STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 13-4286MPI

ANGELS UNAWARE, INC.,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, an administrative hearing was conducted in this case on January 9, 10, and 27, 2014, in Tallahassee, Florida, before Lynne A. Quimby-Pennock, an Administrative Law Judge with the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Douglas James Lomonico, Esquire
Shena Grantham, Esquire
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For Respondent: Frank P. Rainer, Esquire
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STATEMENT OF THE ISSUE

Whether the Agency for Health Care Administration (Agency) is entitled to recover alleged Medicaid overpayments, sanctions,

and investigative, legal and expert witness costs from Angels Unaware, Inc. (Respondent).

PRELIMINARY STATEMENT

On December 11, 2012, the Agency issued a Final Audit Report (FAR) advising Respondent of its intention to seek reimbursement of $50,357.90 in alleged Medicaid overpayments, $10,071.58 in administrative fines, and $4,914.14 in costs from Respondent based on Medicaid claims made by Respondent under Provider No. 024115696 from January 1, 2008, through December 31, 2009 (the audit period). The FAR also notified Respondent that it had the right to request an administrative hearing within 21 days from the receipt of the letter.

Respondent timely requested an administrative hearing under section 120.57, Florida Statutes (2012), and on February 13, 2013, the Agency referred the case to DOAH. On February 22, a Joint Motion to Relinquish Jurisdiction was filed, and the original DOAH case was closed with leave to reopen it should the parties be unable to execute a settlement.

On November 5, 2013, a Motion to Reopen and Set Formal Hearing was filed and the above case number was assigned. On November 14, the case was set for final hearing for January 9 and 10, 2014, and an Order of Pre-hearing Instructions was issued setting forth the discovery timeline and filing instructions.

On December 10, 2013, the Agency filed its witness disclosure notice, and on December 11, the Agency filed an Unopposed Motion to Restrict the Use and Disclosure of Information Concerning Medicaid Applicants and Beneficiaries. On December 12, this motion was granted. On December 20, Respondent filed a Motion for Continuance, and the Agency filed its Response to Motion for Continuance on December 23. An Order denying the continuance was issued on December 30. On January 6, 2014, the Agency filed its Prehearing Stipulation.[1/] Therein, the Agency revised the amount of the overpayment to $48,525.83. On January 6, Respondent filed its witness and proposed exhibit list. On January 7, Respondent's Joinder and Additional Items of Agreement with Petitioner's Prehearing Stipulation was filed. The Agency's Motion to Strike Respondent's Witness List was filed later on January 7.

The hearing commenced on January 9, 2014. The Agency withdrew its Motion to Strike Respondent's Witness List after Respondent announced its witnesses for the hearing. The parties stipulated that the statistical formula used by the Agency was an appropriate method for the determination of the amount of the overpayment within the meaning of section 408.809(5)(a), Florida Statutes (2013),[2/] such that no additional testimony or evidence was required on the statistical information. Additionally, the Agency announced another downward revision of the amount of the

overpayment it was seeking. In reducing the overpayment amount, the sanction was also reduced. At the end of the second hearing day, testimony had not been completed, and by mutual agreement, the case was continued to and concluded on January 27.

At the hearing, the Agency presented the testimony of Robi Olmstead, the case management unit (CMU) manager for the Agency's Office of Medicaid Program Integrity (MPI); Kristen Koelle, a special projects coordinator and a former medical health care program analyst/investigator with the CMU; and Gregory Riley, an Agency registered nurse (RN) consultant. The Agency offered Exhibits 1 through 13,[3/] which were received into evidence without objection, and Exhibits 15[4/] and 16,[5/] which were received into evidence over Respondent's objection. Without objection, official recognition was taken of the relevant handbooks: the Developmental Disabilities Waiver Services Handbook dated November 5, 2007; the Developmental Disabilities Waiver Services Handbook dated November 26, 2008; the Provider General Handbook dated July 2008; and the Provider General Handbook dated January 2007; and the applicable statutes and rules.

Respondent presented the testimony of Ross O'Banion, Jr., executive director of Respondent; James Epperson, personnel director of Respondent; and Sonya Seabrook, licensed practical nurse (LPN) and home manager of Respondent. Respondent offered

composite Exhibit 1, which was admitted over the Agency's objections.

At the close of the hearing, Respondent requested 30 days from the filing of the transcript within which to file proposed recommended orders (PROs). The request was granted.

The five-volume Transcript of these proceedings was filed on February 10, 2014. On March 11, the Agency's Notice of Filing Cost Affidavits was filed at DOAH along with five affidavits. These affidavits have not been reviewed as the parties were advised that any costs would be resolved at a later time. Both parties timely filed a PRO, and both have been duly considered by the undersigned in the preparation of this Recommended Order.

FINDINGS OF FACT

PRELIMINARY

1. The Agency is the state agency responsible for administering the Florida Medicaid Program (Medicaid). Medicaid is a joint federal/state partnership to provide health care and sometimes related services to certain qualified individuals (disabled or indigents). Among its duties, the Agency is required to conduct audits and to recover "overpayments . . . as appropriate."

2. Section 409.913(1)(e), Florida Statutes, defines "overpayment" to mean "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." As found in section 409.913(1)(a)1., "abuse" includes "[p]rovider practices that are inconsistent with generally accepted business or medical practices and that result in an unnecessary cost to the Medicaid program or in reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards of health care."

3. The Agency's Bureau of Medicaid Services has the responsibility for implementing the rules and policies regarding the Developmental Disabilities (DD) Waiver and Provider Reimbursement Programs.

4. One method the Agency uses to discover Medicaid overpayments is by auditing billing and payment records of Medicaid providers. Such audits are performed by staff in the Agency's MPI. MPI is responsible for reviewing providers to assure that the services rendered were done in accordance with the applicable rules, regulations and handbook(s). MPI looks to ensure that the provider is enrolled, the recipient is eligible, the service billed is covered, and the service is billed appropriately.

5. In order to participate in the voluntary Medicaid program, providers have to enroll in a fee-for-service program. The provider submits an application to the Agency and undergoes a

background screening check to ensure they meet the qualifications for enrollment and are not listed on a federal exclusion roster. Once accepted they are issued a provider number, and they receive handbooks and instructions on how to bill for the services they provide. Those providers who provide DD waiver services must also have a contract with the Agency for Persons With Disabilities (APD), as well as a Medicaid Services Agreement with APD.

6. Every individual recipient has a support plan (SP), which identifies the supports and services designed to meet the needs of that recipient. A physician determines the medical necessity for each recipient. Each SP is to include the most appropriate, least restrictive and most cost-beneficial environment for the recipient to accomplish SP's objectives and a specification of all services authorized. The SP delineates who is to provide the services. Once the SP is approved, the support coordinator will develop a cost plan to determine how payment for those needed supports will be made. A cost plan is "a document used by the waiver support coordinator that lists all waiver services requested by the recipient on the support plan and the anticipated cost of each waiver service. The cost plan is updated annually based on the results of the support planning process to reflect current needs and situations." Although a cost plan usually lasts for a year at a time, it may be amended

"only if there is a documented significant change in the recipient's condition or circumstance that affects the recipient's health or welfare."

7. When the Agency audits a Medicaid provider for possible overpayments, it "must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or a combination thereof." See § 409.913(20), Fla. Stat. The parties stipulated to the statistical analysis that was performed, thus, no additional testimony or evidence was received on it, and the amount of overpayments is not at issue, other than Respondent's position that there were no overpayments.

8. In the DD program, once an entity is selected for the review, an Agency investigator develops a request for records and sends it to the entity with a list of the recipients to be reviewed along with the applicable review period. The entity then sends in the records. In a DD program review, the investigator reviews the records and then, if necessary, a qualified nurse reviews any nursing services records. The qualifications of the entity's staff who are providing the service(s) are reviewed first. If the staff is ineligible, then the services provided are disallowed. Once the staff is validated, the review continues to the individual recipients, their SP, including any prescriptions, the cost plan and the documentation for the services provided.

9. The service authorization authorizes a provider to provide a service and bill for that service at a specific rate. If a provider does not have a service authorization, it cannot provide the service, and it cannot submit a claim or be reimbursed for the service.

10. In-home support services are provided to recipients as long as they are authorized and required. In-home support services may include: companionship; personal care or hygiene; and help with different things around the home, including housekeeping, grocery shopping and/or cooking. In-home support is billed in either a unit of service (UOS), which is 15 minutes at a time or at a daily live-in rate, which is eight hours or more. In-home support rates are roughly $3.00 per UOS, and may go up to $120 for a daily live-in rate for 24 hours.

11. Supported living coaching (SLC) is more involved. SLC is limited to adults who rent or own their residence and cannot exceed six hours or 24 quarter hours of service each day. SLC provides one-on-one assistance which may include: locating housing; acquiring, retaining or improving skills related to the activities of daily living (ADLs), which may include household chores; meal preparation; shopping; personal finances; and social and adaptive skills necessary to stay in the residence. SLC rates are roughly $8.00 for a UOS. It may be necessary for a recipient to have SLC and in-home support; however, providers

must coordinate their activities to avoid duplicate billing for the two services.

12. After an Agency investigator reviews the submitted records, an Agency nurse consultant reviews all the nursing records for the recipients to determine whether the care plan has been serviced adequately for the claims billed. This review includes any prescriptions, the nursing service log(s), and the nursing daily assessment or notes.

13. After the Agency's staff completes the review of the records, a preliminary audit report (PAR) is prepared and sent to the provider along with the Agency's worksheets and overpayment calculations. The provider is given the opportunity to submit any additional documentation it may have, and the provider usually does so.

14. Once all the additional records have been received and reviewed, the Agency issues the FAR, along with the Agency's work papers.

ANGELS UNAWARE, INC.

15. Respondent is a 501(c)3 not-for-profit corporation that has been in operation for 40 years, specializing in assisting the severe, profound and/or moderately developmentally disabled population. Respondent's expressed goal and purpose is to provide quality residential living options and services to the developmentally disabled population in the Tampa Bay area.

Respondent provides residential habitation, transportation, nursing, behavioral services, as well as supportive living, in-home supports and other non-remunerative services.

16. Respondent is (and was at all times relevant to this action) enrolled as an authorized provider in the Florida Medicaid Developmental Disabilities Waiver Program (DD Program), having been issued Medicaid provider no. 024115696. Respondent, as an enrolled provider, is required to comply with the Florida Medicaid Provider General Handbook, the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, the Provider Reimbursement Handbook, and the applicable laws and rules. Respondent acknowledged that it used the Medicaid Provider General Handbook, the Developmental Disabilities Waiver Services Coverage and Limitations Handbook, and the Provider Reimbursement Handbook in providing services to and billing for those services on behalf of the recipients. Florida Medicaid providers are required by their agreements with the state to comply with the requisite handbooks, laws and regulations. The handbooks outline the requirements for record-keeping, as well as other pertinent information to assist providers. Additionally, the Agency staff is available should providers have questions.

17. Respondent submitted bills which were processed and paid through the Florida Medicaid payment system. The Medicaid billing services in question include in-home support, home and

community based services under the DD waiver, supported living coaching, residential habitation, skilled nursing, and residential nursing.

SETTING

18. In May 2011, the Agency notified Respondent that MPI was "in the process of completing a review of claims billed to Medicaid during the period January 1, 2008 through December 31, 2009, to determine whether the claims were billed and paid in accordance with Medicaid policy." In July 2011, Respondent provided over 13,000 pages of the "Medicaid-related records requested by the Agency."

19. Investigator Koelle, an experienced MPI investigator, completed the steps of the audit process according to established Agency protocols. She reviewed Respondent's provider information and billing (excluding the nursing records, which were reviewed by an Agency nurse) to determine the staff qualifications, the types of services that were provided, the claims that were submitted, and how much was paid by Medicaid. The Agency identified 20 recipients (or "consumers," as Respondent calls them) who received services from Respondent for which there were billing issues. Following a preliminary review and notification by the Agency, Respondent provided more records to the Agency for its consideration. A PAR was sent to Respondent in May 2012.

Thereafter, Respondent provided additional records for the Agency's consideration.

20. Investigator Koelle reviewed the supported living services and coaching services provided to the consumers. An Agency nurse consultant initially reviewed the nursing records and provided Investigator Koelle with those findings.

21. In those instances when the SP provided for the in-home support services, only the in-home support provider could properly bill for services. When SLC occurred, but was not authorized by the SP, the coach could not bill for the coach's time. Further, neither the in-home support provider nor the coach could bill for certain activities. Mr. Epperson conceded several billing errors in that "unauthorized activities," such as watching TV and/or coloring, are not billable activities and should not have been billed.

22. On December 11, 2012, after reviewing the additional records, Investigator Koelle prepared the FAR, which CMU manager Olmstead executed and sent to Respondent. In the FAR, the Agency notified Respondent of the completion of its review of claims for Medicaid reimbursement for the audit period. Included with the FAR were: the overpayment calculations; a listing of the billing claims by recipient name; and the staff file review findings. The FAR contained an overpayment amount (which was approximately $103,100.00 less than the PAR), sanctions (which were less than

the PAR), and costs. The FAR was attached to the request for hearing that was submitted by Respondent. The overpayment amount and the sanction amount were revised (downward to $48,191.35 and $9,638.27, respectively) at the start of the hearing.[6/] These amounts have not been repaid to the Agency.

23. RN Riley provided an additional review of the nursing services records, including the billing records, in preparation for the hearing.[7/] In those instances where RN Riley determined there were no adjustments to the billing, he would write "no change" and initial the work papers. However, in those instances where RN Riley found an adjustment was necessary, he would make that notation to the side of the entry and sign or initial the adjustment.

24. RN Riley found numerous instances of the nursing services billing more units than were prescribed. Examples of the types of prescriptions issued to various consumers (during the audit period) included the following:

Residential Nursing One hour per Day
Residential Nursing 1 1/2 hours per Day
Medically Necessary Residential Nursing
1 hour (one) per day
Residential Nursing 3 hours/day
Residential Nursing 1 hr per day
Residential nursing x 1 hr per day
Residential Nursing 2 hours per week
Residential Nursing Care 4 hours per week
Residential Nursing 6 hours per month

Only prescriptions for nursing care per week or month allow the nursing staff flexibility to vary daily when those nursing services can be provided. Respondent's theory, that the nurse on duty can provide excess nursing units on any "per day" basis as long as they do not exceed the cost plan or service authorization, is rejected. A prescription is a physician's directive as to how to treat a patient/consumer and is not subject to change without that physician's authorization. (This is not to mean that emergent care should not be rendered when necessary, but that if additional nursing/medical services are necessary in addition to what was prescribed, the attending physician must be notified and a prescription, or authorization, obtained. As to the cost associated with the increased nursing services, that would require another cost plan adjustment.)

25. Respondent's nursing staff provided services to one consumer after that consumer's prescription lapsed. Respondent's staff acknowledged that the Agency's adjustments for this billing were correct.

26. Respondent's consumers are complex. It is understandable that some consumers may require more nursing services than are prescribed. However, the nursing staff has a method to communicate with each consumer's physician to secure an appropriate prescription for the requisite services. The fact that Respondent did not exceed the overall cost plan, in

instances where nursing services exceeded the "per day" prescription, is of no consequence because the actual prescription controlled what nursing services were available for each consumer on each day. Respondent's staff communicates with the consumer's physicians "every couple of months, if not monthly, according to LPN Seabrook." In an emergency, Respondent's staff, whether it is a nurse, support staff or coach, would contact the appropriate emergency services. Respondent's thought, that providing nursing services beyond that which was prescribed but was within the cost plan, is incorrect.

27. According to Respondent's residential nursing staff, if the SP has a prescription for nursing services, the cost for that prescribed nursing service is usually determined after the cost plan is made. This is not an accurate description of the process, as the DD handbook provides that the cost plan "lists all waiver services requested by the recipient on the support plan and the anticipated cost of each waiver service."

28. Respondent did not dispute that it was a provider. Respondent did not dispute it was subject to the handbooks and pertinent guidelines. Respondent did not dispute it was required to maintain records to support the claims. Respondent did not dispute it was paid for the claims submitted to the Agency. Respondent disputed that there was overbilling; however, the audit report and work papers proved otherwise.

CONCLUSIONS OF LAW

29. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding. §§ 120.569, 120.57(1), and 409.913(31), Fla. Stat.

30. The burden of proof is on the Agency to prove the material allegations by a preponderance of the evidence. S. Med. Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440 (Fla. 3rd DCA 1995); Southpoint Pharmacy v. Dep't of HRS, 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).

31. To meet its burden of proof, the Agency may rely on the audit records and report. Subsections 409.913(21) and (22) provide:

> (21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

32. The term "overpayment" is defined as "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." § 409.913(1)(e), Fla. Stat.

33. A claim presented under the Medicaid program imposes on the provider an affirmative duty to be responsible for and to assure that each claim is true and accurate and that the service for which payment is claimed has been provided to the Medicaid recipient prior to the submission of the claim. § 409.913(7), Fla. Stat.

34. The Agency is required to 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 to report the findings of any overpayments in audit reports as appropriate and to prepare and issue audit reports documenting overpayments. § 409.913(2), (21), Fla. Stat.

35. The audit report, if accompanied by supporting work papers, is "evidence of the overpayment." § 409.913(22), Fla. Stat. Although the statute could be clearer, section 409.913(22) provides that the audit report and work papers establish the overpayment, absent contrary evidence. Respondent's evidence did not establish the contrary. In fact, Respondent's own team conceded there were errors in some billing which should have been caught, but were not.

36. The Agency met its prima facie burden to establish the overpayment. This overpayment has been determined through Petitioner's Exhibits 6, 8, and 15 and the testimony of Investigator Koelle and RN Riley.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order sustaining the Medicaid overpayment in the amount of $48,191.35.

Further, jurisdiction is retained to determine the amount of sanctions, costs and attorney's fees, if the parties are unable to agree to the amount, and either party may file a request for a hearing within 30 days after entry of the final order to determine the appropriate amounts.

DONE AND ENTERED this 2nd day of April, 2014, 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 2nd day of April, 2014.

ENDNOTES

[1/] The Agency should have filed a "Unilateral Prehearing Statement," as Respondent did not join in the "Agency's Prehearing Stipulation."

[2/] All references to Florida Statutes are to Florida Statutes (2013), unless otherwise noted.

[3/] Supplemented pages were added to Exhibit 8 during the hearing.

[4/] The Bate-stamp pagination of this exhibit was inconsistent, which caused difficulty in comparing pages to the Transcript.

[5/] Respondent's witnesses were allowed ten days in which to complete the errata sheets to the depositions comprising composite Exhibit 16. The errata sheets for Mr. Epperson and Mr. O'Banion were timely filed. Ms. Seabrook's deposition was transcribed correctly and did not require an errata sheet.

[6/] When the undersigned stated the overpayment amount as provided in the pre-hearing statement, the Agency's counsel revised the amount downward to $48,191.35, and the sanction was reduced to $9,638.27. Respondent's counsel did not object to the lower figures.

[7/] The original Agency nurse reviewer was no longer employed by the Agency.

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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.