

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2017 APR 12 A 8:30

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

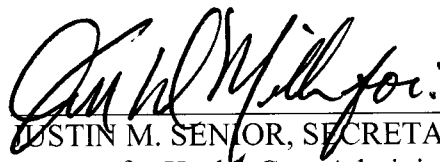
VARIETY CHILDREN'S HOSPITAL, INC.,
d/b/a NICKLAUS CHILDREN'S HOSPITAL,
Respondent.

DOAH CASE NO.: 14-6122MPI
MPI C.I. NO.: 11-1443-000
PROVIDER ID NO.: 010060900
NPI NO.: 1871540237
LICENSE NO.: 4067
MPI CASE NO.: 2015-0002711
RENDITION NO.: AHCA-17-0254-S-MDO

FINAL ORDER

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

DONE and ORDERED on this the 10th day of April, 2017, in Tallahassee, Florida.


JUSTIN M. SENIOR, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

Variety Children's Hospital, Inc.
d/b/a Nicklaus Children's Hospital
Attn: Patient Accounting
3100 S.W. 62 Avenue
Miami, Florida 33155
(U.S. mail)

Jay Adams, Esquire
Broad and Cassel
215 S. Monroe Street, Suite 400
Tallahassee, Florida 32301-1804
jadams@broadandcassel.com
(Electronic Mail)

Kelly Bennett, Chief, MPI
(Electronic Mail)

Bureau of Financial Services
(Electronic Mail)

Health Quality Assurance
(Electronic Mail)

Shena L. Grantham
MAL & MPI Chief Counsel
(Electronic Mail)

Carrol Cherry Eaton
Carrol.CherryEaton@myfloridalegal.com
(Electronic Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail or other designated method on this the 12th day of April, 2017.



Richard J. Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3689/FAX (850) 921-0158

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

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

**DOAH CASE NO.: 14-6122MPI
C.I. NO.: 11-1443-000
MPI CASE NO.: 2015-0002711
PROVIDER ID NO.: 010060900
NPI NO.: 1871540237
LICENSE NO.: 4067**

vs.

VARIETY CHILDREN'S HOSPITAL, INC.
d/b/a NICKLAUS CHILDREN'S HOSPITAL,

Respondent.

SETTLEMENT AGREEMENT

Petitioner, the STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION ("AHCA" or "Agency"), and Respondent, VARIETY CHILDREN'S HOSPITAL, INC. d/b/a NICKLAUS CHILDREN'S HOSPITAL ("PROVIDER"), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties agree to settle DOAH Case No. 14-6122MPI (this matter) wherein PROVIDER filed a petition for a formal administrative hearing regarding the Amended Final Audit Report issued by AHCA on July 25, 2014.
2. PROVIDER is a Medicaid provider in the State of Florida, provider number 010060900, and was a provider during the audit period.
3. A Preliminary Audit Report dated June 1, 2012, was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid \$231,518.09. On September 25, 2012, a Final Audit Report was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid \$203,269.15. Thereafter, the Agency issue an Amended

Final Audit Report dated July 25, 2014.

4. In its Amended Final Audit Report, the Agency notified PROVIDER that a review performed by the Agency's Office of the Inspector General, Medicaid Program Integrity ("MPI"), of PROVIDER's Medicaid claims that were rendered during the period of January 1, 2006, through December 31, 2006, indicated that certain claims, in whole or in part, were inappropriately paid by AHCA. The Agency sought repayment of this overpayment, in the amount of two hundred twenty-two thousand three hundred eighty-eight dollars and sixty cents (\$222,388.60) and assessed the following sanctions in accordance with sections 409.913(15), (16), and (17), Florida Statutes, and Rule 59G-9.070(7), Florida Administrative Code, against PROVIDER: a fine in the amount of two thousand five hundred dollars (\$2,500.00) pursuant to Rule 59G- 9.070(7)(c), Florida Administrative Code; and costs in the amount of two thousand two hundred ninety-two dollars and nineteen cents (\$2,292.19), pursuant to section 409.913(23)(a), Florida Statutes. The total amount due was two hundred twenty-seven thousand one hundred eighty dollars and seventy-nine cents (\$227,180.79).

5. In response to the Amended Final Audit Report dated July 25, 2014, PROVIDER timely filed a Petition for Formal Administrative Hearing.

6. In order to resolve this matter without further administrative proceedings, and based upon additional information received and reviewed by AHCA during the pendency of litigation, PROVIDER and AHCA agree as follows:

- A. AHCA agrees to accept the payment set forth herein in settlement of the overpayment and costs arising from the above-referenced audit.
- B. PROVIDER agrees to pay AHCA the sum of one hundred twenty-five thousand three hundred fifty-seven dollars and twenty-nine cents

(\$125,357.29) which includes a total overpayment in the amount of one hundred twenty-three thousand sixty-five dollars and ten cents (\$123,065.10), plus costs of two thousand two hundred ninety-two dollars and nineteen cents (\$2,292.19).

- C. Any monies PROVIDER has paid to AHCA pursuant to the involuntary lien shall be retained by AHCA as payment of the agreed-upon amount due of one hundred twenty-five thousand three hundred fifty-seven dollars and twenty-nine cents (\$125,357.29). As of January 26, 2017, AHCA has collected from PROVIDER a total of two hundred three thousand two hundred sixty-nine dollars and fifteen cents (\$203,269.15). PROVIDER shall be refunded any amount collected in excess of the agreed upon amount of hundred twenty-five thousand three hundred fifty-seven dollars and twenty-nine cents (\$125,357.29), as follows:
- i. Within thirty (30) days following the issuance of a Final Order in this case, Financial Services shall forward PROVIDER a Refund Application reflecting the refund due to PROVIDER.
 - ii. Once Financial Services has received the signed Refund Application, the refund will be processed.
 - iii. Payment of the refund shall be made within thirty (30) days of Financial Services receipt of the signed Refund Application.
- D. PROVIDER and AHCA agree that full payment, as set forth above, and already made, resolves and settles this case completely and releases both parties from any administrative or civil liabilities arising from the review

determinations relating to the claims as referenced in MPI C.I. Number 11-1443-000.

E. PROVIDER agrees that it shall not re-bill the Medicaid Program in any manner for the claims that are the subject of the review in this case as specifically identified in the Amended Final Audit Report.

7. AHCA and PROVIDER each reserve the right to enforce this Agreement under the laws of the State of Florida, the Rules of the Medicaid Program, and all other applicable rules and regulations.

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

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

10. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Leon County, Florida.

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

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

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

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

14. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, and its agents, representatives, and attorneys of and from all claims, demands, actions, causes of action, suits, damages, losses, and expenses; of any and every nature whatsoever, arising in this matter; and of AHCA's actions herein, including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this Agreement, provided, however, PROVIDER does not discharge the State of Florida, Agency for Health Care Administration, regarding any other matters related to AHCA's payments, practices, policies, or audits of services rendered to undocumented aliens.

15. The parties agree to bear their own attorney's fees and costs, if any, with the exception that PROVIDER shall reimburse, as part of this settlement, \$2,292.19 in cost. This amount is included in the calculations and demand of paragraph 6(B).

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

17. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement; provided, however, if the entitlement to a refund to PROVIDER in paragraph 6 is prohibited, or if a Final Order has not been issued within 180 days from the date of signature by PROVIDER, PROVIDER shall have the right to void this Agreement.


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

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

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

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VARIETY CHILDREN'S HOSPITAL, INC.
D/B/A NICKLAUS CHILDREN'S HOSPITAL



(Signed) Authorized Representative of
VARIETY CHILDREN'S HOSPITAL, INC.

Dated: February 17, 2017

BY: JOSE PERDOMO, SUP + CECO
(Print Name and Title)




Attorney for Provider Signature

Dated: 02-03, 2017

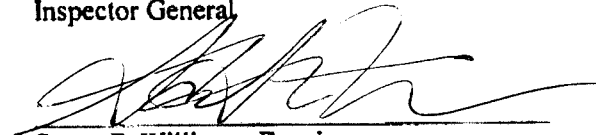
BY: JAY ADAMS - ATTORNEY
(Print Name and Title)

AGENCY FOR HEALTH
CARE ADMINISTRATION
2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403



Eric W. Miller
Inspector General

Dated: 4/10, 2017




Stuart F. Williams, Esquire
General Counsel

Dated: 3/19, 2017



Sheha L. Grantham, Esquire
MAL & MPI Chief Counsel

Dated: 3/16, 2017



Carrol Y. Cherry Eaton
Senior Assistant Attorney
General

Dated: February 20, 2017



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

July 25, 2014

Provider No.: 010060900
NPI No.: 1871540237
License No.: 4067

MIAMI CHILDRENS HOSPITAL
ATTN: PATIENT ACCOUNTING
3100 SW 62ND AVE.
MIAMI, FL 33155

In Reply Refer to
AMENDED FINAL AUDIT REPORT
C.I.: No.: 11-1443-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2006, through December 31, 2006. A preliminary audit report dated June 31, 2012 was sent to you indicating that we had determined you were overpaid \$231,518.09. On September 25, 2012, a Final Audit Report was sent to you determining that you were overpaid \$203,369.15. Based upon this review, we have amended our initial findings and have made an amended final determination that you were overpaid \$222,388.60 for services that in whole or in part are not covered by Medicaid. A fine of \$2,500.00 has been applied. The cost assessed for this audit is \$2,292.19. The total amount due is \$227,180.79.

Be advised of the following:

- (1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. This letter shall serve as notice of the following sanction(s):
 - A fine of \$2,500.00 for violation(s) of Rule Section 59G-9.070(7) (c), F.A.C.
- (2) Pursuant to Section 409.913(23) (a) F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

2727 Mahan Drive • Mail Stop #6
Tallahassee, FL 32308
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

Exhibit 1

This review and the determinations of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining payment pursuant to Medicaid policy, the Medicaid program utilizes descriptions, policies and the limitations and exclusions found in the Medicaid provider handbooks. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Emergency Medicaid for Aliens (EMA) is a Medicaid limited coverage program in which coverage is only for the duration of the emergency. Definitions for Emergency Medical Condition, Emergency Services and Care or Medical Necessity, may be found in the Florida Medicaid Provider General Handbook. Other relevant definitions may be found in the Florida Administrative Codes, Florida Statutes and in federal law.

Below is a discussion of the particular guidelines related to the review of EMA claims and an explanation of why these claims do not meet Medicaid requirements. A list of the paid claims affected by this determination is attached.

REVIEW DETERMINATION(S)

The Medicaid Provider General Handbook(s), 2004, page 3-19, establish Limited Coverage Categories and Program Codes for programs with limited Medicaid benefits. Medicaid policy related to the program, Emergency Medicaid for Aliens, is further described. The Hospital Services Coverage and Limitations Handbook, 2005, page 2-7, also refers to Emergency Medicaid for Aliens policy. These policy references state: "Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated." Medicaid Provider Reimbursement Handbook UB-92, 2004, page 2-9, states: "Medicaid coverage of inpatient services for non-qualified, non-citizens is limited to emergencies, newborn delivery services and dialysis services."

A medical record review was performed by a medical review team including a peer physician reviewer who determined the point at which the alien recipient's emergent complaint was alleviated. Medicaid policy does not allow payment of claims for services rendered beyond the date the emergency has been alleviated. Although medical necessity may continue to exist, Medicaid is not responsible for payment of those continuing services. Consequently, the inpatient services billed to and paid by Medicaid beyond the peer reviewer's determined date of alleviation are identified as an overpayment and are subject to recoupment.

In instances where hospital observation days were allowed, claims were adjusted to allow the outpatient per diem for observations, and the difference was identified as an overpayment and subject to recoupment.

In instances where the medical record was not received or was incomplete, the related claim was denied. The Medicaid Provider General Handbook 2004, page 5-7, states the following:

“Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payment for services or goods when the provider has incomplete records or cannot locate the records.”

In accordance with Medicaid policies, those claims not supported by documentation are identified as overpayments and subject to administrative sanction and recoupment.

The Medicaid Provider General Handbook, 2003, page 5-3, defines “Overpayment” as:

“Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake.”

If you are currently involved in a bankruptcy, you should notify your attorney immediately and then provide them a copy of this letter. Please advise your attorney that we require the following information immediately:

- 1) the date of filing of the bankruptcy petition;
- 2) the case number;
- 3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division);
- 4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit payment by certified check in the amount of \$227,180.79, which includes the overpayment amount as well as any fines imposed and assessed costs.

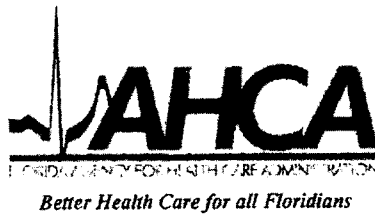
The check must be payable to the **Florida Agency for Health Care Administration**.

To ensure proper credit, be certain you **legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report**. Please mail payment to:

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

Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901.

Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30),



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL No.: **7008 0150 0003 1015 1725**

September 25, 2012

Provider No.: 010060900

MIAMI CHILDRENS HOSPITAL
ATTN: PATIENT ACCOUNTING
3100 SW 62ND AVE
MIAMI, FL 33155

In Reply Refer to
FINAL AUDIT REPORT
C.I. No.: 11-1443-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period July 1, 2006, through December 31, 2006. On June 1, 2012, a preliminary audit report was sent to you indicating that we had determined you were overpaid \$231,518.09. Based upon a review of all documentation submitted, we have determined that you were overpaid \$203,269.15 for services that in whole or in part are not covered by Medicaid. The cost assessed for this audit is \$1,655.72. The total amount due is \$204,924.87.

Be advised of the following:

- (1) Section 409.913, Florida Statutes (F.S.), authorizes the Agency to institute amnesty programs, wherein Medicaid providers may repay overpayments without sanctions being imposed. In the absence of fraud or misrepresentation, you may pursue this amnesty opportunity by remitting the overpayment and cost amount (total amount due) to the Agency by certified check.
- (2) Pursuant to Section 409.913(23) (a), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This review and the determination of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining the appropriateness of Medicaid payment pursuant to Medicaid policy, the Medicaid program utilizes procedure codes, descriptions, policies, limitations and requirements found in the Medicaid provider handbooks and Section 409.913, F.S. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy

2727 Mahan Drive, MS# 6
Tallahassee, Florida 32308



Visit AHCA online at
<http://ahca.myflorida.com>

Exhibit 1

handbooks, billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

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

REVIEW DETERMINATION(S)

Emergencies: The Medicaid Hospital Services Program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status. Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated...

Hospital Services Coverage and Limitations Handbook, 2005

2-7

Emergency Medical Condition A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Provider General Handbook, 2004

D-4

Record review performed by a peer physician review indicated that Medicaid reimbursed for claims where dates of service persisted beyond the date our medical peer reviewer determined the presenting emergency complaint was stabilized. The inpatient services days that were reimbursed beyond the peer reviewer's determined date of stabilization have been identified as an overpayment and are subject to recoupment.

Medical Necessity Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a covered service.

Florida Medicaid Hospital Services Coverage and Limitation Handbook, 2005

2-1 - 2-2.

Record review performed by a peer physician review indicated that Medicaid reimbursed for inpatient claims where inpatient services were determined to be in excess of the recipient's needs; services could have safely and more cost effectively been provided in a lower level of care. Claims for inpatient service that were in excess of recipient needs were identified as an overpayment and subject to recoupment. In instances where hospital observation days were allowed, claims were adjusted to allow the outpatient per diem for observations, and the difference was identified as an overpayment and subject to recoupment.

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

If you are not in bankruptcy and you concur with our findings, remit by certified check in the amount of \$204,924.87, which includes the overpayment amount as well as any fines imposed and assessed costs. The check must be payable to the **Florida Agency for Health Care Administration**. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your **Medicaid provider number** and the **C.I. number** listed on the first page of this audit report. Please mail payment to:

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

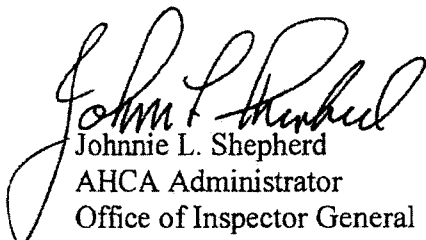
Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of

a repayment agreement is subject to termination from the Medicaid program. Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

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

Any questions you may have about this matter should be directed to: **Megan Scileppi, Case Analyst, Agency for Health Care Administration, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4654, facsimile (850) 410-1972.**

Sincerely,


Johnnie L. Shepherd
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity

JLS/MS/CML

Enclosure(s)
Notice of Administrative Hearing and Mediation Rights
Provider Overpayment Remittance Voucher
Claims Analysis Spreadsheets
Medical Peer Review Worksheets

Copies furnished to:

Finance & Accounting
(Interoffice mail)

Health Quality Assurance
(E-mail)

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

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

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

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

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

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

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

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

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

MIAMI CHILDRENS HOSPITAL
Provider No.: 010060900
C.I. No.: 11-1443-000

FAR

Provider Overpayment Remittance Voucher

If you choose to make payment, please return this form along with your check.

Complete this form and send along with your check to:

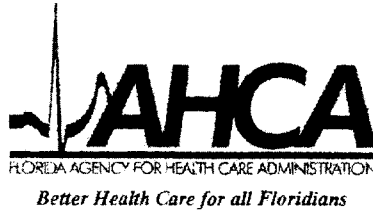
Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

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

Provider Name: MIAMI CHILDRENS HOSPITAL
Provider ID: 010060900
MPI Case #: 11-1443-000
Overpayment Amount: \$203,269.15
Costs: \$1,655.72
Total Due: \$204,924.87
Check Number: # _____

A final order will be issued that will include the final identified overpayment, applied Sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter.

Payment for Medicaid Program Integrity Audit



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL No.: 7008 0150 0003 1015 1602

JUN 01 2012

Provider No: 010060900

MIAMI CHILDRENS HOSPITAL
ATTN: PATIENT ACCOUNTING
3100 SW 62ND AVE
MIAMI, FL 33155

In Reply Refer to
PRELIMINARY AUDIT REPORT
C.I. No.: 11-1443-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2006, through December 31, 2006. Based on this review, we have made a preliminary determination that you were overpaid \$231,518.09 for claims that in whole or in part are not covered by Medicaid.

As cited in Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. Sanctions include, but are not limited to, fines, suspension and termination. Sanctions will be imposed in the final audit report or subsequent notifications.

As cited in Section 409.913(23), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This review and the determinations of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining payment pursuant to Medicaid policy, the Medicaid program utilizes descriptions, policies and the limitations and exclusions found in the Medicaid provider handbooks. In applying for Medicaid reimbursement, providers are required to follow the guidelines set forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, billing bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

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

Exhibit 1

REVIEW DETERMINATION(S)

Record Keeping Requirements Authorized state and federal agencies and their authorized representatives may audit or examine a provider's or facility's records. This examination includes all records that the agency finds necessary to determine whether Medicaid payment amounts were or are due. This requirement applies to the provider's records and records for which the provider is the custodian. The provider must give authorized state and federal agencies and their authorized representatives access to all Medicaid patient records and to other information that cannot be separated from Medicaid-related records...At the time of the request, all records must be provided regardless of the media format on which the original records are retained by the provider...Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.

Provider General Handbook, 2004

2-44 - 2-46

Review of documentation submitted in response to a formal request for records for review to support of inpatient claims for emergency services provided to a select group of Medicaid recipients revealed that not all claims were supported by documentation. In accordance with Medicaid policies, those claims not supported by documentation are identified as overpayments and subject to administrative sanction and recoupment.

Emergencies: Medicaid for Aliens The Medicaid Hospital Services Program reimburses for emergency services provided to aliens who meet all Medicaid eligibility requirements except for citizenship or alien status. Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated...

Hospital Services Coverage and Limitations Handbook, 2005

2-7

Emergency Medical Condition A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of a patient, including a pregnant woman or a fetus; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Provider General Handbook, 2004

D-4

Record review performed by a peer physician review indicated that Medicaid reimbursed for claims where dates of service persisted beyond the date our medical peer reviewer determined the presenting emergency complaint was stabilized. The inpatient services days that were reimbursed beyond the peer reviewer's determined date of stabilization have been identified as an overpayment and are subject to recoupment.

Medical Necessity Medicaid reimburses for services that are determined medically necessary, do not duplicate another provider's service, and are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a covered service.

Florida Medicaid Hospital Services Coverage and Limitation Handbook, 2005

2-1 - 2-2.

Record review performed by a peer physician review indicated that Medicaid reimbursed for inpatient claims where inpatient services were determined to be in excess of the recipient's needs; services could have safely and more cost effectively been provided in a lower level of care. Claims for inpatient service that were in excess of recipient needs were identified as an overpayment and subject to recoupment. In instances where hospital observation days were allowed, claims were adjusted to allow the outpatient per diem for observations, and the difference was identified as an overpayment and subject to recoupment.

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

If you are not in bankruptcy and you concur with the overpayment, you may remit by certified check in the amount of \$231,518.09. The check must be payable to the **Florida Agency for Health Care Administration**. Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901. To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

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

As previously noted, this is not a final Agency action. You may choose from the following options:

- 1) Pay the overpayment identified in this notice within 15 days of receipt of this letter, and no final audit report will be issued. This audit will be closed.
- 2) If you wish to submit further documentation in support of the claims identified as overpayments, you must do so within 15 days of receipt of this letter. **However, please be advised that additional documentation may be deemed evidence of non-compliance with the Agency's initial request for documentation in which you were required to provide all Medicaid-related records. Sanctions for this non-compliance will be imposed.** Any additional documentation received will be taken under consideration and you will be notified of the results of the audit in a final audit report.

We initially requested documentation in response to our demand letter be sent to KePro, Attn: Medical Records, 4511 N. Himes Avenue, Suite 245, Tampa, FL, 33641. However, should you choose to submit documentation in response to this Preliminary Audit Report, please send your documents to the following address to the attention of the below indicated MPI analyst:

Megan Scileppi, Investigator
Agency for Health Care Administration
Office of Inspector General
Medicaid Program Integrity
2727 Mahan Drive, Mail Stop # 6
Tallahassee, FL 32308-5403

- 3) If you choose not to respond, wait for the issuance of the final audit report. A final audit report will be issued that will include the final identified overpayment, applied sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter. The final audit report will inform you of any hearing rights that you may wish to exercise.

Documents submitted after the completion of an audit may require an affidavit or other sworn statement, in addition to the documents, as a means to authenticate the documentation. Documentation that appears to be altered, or in any other way appears not to be authentic, will not serve to reduce the overpayment. Furthermore, additional documentation **must** clearly identify which discrepancy, as set forth in the attached audit findings, it purports to support.

MIAMI CHILDRENS HOSPITAL

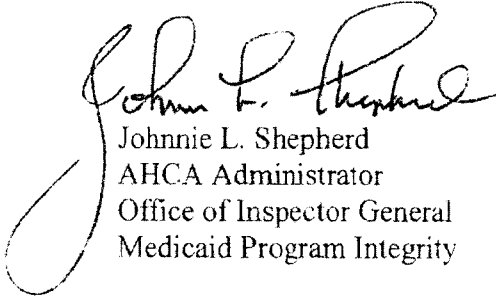
Provider No.: 010060900

C.I. No.: 11-1443-000

Page 5

Any questions you may have about this matter should be directed to: **Megan Scileppi, AHCA Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone (850) 412-4579, facsimile (850) 410-1972.**

Sincerely,



Johnnie L. Shepherd
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity

JS/MS/CML

Enclosure(s)

Provider Overpayment Remittance Voucher

Claims Analysis Spreadsheet(s)

Audit Worksheet(s)

MIAMI CHILDRENS HOSPITAL

Provider No.: 010060900

C.L.No.: 11-1443-000

Page 6

PAR

Provider Overpayment Remittance Voucher

If you choose to make payment, please return this form along with your check.

Complete this form and send along with your check to:

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

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

Provider Name: MIAMI CHILDRENS HOSPITAL

Provider ID: 010060900

MPI Case #: 11-1443-000

Overpayment Amount: \$231,518.09

Check Number: # _____

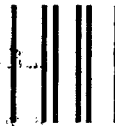
A final audit report will not be issued. Any cost and sanctions will be waived and the audit will be closed.

Payment for Medicaid Program Integrity Audit

SENDER: COMPLETE THIS SECTION	COMPLETE THIS SECTION ON DELIVERY
<ul style="list-style-type: none"> ■ Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired. ■ Print your name and address on the reverse so that we can return the card to you. ■ Attach this card to the back of the mailpiece, or on the front if space permits. 	<p>A. Signature <input checked="" type="checkbox"/> Agent <input type="checkbox"/> Addressee <i>x Chray Brent</i></p> <p>B. Received by (Printed Name) <i>Elroy B.</i></p> <p>C. Date of Delivery <i>10/11/12</i></p>
<p>1. Article Addressed to:</p> <p>Miami Childrens Hospital Attn: Patient Accounting 3100 SW 62nd Ave Miami, FL 33155 C.I.#: 11-1443-000/MS/cml/FAR</p>	<p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>Mail <input type="checkbox"/> Express Mail <input type="checkbox"/> Return Receipt for Merchandise <input type="checkbox"/> Insured Mail <input type="checkbox"/> C.O.D.</p> <p>4. Restricted Delivery? (Extra Fee) <input type="checkbox"/> Yes</p>
<p>2. Article Number (Transfer from service label)</p>	<p><i>7008 0150 0003 1015 1725</i></p>

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

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 Medicaid Program Integrity
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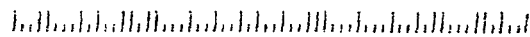


Exhibit 2

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- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Miami Childrens Hospital
 Attn: Patient Accounting
 3100 SW 62nd Ave
 Miami, FL 33155
 CI#: 11-1443-000/MS/cml/PAR

2. Article Number (Copy from service label)

7008 0150 0003 1015 1602

COMPLETE THIS SECTION ON DELIVERY

A. Received by (Please Print Clearly) B. Date of Delivery
 6/4/12

C. Signature
 X *Aurora J. Rodriguez* Agent Addressee
 Is delivery address different from item Yes
 If YES, enter delivery address below: No

3. Service Type
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 Registered Return Receipt for Merchandise
 Insured Mail C.O.D.

4. Restricted Delivery? (Extra Fee) Yes

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• ε
 Agency for Health Care Administration
 Medicaid Program Integrity
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 Institutional Unit

Exhibit 2

English

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LOCATION

FEATURED

Delivered

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MIAMI, FL 33155

Certified Mail™

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MIAMI, FL 33155

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