STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

THE CHRYSALIS CENTER, INC.,

Respondent.
_____/

DOAH CASE NO. 14-0136MPI
C.I. NOS. 13-1375-000, 13-1376-000, 13-1377-000
RENDITION NO.: AHCA-14 - 757 -FOF-MDO

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), Robert E. Meale, issued a Recommended Order after conducting a formal hearing. At issue in this proceeding is whether the Agency for Health Care Administration ("Agency") is entitled to recover alleged Medicaid overpayments from Respondent for services rendered to Medicaid recipients from January 1, 2008 to December 31, 2011; and whether Petitioner is liable to Respondent for attorney's fees under Section 57.105(1)(a) and (5), Florida Statutes. The Recommended Order dated June 3, 2014, is attached to this Final Order and incorporated herein by reference.

RULING ON EXCEPTIONS

Petitioner filed exceptions to the Recommended Order, and Respondent filed a response to Petitioner's exceptions.

In determining how to rule upon Petitioner's exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow Section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over

> which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

§ 120.57(1)(*l*), Fla. Stat. Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on Petitioner's exceptions:

In Exception #1, Petitioner takes exception to the findings of fact in Paragraphs 12, 16 and 17 of the Recommended Order, arguing that there is no competent, substantial evidence to support the ALJ's determination that Mr. Young would have determined that codes H0032 and H2019HW were not covered by the Nursing Home Diversion Waiver ("NHDW") standard contract as the ALJ found in Paragraphs 16 and 17 of the Recommended Order. Contrary to Petitioner's argument, the findings of fact in Paragraphs 16 and 17 of the Recommended Order are reasonable inferences based on competent, substantial evidence. See Transcript, Volume II, Pages 232-238; Respondent's Exhibits 2 and 10. Thus, the Agency cannot disturb them. See § 120.57(1)(l), Fla. Stat.; Heifetz v. Dep't of Bus. Reg., 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there

is no competent, substantial evidence from which the finding could reasonably be inferred"). Therefore, the Agency denies Exception #1.

In Exception #2, Petitioner takes exception to the findings of fact in Paragraph 25 of the Recommended Order, arguing that there is no competent, substantial evidence to support the ALJ's inference that testimony regarding one set of services can be used to make assumptions about another set of services. Petitioner also argues the ALJ credited Ms. Lynch's testimony regarding the physician's involvement in the services at issue without properly evaluating the applicable handbook and therefore ignored competent, substantial evidence. The findings of fact in Paragraph 25 of the Recommended Order are based on competent, substantial evidence. See Transcript, Volume II, Pages 192-200. Thus, the Agency is not permitted to disturb the ALJ's findings of fact in this paragraph. See § 120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception #2.

In Exception #3, Petitioner takes exception to the findings of fact in Paragraphs 29 and 30 of the Recommended Order, arguing that the findings in these paragraphs are actually erroneous legal conclusions by the ALJ that should be overturned. Paragraphs 29 and 30 of the Recommended Order contain ultimate findings of fact that are based on the ALJ's weighing of competent, substantial evidence (See, e.g., Transcript, Volume II, Pages 175-180 and 192-196). Thus, the Agency is prohibited from rejecting or modifying them. See § 120.57(1)(l), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Exception #3.

In Exception #4, Petitioner takes exception to the findings of fact in Paragraphs 37, 38 and 39 of the Recommended Order, arguing that the ALJ incorrectly required Petitioner to demonstrate that physicians provided nearly all of the services at issue in this matter. The findings of fact in Paragraphs 37 and 38 of the Recommended Order are based on the ALJ's

weighing of the evidence presented in this matter. Compare Transcript, Volume II, Pages 194 and 198-202 with Petitioner's Exhibit 25. The Agency cannot re-weigh evidence in order to reach findings that differ from those of the ALJ. See McDonald v. Dep't of Banking & Fin., 346 So. 2d 569, 579 (Fla. 1st DCA 1977); Schrimsher v. Sch. Bd. Of Palm Beach County, 694 So. 2d 856, 860 (Fla. 4th DCA 1997). In addition, the findings of fact in Paragraph 39 of the Recommended Order concern an evidentiary issue that is outside of the Agency's substantive jurisdiction. See Barfield v. Dep't of Health, 805 So. 2d 1008 (Fla. 1st DCA 2002). Thus, the Agency cannot address it. Therefore, the Agency must deny Exception #4.

In Exception #5, Petitioner takes exception to the findings of fact in Paragraphs 40, 41 and 42 of the Recommended Order, arguing that the findings are actually erroneous conclusions of law that should be overturned. Contrary to Petitioner's argument, Paragraphs 40, 41 and 42 of the Recommended Order are ultimate findings of fact based on the ALJ's weighing of competent, substantial evidence. See Transcript, Volume II, Pages 178-179 and 192-200. The Agency cannot re-weigh such evidence in order to make findings that differ from those of the ALJ. Therefore, the Agency must deny Exception #5.

In Exception #6, Petitioner takes exception to the findings of fact in Paragraph 43 of the Recommended Order, arguing the ALJ erred in requiring Petitioner demonstrate that a physician provided the services at issue in this matter. Based on the reasoning set forth in the ruling on Exception #5 supra, the Agency also denies Exception #6.

In Exception #7, Petitioner takes exception to the findings of fact in Paragraphs 47 and 48 of the Recommended Order, arguing that the ALJ inappropriately found and concluded that Respondent is entitled to attorney's fees under Section 57.105, Florida Statutes, because there is no competent, substantial evidence to demonstrate that the Agency should have known its claim

was unsupported by the necessary material facts. To the extent Paragraphs 47 and 48 of the Recommended Order are findings of fact, they are based on competent, substantial evidence. See the Agency's rulings on Exception #1 - #6 supra. To the extent Paragraphs 47 and 48 of the Recommended Order are legal conclusions, they address an issue that is outside of the Agency's substantive jurisdiction. Therefore, the Agency must deny Exception #7. However, the Agency notes that the ALJ erred in calling his recommendation on the issue of attorney's fees a "Final Order" on Page 40 of the Recommended Order. The ALJ's recommendation is non-final in nature, and does not become final upon issuance of this Final Order. Instead, the issue must be litigated further before reaching finality in order to give both parties ample opportunity to present evidence on the issue. See Ag. For Health Care Admin. v. The Chrysalis Center, 2014 WL 3805749 (Fla. 1st DCA 2014).

In Exception #8, Petitioner takes exception to the findings of fact in Paragraphs 69 and 70 of the Recommended Order, arguing that the entirety of the evidence establishes that the services at issue in this matter were covered by a managed care plan. As demonstrated by the Agency's rulings on Exceptions #1 - #6 supra, Petitioner's argument has no merit. Therefore, the Agency denies Exception #8.

In Exception #9, Petitioner takes exception to the conclusions of law in Paragraphs 82, 83 and 84 of the Recommended Order, arguing that the evidence established the full amount of the overpayment sought by the Agency in this matter. Based on the Agency's reasoning set forth in the rulings on Exceptions #1 - #6 supra, the Agency also denies Exception #9.

In Exception #10, Petitioner takes exception to the findings of fact in Paragraphs 47 and 48 of the Recommended Order as well as the ALJ's Recommendation, arguing the Agency has established that it is entitled to the total overpayment that it sought in this matter. Based on the

Agency's reasoning set forth in the rulings on Exceptions #1 - #6 supra, the Agency also denies Exception #10.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order.

IT IS THEREFORE ADJUDGED THAT:

Respondent is required to repay $5,232.54 in Medicaid overpayments, plus interest at a rate of ten (10) percent per annum as required by Section 409.913(25)(c), Florida Statutes, to the Agency resulting from the claims audited by the Agency in C.I. Nos. 13-1375-000, 13-1376-000 and 13-1377-000 that did not involve codes H2017, H2019HR, H2019HQ, H0032TS and H0032. Respondent shall make full payment of the overpayment to the Agency for Health Care Administration within 30 days of the rendition date of this Final Order unless other payment arrangements have been agreed to by the parties. Respondent shall pay by check payable to the Agency for Health Care Administration and mailed to the Agency for Health Care Administration, Office of Finance and Accounting, 2727 Mahan Drive, Mail Stop 14, Tallahassee, Florida 32308.

DONE and ORDERED this 2 day of September, ~~201~~4, in Tallahassee, Florida.

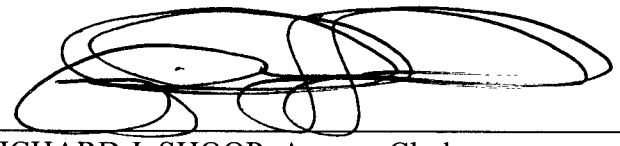
ELIZABETH DUDEK, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

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

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or interoffice mail to the persons named below on this 2nd day of September, 2014.



RICHARD J. SHOOP, Agency Clerk
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Medicaid Program Integrity
Office of the Inspector General

Medicaid Accounts Receivable
Finance & Accounting

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 14-0136MPI

THE CHRYSALIS CENTER, INC.,

Respondent.
_____/

RECOMMENDED ORDER

On March 17, 2014, Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings (DOAH), conducted the final hearing in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

The primary issue is whether, under section 409.913(16)(j), Florida Statutes, Petitioner can establish and recover from Respondent overpayments for Medicaid claims for community mental health services that Respondent provided to recipients who were enrollees in plans of various managed care organizations (MCOs) that, pursuant to the standard contract between these MCOs and the Department of Elder Affairs (DOEA), provided services under the Nursing Home Diversion Waiver (NHDW) program.[1/] A secondary issue is whether Petitioner is liable to Respondent, under sections 57.105(1)(a) and (5), Florida Statutes, for attorneys' fees for presenting a claim for overpayment that Petitioner knew or should have known was not supported by the necessary material facts.

PRELIMINARY STATEMENT

By three Final Audit Reports (FARs) dated July 10, 2013, Petitioner advised Respondent that Petitioner was seeking to recover overpayments to Respondent totaling $284,535.83, to impose fines of $56,907.17, and to assess costs of $172.29. There are three FARs, as well as three preliminary audit reports, due to Respondent's submittal of reimbursement claims under three provider numbers; for ease of reference, this recommended order will refer to the audits and reports in the singular.

After obtaining an extension of time, by letter dated August 23, 2013, Respondent requested a hearing or, in the alternative, a revision to the FAR to reduce the total overpayments to $2587.38. Respondent stated that it had properly billed and obtained payment for all but $2587.38 of the paid services. Respondent's letter states that Petitioner capitated NHDW plans for specific community based mental health services, and providers of other community based mental health services to enrollees of NHDW members could bill Medicaid for reimbursement on a fee-for-service basis for these services. The letter states that a "majority" of the codes at issue--psychosocial rehabilitation services (H2017), therapeutic behavioral services (H2019HR), and treatment plan review (H0032TS)--are services that Respondent properly billed on a fee-for-service basis. The overpayment amount of $2587.38 represents the total overpayment attributable to services under all of the Codes except Codes H2017, H2019HR, and H0032TS.

The letter states that Mr. Keith Young, a program analyst employed by Petitioner, had previously determined that services under the three above-mentioned codes were reimbursable on a fee-for-service basis, even when the recipients were enrollees of NHDW plans, because the NHDW plans did not cover services under these codes. The letter adds that Ms. Megan O'Malley, a program analyst employed by DOEA, agreed with Mr. Young.

On September 10, 2013, implicitly claiming an overpayment amount in excess of $2587.38, Petitioner transmitted the three files to DOAH where they were designated DOAH Case Nos. 13-3380MPI, 13-3385MPI, and 13-3386MPI and consolidated by Order entered September 12, 2013. On September 13, 2013, the parties filed an Agreed Motion to Relinquish Jurisdiction and Remand Consolidated Cases to the Agency for Health Care Administration. On September 16, 2013, the undersigned Administrative Law Judge entered an Order Closing Files and Relinquishing Jurisdiction.

On January 9, 2014, Petitioner filed a Motion to Reopen Proceedings. By Notice of Hearing issued January 15, 2014, the Administrative Law Judge set the final hearing for March 17, 2014.

On February 25, 2014, Respondent filed a Notice of Intent to Seek Costs and Fees. The notice cites sections 57.105, 57.111, 120.595, and "other applicable law." On the next day, Petitioner filed a Notice of Intent to Seek Investigative, Legal, and Expert Witness Costs. The notice cites section 409.913(23)(a).

At the hearing, Petitioner called two witnesses and offered into evidence 24 exhibits: Petitioner Exhibits 1-24. Respondent called three witnesses and offered into evidence eight exhibits: Respondent Exhibits 1-5, 10, and 13. During the hearing, Tr. 271, the Administrative Law Judge identified Respondent's

exhibits, whose numbering did not conform to the numbering shown in the Joint Prehearing Stipulation. All exhibits were admitted.

The court reporter filed the transcript of the final hearing on April 7, 2014. With leave of the Administrative Law Judge, on April 14 and 28, respectively, Respondent filed as a late-filed exhibit the transcript of the deposition of Matthieu Doucet, and Petitioner filed as a late-filed exhibit the transcript of a second deposition of Mr. Young. These are admitted into evidence as Respondent Exhibit 14 and Petitioner Exhibit 25, respectively.

By Motion for Extension of Time filed May 6, 2014, without objection from Respondent, Petitioner requested an extension of one week to May 16, 2014, within which to file proposed recommended orders. The Administrative Law Judge granted the motion by Order entered on May 7, 2014. On May 16, 2014, the parties filed their proposed recommended orders.

FINDINGS OF FACT

I. Audit, PAR, and FAR

1. At all material times, Respondent, as an enrolled Medicaid provider, has operated as a community behavioral health provider of community behavioral health services to Medicaid recipients. Petitioner conducted an audit of Respondent's fee-for-service reimbursement claims from January 1, 2008, through December 31, 2011. As a result of this audit, Petitioner determined that Respondent's services duplicated services that

MCOs were already required, and paid capitated rates, to provide, pursuant to the NHDW standard contract, so that the reimbursements that Respondent received constituted overpayments.

2. This case reveals a division of responsibility within Petitioner. The audit was conducted by employees of Petitioner's Office of Medicaid Program Integrity, which is within Petitioner's Office of the Inspector General. Program-specific expertise resided with a program analyst in another part of Petitioner. In fact, because operational authority for the NHDW program was divided between Petitioner and DOEA, program-specific expertise resided in one program analyst in each agency: Mr. Young with Petitioner and Megan O'Malley with DOEA.

3. By letter dated March 25, 2013, Petitioner provided Respondent with a Preliminary Audit Report (PAR) advising that Petitioner had completed an audit, determining that Petitioner had overpaid Respondent a total of $284,535.83 in Medicaid reimbursements, and seeking repayment of these alleged overpayments. The PAR explains:

> Medicaid fee-for-service payments have been identified for recipients while they were enrolled in the Medicaid [NHDW] Program. The fee-for-service payments, shown on the attached work papers, were for services that were to be covered by the recipient's [NHDW] provider. The total amount reimbursed to you for these fee-for-service payments has been identified as an overpayment.

4. After receiving the PAR, Respondent's representatives contacted Petitioner's representatives to discuss the proposed overpayment determination. In an email dated April 29, 2013, Carol Platt, an employee in Petitioner's Bureau of Managed Care, advised Vivian Demille, a representative of Respondent, that Ms. Platt had spoken with Mr. Young and learned from him that the capitated rates paid to NHDW plans for specific community based mental health services would not preclude fee-for-service billing of community based mental health services to NHDW plan enrollees, if the services were not included in the NHDW plan. According to Mr. Young, mental health services covered by NHDW plans fell under Healthcare Common Procedure Coding System procedure codes (Codes) H2000HP, H2010HO, H2000, H0031HO, H0031HN, H2019, and H0031.[2/] But Mr. Young determined that Codes H2017, H2019HR, and H0032TS were not covered by NHDW plans and would properly be billed on a fee-for-service basis to Petitioner.

5. About one week later, by email dated May 7, 2013, Ms. Platt advised Ms. Demille that Ms. Platt had been provided with incorrect information. The meaning of the May 7 email is unclear, but, as noted below, Mr. Young never changed his opinion that Codes H2017, H2019HR, and H0032TS were not covered by NHDW plans and could be billed on a fee-for-service basis when these services were provided to enrollees of NHDW plans.

6. By letter dated July 10, 2013, Petitioner issued the FAR. The FAR restates the overpayment amount of $284,353.83, adds the fines and costs identified in the Preliminary Statement, and contains the same explanation that was included in the PAR.

7. The work papers comprise 78 pages of "[NHDW] Fee for Service Match."[3/] As the title of the work papers suggests, the work papers document the results of a database search that matched recipients serviced by Respondent with recipients enrolled in a NHDW plan. The work papers also identify by Codes the services that Respondent billed on a fee-for-service basis. Among the Codes appearing in the work papers, Code H2017 accounts for nearly all of the reimbursement claims. The next most common Code billed was H2019HR, which appears at a frequency of about one-seventh of the rate of H2017 claims. On a dollar basis, the three Codes that Mr. Young determined should be reimbursed to Respondent account for over 99% of the total amount claimed by and reimbursed to Respondent during the audit period for all ten Codes identified by Mr. Young.

8. By email dated August 15, 2013, Eduardo R. Lacasa, general counsel of Respondent, asked Ms. O'Malley whether services billed under Codes H2017, "H2019," and H0032TS were reimbursable on a fee-for-service basis when provided to enrollees of NHDW plans. Mr. Lacasa disclosed to Ms. O'Malley the status of the matter between Petitioner and Respondent

because, attached to the email, were the PAR and FAR, as well as a recent email from Mr. Young confirming the accuracy of Ms. Platt's email describing his earlier advice.

9. Less than 30 minutes after receiving Mr. Lacasa's email, Ms. O'Malley responded that she too understood that these three Codes described services that were not covered by the NHDW plan, and she was forwarding this email to her "upper management" to discuss with their counterparts at Petitioner.

II. Services Provided by Respondent and Services Covered by NHDW Standard Contract

A. Identifying the Codes at Issue

10. An oddity of this case is the absence from the record of even a single recipient record of the service provided by Respondent. Petitioner has not disputed that the billed Codes aptly describe the services rendered, so the Codes provide the information necessary to describe the services provided by Respondent.

11. The reimbursement claims cover a total of 11 Codes, not ten, as indicated by Mr. Young, according to Ms. Platt's email of April 29, 2013. By email to a program administrator dated July 10, 2013, Sheri Creel, a program analyst in the Office of Medicaid Program Integrity, listed the 11 Codes that Respondent billed. But Mr. Young's list is important because: 1) as noted above, by dollar amount, over 99% of the reimbursement claims

involve the three Codes that he advised could be billed on a fee-for-service basis, and 2) possibly reflecting this fact, Respondent's August 2013 letter requesting a hearing asked only that Petitioner implement Mr. Young's determinations, including those adverse to Respondent. This means: 1) Respondent has not challenged overpayment claims based on Codes that Mr. Young determined were covered by the NHDW standard contract, and 2) Petitioner's claim for overpayment in this case is the total overpayment in excess of the $2587.38 that Respondent has conceded is due.

12. Fortunately, Mr. Young's list was accurate as to the three Codes that he determined were not covered by the NHDW standard contract: H2017, H2019HR, and H0032TS. Because Petitioner has declined to implement Mr. Young's determination as to these three Codes, it is necessary to consider them in detail below.

13. Mr. Young's list was also accurate as to three of the remaining seven Codes on his list: H2010HO, H0031HN, and H0031. A fourth Code on Mr. Young's list, H2000HP, probably contains a typographical error and should have been Code H2000HO. It is unnecessary to consider these four Codes because, as noted above, Respondent's request for hearing does not contest Mr. Young's determination that these Codes were covered by the NHDW standard contract.

14. This leaves three Codes that Mr. Young incorrectly listed and one that he missed entirely. The three Codes that Mr. Young listed that were not billed by Respondent are H2000, H0031HO, and H2019; the Codes that Respondent billed were H0001, H0032, and H2019HQ.

15. Mr. Young would have determined that Code H0001 was covered under the NHDW program and thus not reimbursable on a fee-for-service basis. He made this determination as to Codes H2000, H0031HO, and H2019, which are under Assessment Services in Appendix P of the Community Behavioral Health Coverage and Limitations Handbook, October 2004 (Coverage Handbook). Code H0001 is also under Assessment Services and is not materially different from the three Codes in Assessment Services that Mr. Young determined were covered by the NHDW standard contract. None of the three Codes that Mr. Young determined were reimbursable were under Assessment Services. It is therefore unnecessary to consider Code H0001 in detail below.

16. Mr. Young would have determined that Codes H0032 and H2019HQ were not covered by the NHDW standard contract. Code H0032 is not materially different from Code H0032TS, which Mr. Young determined was not covered by the NHDW standard contract; both Codes are under Treatment Plan Development and Modification in Appendix P of Coverage Handbook. Code H0032TS is for mental health service plan followup or mental health

treatment plan review, and Code H0032 is for mental health service plan development or mental health treatment plan development.

17. Likewise Code H2019HQ is not materially different from Code H2019HR, which Mr. Young determined was not covered by the NHDW standard contract; both Codes are under Behavior Health Therapy Services in Appendix P of Coverage Handbook. Code H2019HR is for individual or family counseling and Code H2019HQ is for group counseling.

18. The eleventh Code, which Mr. Young missed altogether, is Code T1015. It bears no resemblance to any of the Codes that Mr. Young considered because it is the sole Code in this case that is under Medical and Psychiatric Services in Appendix P of Coverage Handbook. It is thus necessary to consider Code T1015 in detail below.[4/]

B. Respondent's Services Billed Under Codes H2017, H2019HR, H2019HQ, H0032TS, H0032, and T1015

19. Of the six Codes in dispute in this case, Code H2017 is the most important because it accounts for the overwhelming majority of the 2,658 reimbursement claims and an even greater share of the total reimbursements paid to Respondent. The sole Code among the 11 to be under Community Support and Rehabilitative Services in Appendix P of Coverage Handbook, Code H2017 is "[p]sychosocial rehabilitation services, per 15 minutes"

under the HIPAA description or "[p]sychosocial rehabilitation services" under the Medicaid description.

20. Coverage Handbook explains that psychosocial rehabilitation services:

> are designed to assist the recipient to compensate for or eliminate functional deficits and interpersonal and environmental barriers created by their disabilities, and to restore social skills for independent living and effective life management. This activity differs from counseling and therapy in that it concentrates less upon the amelioration of symptoms and more upon restoring functional capabilities. . . . It includes work readiness assessment, job development on behalf of the recipient, job matching, on the job training, and job support.

Coverage Handbook 2-1-30.

21. Psychosocial rehabilitation services must be provided by a person with no less a credential than a behavioral health technician under the supervision of a bachelor's level practitioner, substance abuse technician, or certified addictions professional. Id. These services must be documented with a daily service note and a monthly progress note. Id. at 2-1-31.

22. As noted above, Codes H2019HR and H2019HQ are for "[t]herapeutic behavioral services" involving an individual, family, and group. Coverage Handbook explains that the purpose of individual and family therapy is to provide "insight oriented, cognitive behavioral, or supportive therapy." Id. at 2-1-25.

This therapy must be provided by at least a master's level practitioner. Documentation must include the "topic, assessment . . ., level of participation, findings, and plan." Id. Group therapy is similar, but may be provided by a bachelor's level practitioner or certified addictions professional.

23. As noted above, Codes H0032 and H0032TS, respectively, are for the development and review of a mental health service plan or mental health treatment plan. For the development of the plan, which would be Code H0032, Coverage Handbook explains that the "treatment plan is a structured, goal-oriented schedule of services developed jointly by the recipient and the treatment team." The treatment plan must be preceded by a "Brief Behavioral Health Status Examination" or "Psychiatric Evaluation" conducted by a physician. Coverage Handbook 2-1-15. For the review of the plan, which would be Code H0032TS, Coverage Handbook requires that the plan be reexamined no less often than six months and does not require an updated Brief Behavioral Health Status Examination or Psychiatric Evaluation.

24. As to Code T1015, Coverage Handbook identifies two general services under Medical and Psychiatric Services: medication management and brief individual medical psychotherapy. It would appear that Code T1015 involves medication management, not medical psychotherapy, but Coverage Handbook's primary description of these services is the "prescribing, dispensing,

and administering of psychiatric medications." Coverage Handbook 2-1-19. Coverage Handbook requires that Medical and Psychiatric Services be provided, at a minimum, by a "psychiatrist, other physician, physician assistant, or psychiatric ARNP."

25. Leslie Lynch, Respondent's administrative director and part owner, testified that physicians never provide the psychosocial rehabilitation services billed under Code H2017, and about 90% of these claims involve services that are not recommended by physicians. Ms. Lynch testified that physicians never provide the behavioral therapy billed under Code H2019HR, and about 95% of these claims involve services that are not recommended by physicians; it is inferred that the same percentage applies to the behavioral therapy billed under Code H2019HQ. Ms. Lynch testified that physicians do not participate in providing or recommending the treatment plan review billed under Code H0032TS; it is inferred that the same limitations apply to the treatment plan development billed under Code H0032. Ms. Lynch's testimony as to these matters is credited.

C. NHDW Standard Contract Services

26. Included among Petitioner's exhibits is a brief excerpt of the standard contract between DOEA and MCOs operating NHDW plans (NHDW standard contract) for each of the years of the audit.[5/] Presumably, Petitioner has determined that this excerpt describes the services covered by the NHDW program that most

closely approximate the services actually provided by Respondent. The relevant provision, which is under the category of "acute-care services," provides that the NHDW standard contract includes only those community mental health services that are: "Community-based rehabilitative services, which are psychiatric in nature, recommended or provided by a psychiatrist or other physician." NHDW standard contract § 1.3.3.3.

27. During the audit period, psychiatric, community-based rehabilitative services accounted for very few of the services, by dollar value, provided by MCOs under the NHDW standard contract. A broader category, community mental health services, accounted for little, if any, of the annual capitated rates calculated for the NHDW plans and their MCOs. After testifying that community mental health services totaled only $123,000 of the $172.3 million allocation in 2009 and $57,000 of the $250.2 million allocation in 2011, Tr. 25 and 29, Mathieu Doucet, an actuary with Milliman, Inc., who was responsible for developing the capitated rates for the NHDW program, opined that community mental health services are not provided by the NHDW plans. Tr. 28 and 33.

III. Codes H2017, H2019HR, H2019HQ, H0032TS, and H0032 Are Not Covered by the NHDW Standard Contract; Code T1015 Is Covered by the NHDW Standard Contract

28. As noted above, the NHDW standard contract imposed two conditions for coverage of services that are relevant to this case: 1) the service must be psychiatric in nature and 2) the service must be provided or recommended by a physician. If either of these conditions is unmet, the NHDW standard contract does not cover a service, leaving it reimbursable on a fee-for-service basis.

29. Petitioner has failed to prove that the NHDW standard contract covered services under Code H2017. These psychosocial rehabilitative services are obviously not psychiatric in nature. Psychosocial rehabilitation helps a recipient compensate for his deficits and lead an independent life and does not focus on the treatment or amelioration of symptoms. Psychiatry treats mental disorders.[6/] It would be a poor example of psychiatry that attempted neither treatment nor amelioration of symptoms; it would seem that psychosocial rehabilitation picks up where psychiatry leaves off.

30. Because psychosocial rehabilitative services are not psychiatric in nature, they are not covered by the NHDW standard contract, regardless of whether 10% of the underlying services were recommended by physicians or 100% of the underlying services were rendered by physicians.

31. By the end of the hearing, it seemed that Ms. Lynch would have the last--and only--word as to the extent to which any of the services had been recommended or provided by physicians. But, after the hearing, Mr. Young had--or relayed--the last word on this issue.

32. Petitioner deposed Mr. Young on April 17, 2014. Previously having been deposed by Respondent, Mr. Young testified that, after his first deposition, he contacted Ms. Creel to get a list of Respondent's claims because he was concerned that the "fee for service claims potentially could cause problems in our Long Term Care program." Tr. 7.[7/] He asked for a service-transaction summary that would show, by each claim submitted by Respondent, who had provided the service. Id. The summary is attached to the deposition transcript as an exhibit.

33. The summary lists 2,658 service transactions and provides details from the CMS 1500 claim forms submitted for each transaction, such as recipient identifying information, date of service, reimbursement amount, "billing provider" name and identification number, and "rendering provider" name and identifying number, as well as, of course, the Code applied to each service transaction.

34. The "rendering provider" for all but 62 of the service transactions is an "MD" named Noel A. Cabrera. The "rendering provider" for 60 of the remaining 62 service transactions is an

"MD" named Antonio de Filippo.[8/] Two of the service transactions show a "rendering provider" who is not a physician.

35. On direct, Mr. Young never testified that physicians rendered these 2,656 services, nor did he withdraw his earlier determination that Codes H2017, H2019HR, and H0032TS were not covered by the NHDW standard contract. Instead, he testified about the CMS-1500, the information about the rendering provider to be included in item 24J of the CMS-1500, and, of course, the summary, which he sponsored as an exhibit. The intended implication of his testimony and the summary was that physicians had provided all of the services but two, so at least this condition of coverage under the NHDW program had been met.

36. During cross-examination, Mr. Young admitted that Coverage Handbook provides generally that community behavioral health services are provided under the authorization of a group's treating practitioner,[9/] and provider reimbursement claims for community behavioral health services must include the treating provider's individual Medicaid number, regardless of who actually renders the service. Id. at 21. In this testimony may lie a hint of why Respondent listed a physician on each CMS-1500 as the referring provider.

37. In any event, for whatever reason that Respondent entered physicians' names in item 24J, the CMS-1500 does not establish that physicians provided nearly all of the services at

issue in this case. Several problems preclude any reliance on Mr. Young's testimony or the summary as proof of an assertion to the effect that physicians provided the services in 2,656 claims. First, the inferential evidence of Mr. Young's testimony and the summary is outweighed by the direct evidence of Ms. Lynch's testimony that physicians provided none of the services, at least as billed under Codes H2017, H2019HR, and H0032TS. Ms. Lynch was in the position to know this fact. Mr. Young's "knowledge" is derived from the summary, which is derived from the CMS-1500s, whose preparation, as to the rendering provider, may have been for a reason covered during the cross-examination of Mr. Young.

38. Second, a number of Codes explicitly permit or stipulate the use of a provider who would be less-educated and presumably lower-compensated than a physician. The suggestion that Respondent would use more expensive physicians to provide thousands of service transactions under these Codes does not make any sense and further undermines Petitioner's reliance on the summary to claim that the rendering provider was a physician in 2,656 of the 2,658 service transactions.

39. Third, for the reasons noted in the Conclusions of Law, Mr. Young's testimony during his second deposition, which was essentially a relation of the contents of the summary, and the summary itself were improperly noticed by Petitioner and thus inadmissible. The timing of these items of evidence--

posthearing, when Respondent would have no chance to answer the implications arising therefrom--underscores the importance of adequate notice of the use of the summary.

40. Petitioner has also failed to prove that the NHDW standard contract covered services under Codes H2019HR and H2019HQ. Like psychosocial rehabilitation, individual and group behavioral therapy is not "psychiatric" in nature.[10/] Appendix P mentions "psychotherapy"--Code H2010HE, under Medicaid, is for "[b]rief individual medical psychotherapy" and is under Medical and Psychiatric Services. But individual and group therapy provided by someone with not more than a master's degree (individual and family) or a bachelor's degree or certification as an addictions professional is not demonstrably psychiatric in nature.

41. Because individual and group therapy services are not demonstrably psychiatric in nature, they are not covered by the NHDW standard contract, regardless of whether 5% of the underlying services were recommended by physicians or 100% of the underlying services were rendered by physicians. But, for the reasons noted immediately above, Petitioner has also failed to prove that Respondent provided these services through physicians.

42. Lastly, Petitioner has failed to prove that the NHDW standard contract covered services under Codes H0032TS and H0032. Under the HIPAA descriptions of these Codes, nonphysicians are to

develop and follow up on mental health service plans. If the treatment team, as testified by Ms. Lynch, does not routinely include a physician, it is difficult to understand how the services under these Codes could be psychiatric in nature.

43. Because the development and review of mental health treatment plans by the treatment teams, which routinely do not include a physician, are not psychiatric in nature, they are not covered by the NHDW standard contract, regardless of whether 100% of the underlying services were rendered by physicians. But, for the reasons noted immediately above, Petitioner has also failed to prove that Respondent provided these services through physicians.

44. Code T1015 is different from the other Codes just discussed because the underlying services, which involve medication management, must be provided by a physician, although not necessarily a psychiatrist. Services under Code T1015 thus satisfy one of the conditions required for coverage under the NHDW standard contract. Services under this Code are also psychiatric in nature, as in the prescribing, dispensing, and administering of "psychiatric" medication. Petitioner has thus proved that the NHDW standard contract covered services under Code T1015.

45. In summary, the results are almost identical to the determinations of Mr. Young and Ms. O'Malley in 2013. Codes

H2017, H2019HR, and H0032TS are not covered by the NHDW standard contract so they were reimbursable on a fee-for-service basis to Respondent. The same is true for Codes H2019HQ and H0032, which, although unaddressed by Mr. Young, are insubstantially different from Codes H2019HR and H0032TS, respectively.[11/] Based on Mr. Young's advice, with which Ms. O'Malley immediately agreed, only about 1% of the total overpayments sought by Petitioner were actually overpayments. As a result of the recommended order, if adopted by the final order, the total of actual overpayments will actually decrease by a small amount, but, essentially, Respondent will remain entitled to the 99% of the reimbursements that it staked out in its August 2013 letter requesting a hearing.

IV. Lack of Necessary Material Facts Supporting Petitioner's Claim for Overpayment in Excess of Amount to Which Respondent Agreed in August 2013 Letter Requesting Hearing

46. At the time of the transmittal of the agency files to DOAH: 1) Mr. Young had advised that Codes H2017, H2019HR, and H0032TS were not covered by the NHDW standard contract and thus were reimbursable to Respondent on a fee-for-service basis, and 2) Respondent had indicated that a hearing would not be necessary if Petitioner would accept Mr. Young's determinations, which reduced by over 99% the total overpayment sought by Petitioner in the PAR and FAR. The transmittal thus constituted Petitioner's rejection of Mr. Young's advice and claim to overpayments in excess of Respondent's concession of $2587.38 of overpayments.

As a result of this hearing, Petitioner has proved an overpayment that is slightly less than the amount that Respondent conceded was due.

47. At the time of file transmittal, Petitioner knew or should have known that its claim to overpayments in excess of $2587.38 was not supported by the necessary material facts. Petitioner's program analyst with the most knowledge of the NHDW program had so advised. And Petitioner has produced not a single piece of analysis contradicting Mr. Young's analysis, which was confirmed by Ms. O'Malley without hesitation.

48. In the PAR and FAR, Petitioner contented itself with the establishment of a threshold issue over which there is no controversy whatsoever: matching Petitioner's recipients with enrollees of NHDW plans. Through these critical stages, Petitioner completely ignored the two material facts that were necessary to support its overpayment claim in excess of $2587.38:
1) Respondent's services were psychiatric in nature, and
2) Respondent's services were recommended or provided by physicians.

49. In discovery and at hearing, three of Petitioner's employees testified. The first was Mr. Young, who was deposed by Respondent prior to the hearing. During his deposition on February 24, 2014, Mr. Young identified the April 2013 email and admitted that it was a "fair representation" of his conversation

with Ms. Platt. Id. at 32; Depo. Ex. 6. During the deposition, Mr. Young seemed to take a circuitous route to reaffirming his original opinion, but he eventually did.

50. As Mr. Young now understood the issue, a number of NHDW enrollees had "community mental health claims" that were improperly paid on a fee-for-service basis. Tr. 8.[12/] In examining the issue, Mr. Young determined that the claims billed by Respondent were "in the range of procedure codes that we would expect a community mental health provider to use." Id. at 10. The problem was that "a number of mental health providers providing these behavioral health services had billed the state plan program as opposed to sending their bills to the [NHDW] plans for reimbursement." Id. at 24. According to Mr. Young, Petitioner had instructed these providers that "they're supposed to check the person's Medicaid eligibility and if they had done a thorough job of that, they would become aware that this person was a [NHDW] plan member and they needed to check with the plan to see if there was coverage of their particular service." Id.

51. At this point of his testimony, Mr. Young was previewing the argument to be presented in testimony at hearing by Petitioner's two witnesses from the Office of Medicaid Program Integrity: Respondent was required either to obtain prior authorization from an MCO before providing services to an MCO's enrollee or to invoice the MCO, not Petitioner, to obtain

compensation for services that it rendered to an enrollee. These arguments are rejected below in the discussion of the testimony of these two witnesses.

52. At one point, Mr. Young testified that he was unable to answer a question as to whether the procedure codes that Respondent billed to Petitioner were for services for which the NHDW standard coverage required coverage. Id. at 28-29. Mr. Young said that he was unfamiliar with the procedure codes that Respondent billed and stated that he would have to rely on Petitioner's mental health program specialist for further information. Id. at 30. Under the facts of this case, including Mr. Young's repeated determinations that Codes H2017, H2019HR, and H0032TS were not covered by the NHDW standard contract, this testimony was evasive.

53. At another point, though, Mr. Young acknowledged that the NHDW plans were required to cover specific community based mental health services, and, if a NHDW plan enrollee required another Medicaid-covered service not covered by the NHDW plans, her service would be reimbursed on a fee-for-service basis. Id. at 24-25. Mr. Young also conceded that, if Codes had not been included in the capitated rate to be paid each MCO in the NHDW program, then the NHDW plans would not be required to pay for the services underlying these Codes. Id. at 38.

54. And, eventually, Mr. Young admitted that, as he had advised previously, Respondent's reimbursement claims for Codes H2017, H2019HR, and H0032TS were properly paid on a fee-for-service basis. Id. at 42. The net effect of Mr. Young's deposition was that he confirmed that Codes H2017, H2019HR, and H0032TS were not covered under the NHDW standard contract, and Respondent could thus obtain fee-for-service reimbursements for these services billed to enrollees of MCO's NHDW plans.

55. Petitioner called two witnesses at hearing. Instead of addressing whether Respondent's services were psychiatric in nature and recommended or provided by a physician, these witnesses addressed the arguments that Mr. Young previewed during his deposition. These arguments are based on misreadings of the underlying Medicaid documents, which in no way relieve Petitioner of the necessity of proving that Respondent's services were psychiatric in nature and were provided or recommended by physicians.

56. Pamela Fante, a program administrator in the Office of Medicaid Program Integrity, testified as to the scope of the audit. She stated: "the audit was an overview, not particularly [sic] to this particular provider. It was the issue that services that were to be covered by the [NHDW], which is a managed care program, had possibly--had erroneously been paid as fee-for-service." Tr. 35. Ms. Fante added that "we started

looking to see whether any of those services [covered by the NHDW program] were billed and paid fee-for-service." Id.

57. To this point, Ms. Fante is merely describing the process by which the auditors matched Respondent's recipients with enrollees of MCOs operating NHDW plans.

58. Ms. Fante testified Respondent was obligated to determine if a particular recipient was a NHDW enrollee and, if so, "contact the managed care plan to request prior authorization." Id. at 38. Ms. Fante described the authorization process. She testified that Respondent needed to contact the relevant MCO to determine if Respondent was "contracted with [the MCO]" and if the MCO would permit Respondent to provide the service--with the expectation of payment from the MCO. Id. at 39.

59. Ms. Creel's testimony was largely a replay of Ms. Fante's prior authorization/MCO-billing testimony. Ms. Creel testified that Respondent was obligated to determine if the patient was enrolled with an MCO--essentially, in a NHDW plan. Id. at 113-14. Ms. Creel testified that, if the patient was a NHDW enrollee, Respondent then had to "seek authorization from the HMO in which the recipient is currently enrolled prior to providing service unless it's an emergency." Id. at 115 and 156-57. Ms. Creel also addressed the situation in which Respondent sought prior authorization from an MCO, obtained

authorization, and then billed the MCO for the service. Id. at 127. Ms. Creel explained: "If [the MCO] denied [prior authorization] as a covered service and [the patient] is a Medicaid recipient, then the provider [e.g., Respondent] could seek reimbursement with Medicaid fee-for-service." Id. at 127-28.

60. In one respect, Ms. Creel goes further than Ms. Fante. Ms. Creel testified that Respondent could seek reimbursement on a fee-for-service basis, if the MCO denied Respondent's request for prior authorization due to a lack of coverage under the NHDW standard contract. Requiring the provider to deal with the MCO under these circumstances seems to raise the MCO to gatekeeper status by treating the MCO denial of coverage as a precondition to reimbursement on a fee-for-service basis, even in situations in which the NHDW standard contract does not cover the service.

61. In any event, none of this prior-authorization/MCO-billing testimony offers any factual support whatsoever for the overpayment claims of Petitioner. This testimony either assumes that the NHDW standard contract covers the service in question or adds prior authorization and MCO billing as conditions for the reimbursement of Respondent's service, even if the NHDW standard contract does not cover the subject service. When Respondent argues in its proposed recommended order that it is allowed to "roll the dice," Respondent is saying that it is allowed to

provide the Medicaid-covered service without dealing with the MCO that has enrolled Respondent's recipient: if the NHDW standard contract covers the service, Respondent loses, and if the standard contract does not cover the service, Respondent wins. A close examination of Petitioner's position is that Respondent loses both ways.

62. If the NHDW standard contract covers the service that Respondent has provided, Petitioner has no obligation to reimburse Respondent because doing so would mean that Petitioner is paying twice for the same service. This scenario is entirely irrelevant to the present case, and the focus of Petitioner's witnesses on the prior authorization/MCO-billing issues cannot possibly address the coverage scenario because, if Respondent's service were covered by the NHDW standard contract, Respondent is not going to be reimbursed or, if reimbursed, is going to have to repay the reimbursement. Obtaining prior authorization from the MCO or billing the MCO might spare Respondent the financial loss, but that is a risk that Respondent may choose to run, if it provides the service first; the Medicaid documents do not prohibit Respondent from proceeding in this fashion.

63. The scenario that Petitioner's witnesses are really addressing is the one in which the NHDW standard contract does not cover the service that Respondent has provided: if, through a misapplication of the Medicaid documents, Petitioner were to

avoid reimbursing Respondent for such a service, the result is, not that Petitioner avoids paying twice for a service, but it avoids paying at all for a service. To achieve this dubious result, Petitioner turns its focus from the underlying coverage issue and posits prior authorization/MCO-billing as prerequisites for reimbursement for all services, thus assigning to the MCO a gatekeeper role, even for services that it does not cover under the NHDW standard contract. But this illogical construction of the Medicaid documents finds no support in the documents themselves.

64. To support their prior authorization/MCO-billing testimony, Petitioner's witnesses cite to various provisions in the Medicaid documents, but misread each one of them. The Medicaid Provider General Handbook, January 2007 (Provider Handbook)[13/] addresses HMOs. Provider Handbook requires a provider to verify a recipient's eligibility for Medicaid and whether the recipient is enrolled in an HMO. Provider Handbook 1-26. Provider Handbook adds: "If a recipient is an HMO member, the provider must seek authorization from the HMO . . . prior to providing services." Id. However, the next paragraph explains that this requirement applies only for services covered by the HMO: "Providers must seek authorization and reimbursement from the HMO for services the HMO covers for its members." Id.

65. Provider Handbook also states: "Medicaid reimbursement is restricted when a Medicaid recipient is enrolled in a managed care program. A provider must verify if the recipient is enrolled in a managed care program prior to providing services." Id. at 3-9. However, the next paragraph adds: "For certain managed care plans such as HMOs and PSNs, the provider must receive authorization for the services that are included in the plan and bill the plan directly." Id. Again, the condition attached to obtaining prior authorization from, and billing, the managed care program is that the subject service is "included in the plan."

66. More broadly, Provider Handbook endorses Respondent's reading of its rights and responsibilities in this case. Provider Handbook[14/] explains that fee-for-service reimbursement results in the payment of a fee to a provider for each procedure performed and billed within Medicaid policy limitations, id. at 1-3, and capitation reimbursement is for HMOs and other MCOs that are prepaid a fixed amount monthly for each enrolled recipient. Id. at 1-4. Capitation reimbursement is calculated using "actual fee-for-service Medicaid claims experience for each eligibility category in the plan's operating area."
Id. at 1-32.

67. Addressing managed care programs, Provider Handbook notes that most Medicaid recipients are required to obtain

services through such programs, but adds: "Recipients who aren't required to enroll in managed care obtain services through the Medicaid providers of their choice on a 'fee-for-service' basis." Id. at 1-19.

68. Nor does the Medicaid Provider Reimbursement Handbook, CMS-1500, July 2008 (CMS-1500 Handbook) support Ms. Fante's testimony. CMS-1500 Handbook provides a checklist to be reviewed before submitting a CMS-1500 claim form. Among the checklist items are obtaining HMO authorization, "if applicable"; obtaining service authorization, "if applicable"; and obtaining service authorization, "if applicable." CMS-1500 Handbook 1-10. For the reasons discussed above, these requirements are applicable only if the HMO or other entity provides coverage for the service that the fee-for-service provider is claiming reimbursement.

69. By the conclusion of the hearing, Petitioner had produced absolutely no evidence on the necessary material facts of whether the subject services repeatedly approved by Mr. Young for reimbursement were psychiatric in nature and whether these services were provided or recommended by a physician. Posthearing, Petitioner turned, once more, to Mr. Young to solicit evidence as to the issue of whether a physician provided or recommended the services at issue.

70. For the reasons already stated, the multiple problems with this evidence preclude a finding that Petitioner thus

avoided liability under section 57.105, Florida Statutes. But even if this evidence constituted a material fact sufficient to support the issue of whether a physician provided or recommended the services, it did not constitute a material fact sufficient to support Petitioner's claim because it fails to address the issue of whether the service was psychiatric in nature. As noted above, these issues are conjunctive, not disjunctive. Without any evidence that, most importantly, psychosocial rehabilitation is psychiatric, Petitioner failed even to introduce evidence necessary to its overpayment claim for the simple fact that there is none.

CONCLUSIONS OF LAW

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

72. Petitioner is authorized to establish and recover overpayments from Medicaid providers. § 409.913(16)(j). In determining that an overpayment has occurred, Petitioner is required to prepare and issue an audit report showing the calculation of the overpayments. § 409.913(21).

73. In general, Petitioner must prove the overpayment by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of Health & Rehab. Serv., 596 So. 2d 106 (Fla. 1st DCA 1992). In its proposed recommended order, Respondent contends for a clear-

and-convincing standard due to the presence of a substantial fine.

74. In making this contention, Petitioner relies on Department of Banking and Finance v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996), but Osborne Stern supports the higher evidentiary standard for the imposition of the fine, not the recovery of the overpayment. The court stated: "We look to the nature of the proceedings and their consequences to determine the degree of proof required to justify the Department's imposition of administrative fines . . . ." Id. at 935. In the present case, the nature of the proceeding is an attempt to recover alleged Medicaid overpayments, and the consequence of the proceeding, if Petitioner were to prevail, would be primarily the recovery of Medicaid overpayments and secondarily the imposition of a comparatively small fine and costs. Barring a case in which the fine exceeds the overpayment, this case must be governed by the preponderance standard, at least as to elements that do not pertain exclusively to the fine.

75. Respondent's reliance on Agency for Health Care Administration v. Sharing Facility Group Home, Case 12-1664MPI, 2013 WL 683330 (Fla. Div. Adm. Hrngs., Feb. 21, 2013), is also misplaced because this case involved only the imposition of a fine, not the recovery of an overpayment. In a pure-fine case, the clear-and-convincing standard applies.

76. As concluded above, the burden of proving the overpayment is on Petitioner. South Med. Serv., Inc. v. Agency for Health Care Admin., 653 So. 2d 440 (Fla. 3d DCA 1995). However, section 409.913(22) provides: "The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." The question is whether the effect of this provision shifts the burden of going forward with the evidence to Respondent.

77. This is a difficult question in most cases. However, the FAR, as augmented by the work papers, does not even address the two factual issues required for a determination of overpayments in this case: whether the services were psychiatric in nature and whether the services were provided or recommended by a physician. The FAR summarily states that the services were covered by the NHDW standard contract, but fails to address these two constituent issues, on which its conclusory statement is based. The work papers solely support a threshold issue, which is not in dispute in this case: the match between Petitioner's recipients and enrollees of NHDW plans of various MCOs. Under the facts of this case, at least, the FAR and working papers are so deficient in addressing the determinative issues that they could not operate to shift the burden of going forward to Respondent, even if they might so operate in other overpayment cases.

78. During the posthearing deposition of Mr. Young, Respondent objected to the testimony and the summary that Mr. Young sponsored. Respondent's objections are sustained, although possibly on different grounds. In its proposed recommended order, Respondent argues that this summary violates the best evidence rule. Perhaps this use of the summary as evidence of the documented services provided to recipients violates section 90.954, Florida Statutes, which dispenses with the necessity of producing the original of a document when the original is generally unavailable. But Petitioner's use of the summary was not an attempt directly to prove the contents of documented services provided to recipients.

79. Petitioner's use of the summary was an attempt to provide a data summary excerpting rendering-provider information in item 24J from hundreds, if not thousands, of CMS-1500 claim forms. As such, the summary violated section 90.956, Florida Statutes, which permits the use of summaries only upon timely written notice and the production of the underlying records to the opposing party. The statutory requirement applies equally to the introduction of the summary as an exhibit or the introduction of testimony based on the summary. Bowmar Instrument Corp. v. Fidelity Elect., 466 So. 2d 344, 345 (Fla. 3d DCA 1985) (dictum).

80. Nor is Petitioner's use of the summary a technical violation. Petitioner reasonably should have known that its

burden in this case was to prove that the subject services were psychiatric in nature and provided or recommended by a physician. Clearly, Petitioner was unprepared to prove either of these twin requirements during the hearing. There was no good reason to present, for the first time, evidence on either of these requirements after the conclusion of the hearing, especially without providing the required statutory notice, so that Respondent could have perhaps produced recipient records for Mr. Young to address during cross-examination.

81. For the reasons set forth in the Findings of Fact, Petitioner has proved overpayments, but only as to the services provided by Respondent and billed under Codes other than Codes H2017, H2019HR, H0032TS, H2019HQ, and H0032. As noted above, Petitioner has thus proved overpayments of less than 1% of the total overpayment sought in the FAR and, due to the inclusion of Codes H2019HQ and H0032, less than the amount of overpayment conceded by Respondent in its August 2013 letter requesting a hearing. This means that Petitioner has failed to prove its claim of overpayments in excess of the $2587.38 that Respondent originally conceded.

82. Section 57.105(1)(a) requires the court, on its own initiative, to award a reasonable attorney's fee on any claim that, at any time during a civil proceeding, the court finds that the losing party "knew or should have known that a claim . . .

when initially presented or at any time before trial . . . [w]as not supported by the material facts necessary to support the claim . . . ." Section 57.105(5) extends this relief to administrative proceedings, although it prohibits an award against an agency attorney.

83. For the reasons stated above, the claim is the substantial portion (over 99%) of the overpayment in excess of the $2587.38 that Respondent conceded was due in its request for hearing. For the reasons stated above--Mr. Young's determinations, Ms. O'Malley's quick endorsement of Mr. Young's determinations, and the complete lack of coverage evidence to the contrary--Petitioner knew or should have known from the outset that it lacked necessary material facts to support its claim.

84. Notwithstanding Respondent's filing of a notice of intent to seek attorneys' fees under section 57.105, it has not yet done so, and this attorneys' fee award is on the Administrative Law Judge's own initiative. The Administrative Law Judge has determined that there is no need for an evidentiary hearing on Petitioner's liability for attorneys' fees under section 57.105(1)(a). This case was disposed of after a full hearing during which Petitioner had ample opportunity to present its evidence, not in a summary fashion, such as on an order granting a motion to relinquish jurisdiction. Additionally, this case does not turn on the good-faith issue that may be raised

when the fees are otherwise imposed against the nonagency attorney of the party whose claim triggers liability under section 57.105(1).

RECOMMENDATION

It is

RECOMMENDED that Petitioner enter a final order determining a total overpayment for the services billed by Respondent during the audit period that are not under Codes H2017, H2019HR, H2019HQ, H0032TS, and H0032.

FINAL ORDER

It is

ORDERED that, pursuant to section 57.105(1)(a) and (5), Florida Statutes, Petitioner shall pay reasonable attorneys' fees to Respondent for the defense of this case. If the parties cannot agree on an amount within the earlier of 30 days from the date on which the final order becomes final or 120 days from the date of this recommended order, Respondent shall have 30 days from the applicable deadline to commence a proceeding at DOAH for the purpose of establishing the amount of reasonable attorneys' fees; if it fails to timely do so, it shall have waived its right to attorneys' fees under section 57.105.

DONE AND ENTERED this 3rd day of June, 2014, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of June, 2014.

ENDNOTES

[1/] In 2013, the NHDW program was incorporated into the Long-Term Managed Care program.

[2/] Mr. Young's list of Codes is accurate as to the three Codes that he determined were not covered by the NHDW standard contract, but inaccurate as to some of the remaining Codes. This is discussed in detail below.

[3/] The work papers pertain to only one of the three audits and one of the three PARs and FARs, but nothing in the record suggests that the work papers for this audit are not representative of the work papers supporting the other two audits.

[4/] Mr. Young's mislisting of Codes could not increase the $2587.38 that Respondent conceded as an overpayment in its request for hearing. For the most part, Mr. Young's mislisting of Codes simply confused some of the Code designations for services that were not reimbursable to Petitioner, even if they bore the correct Code, or he omitted a Code that proved not reimbursable to Petitioner. That three Codes--H2017, H2019HR, and H0032TS--produced so much overpayment is evidence of the frequency of the services under these Codes, especially H2017.

Of course, characterizing two additional Codes--H2019HQ and H0032--as reimbursable would reduce the $2587.38, but by a very small amount.

[5/] Complete contracts for selected years within the audit period are attached to a couple of the deposition transcripts.

[6/] "Psychiatry" is the "medical study, diagnosis, treatment, and prevention of mental illness." The American Heritage Dictionary of the English Language 1055 (1981).

[7/] All references to page numbers in this section are to the second deposition of Mr. Young.

[8/] The very few billings of Code T1015 are associated exclusively with Dr. Filippo's provider number.

[9/] Coverage Handbook explains the appearance of Dr. Cabrera as the "rendering provider" on nearly 2000 of the CMS-1500 reimbursement claims that Respondent submitted in this case:

> Community behavioral health services are provided under the authorization of the group's treating practitioner. Provider claims for community behavioral health services must include the provider's group Medicaid number and the treating practitioner's individual Medicaid number regardless of who actually renders the service.

Coverage Handbook, 2-1-1.

[10/] Unlike the situation with respect to psychosocial rehabilitation, where a psychiatrist providing the service would not transform it to psychiatric in nature, a closer question would arise if a psychiatrist conducted the individual or group therapy described under Codes H2019HR and H2019HQ. It would seem that the service would remain behavioral therapy, not psychotherapy, especially if billed at a lower rate for behavioral therapy, but perhaps not. But this question does not emerge in the present case due to Petitioner's failure to prove that all of the services underlying these codes were provided by psychiatrists; as noted above, Petitioner failed to prove even that the services were provided by physicians, let alone psychiatrists.

[11/] Ms. O'Malley arguably addressed Code H2019HQ because, as noted above, she was asked to address Code H2019 without a modifier.

[12/] The references to a transcript in this section are to the transcript of the second deposition of Mr. Young.

[13/] The provisions of Provider Handbook July 2008 are not materially different.

[14/] The Administrative Law Judge has taken official notice of the entire General Handbook, which is at http://www.agingflorida.net/resources/medicaid_waiver/GH_09_090204_Provider_General_Hdbk_ver1.3.pdf.pdf

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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.