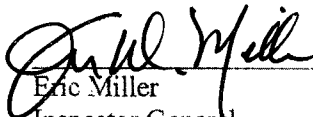
Dated: 2/28, 2014



Counsel for Provider

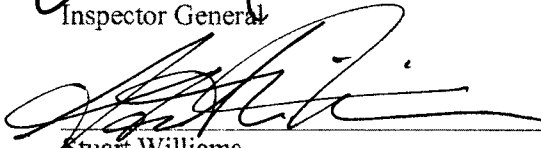
Dated: 2/28, 2014

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION**
2727 Mahan Drive, Mail Stop #3
Tallahassee, Florida 32308-5403



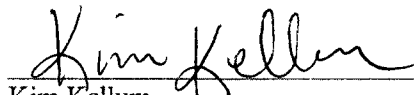
Eric Miller
Inspector General

Dated: 3/25, 2014



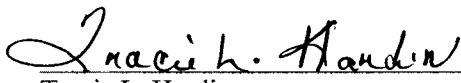
Stuart Williams
General Counsel

Dated: 3/20, 2014



Kim Kellum
Chief Medicaid Counsel

Dated: 3/11, 2014



Tracie L. Hardin
Assistant General Counsel

Dated: March 3, 2014



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FEDERAL EXPRESS MAIL No.: 8027 0367 2785

March 18, 2013

Provider No: 087570800
NPI No: 1144328881
License No.: 5005096

GULFSIDE REGIONAL HOSPICE, INC.
6117 TROUBLE CREEK RD
NEW PORT RICHEY, FL 34653-5240

In Reply Refer to
FINAL AUDIT REPORT
C.I. No.: 13-0812-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2008 through December 31, 2011. A preliminary audit report dated January 18, 2013 was sent to you indicating that we had determined you were overpaid \$44,870.35. Since no documentation was produced to refute these billings, all the claims are considered overpayments. We have determined that you were overpaid \$44,870.35 for services that in whole or in part are not covered by Medicaid. A fine of \$8,974.07 has been applied. The cost assessed for this audit is \$54.16. The total amount due is \$53,898.58.

Be advised of the following:

- (1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (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. This letter shall serve as notice of the following sanction(s):
 - A fine of \$8,974.07 for violation(s) of Rule Section 59G-9.070(7) (e), F.A.C.
- (2) Pursuant to Section 409.913(23) (a), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.



The Medicaid program is authorized by Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations. The Florida Medicaid Program is authorized by Chapter 409, F.S., and Chapter 59G, F.A.C. This review and the determination of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining the appropriateness of Medicaid payment pursuant to Medicaid policy, the Medicaid program utilizes procedure codes, descriptions, policies, limitations and requirements found in the Medicaid provider handbooks and Section 409.913, F.S. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks (in accordance with Chapter 59G, F.A.C.), billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Below is a discussion of the particular guidelines related to the review of your claims, and an explanation of why these claims do not meet Medicaid requirements. The audit work papers are attached, listing the claims that are affected by this determination.

REVIEW DETERMINATION(S)

A Medicaid Provider is required to comply with Medicaid policy requirements (e.g. laws, rules, regulations, handbooks, policy). These requirements include, but are not limited to, providing goods and services in accordance with provisions of Medicaid policy and retaining medical, financial, and business records pertaining to the goods and services furnished. This review included a review of your claims reimbursed to you by Medicaid for goods and services to determine compliance with Medicaid policy. Payments for goods or services that are not documented and/or not billed in accordance to Medicaid policy are deemed to be overpayments. Our review has determined that you have failed to comply with Medicaid policy as outlined below.

- Medicaid fee-for-service payments have been identified for recipients while they were enrolled in the Medicaid Nursing Home Diversion Waiver Program. Medicaid providers are required to verify Medicaid recipient eligibility prior to rendering Medicaid services. The fee-for-service payments, shown on the attached work papers, were for services that were to be covered by the recipient's Nursing Home Diversion Waiver Provider. The total amount reimbursed to you for these fee-for-service payments has been identified as an overpayment.

If you are currently involved in a bankruptcy, you should notify your attorney immediately and provide a copy of this letter for them. Please advise your attorney that we need the following information immediately: (1) the date of filing of the bankruptcy petition; (2) the case number; (3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division); and, (4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit by certified check the total amount reflected on page one, paragraph one, of this letter which includes the overpayment amount as well as any fines imposed and assessed costs. The check must be payable to the **Florida Agency for Health Care Administration**. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

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.

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Any questions you may have about this matter should be directed to: **Sheri Creel, Auditor, Agency for Health Care Administration, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4600, facsimile (850) 410-1972.**

Sincerely,



Pamela Fante
Program Administrator
Office of Inspector General
Medicaid Program Integrity

PF/SC/SG

Enclosure(s)

Copies furnished to:

Finance & Accounting
(Interoffice mail)

Health Quality Assurance
(E-mail)

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration, by 5:00 P.M. no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158
Phone: (850) 412-3630

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.

If you are in agreement with this audit and wish to make payment, please return this form along with your check.

Complete this form and send along with your check to:

Agency for Health Care Administration
Medicaid Accounts Receivable
2727 Mahan Drive, Mail Stop #14
Tallahassee, Florida 32308

**CHECK MUST BE MADE PAYABLE TO:
FLORIDA AGENCY FOR HEALTH CARE
ADMINISTRATION**

Provider Name	GULFSIDE REGIONAL HOSPICE, INC.
Provider ID	087570800
MPI Case Number	13-0812-000
Overpayment Amount	\$ 44,870.35
Fine Amount	\$ 8,974.07
Costs Assessed	\$ 54.16
Total Amount Due	\$ 53,898.58
Check Number	

Payment for Medicaid Program Integrity Audit