STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 16-6490MPI

HALIFAX HOSPICE, INC., d/b/a HALIFAX HEALTH HOSPICE,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held April 24, and 25, 2017, in Tallahassee, Florida, before Yolonda Y. Green, a duly-designated Administrative Law Judge of the Division of Administrative Hearings ("Division").

APPEARANCES

For Petitioner: Rex D. Ware, Esquire
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STATEMENT OF THE ISSUES

The issues are whether Petitioner is entitled to recover Medicaid funds paid to Respondent pursuant to section 409.913(1), Florida Statutes, for hospice services Respondent provided during the audit period between September 1, 2009, and December 31, 2012; and the amount of sanctions, if any, that should be imposed pursuant to section 409.913(15), (17).

PRELIMINARY STATEMENT

Petitioner, Agency for Health Care Administration ("Petitioner" or "Agency" or "AHCA"), issued a Final Audit Report ("FAR") dated August 21, 2015, in which it indicated that Respondent, Halifax Hospice, Inc., d/b/a Halifax Health Hospice ("Halifax"), had been overpaid in the amount of $694,250.75 (subsequently reduced to $529,906.88) for services performed between September 1, 2009, and December 31, 2012, that in whole or in part are not covered by Medicaid. AHCA also seeks to impose an administrative fine, in the amount of $105,981.38 (reduced from $138,850.15) as a sanction in accordance with section 409.913(15), (16), (17), for violating Florida Administrative Code Rule 59G-9.070(7)(e) and to recoup investigative, legal, and expert witness costs.

Respondent timely requested a hearing and AHCA referred this matter to the Division for a final hearing. On November 15, 2016, this matter was assigned to Administrative

Law Judge W. David Watkins, and on November 15, 2016, this matter was transferred to the undersigned. The undersigned issued a Notice of Hearing scheduling the final hearing for January 23, 2017. The parties twice filed a Joint Motion for Continuance of Final Hearing. The hearing was ultimately scheduled for April 24 through 26, 2017.

The parties filed a Joint Prehearing Stipulation stipulating to certain facts, which to the extent relevant, have been incorporated in the findings of fact below.

On April 24, 2017, the hearing convened as scheduled and concluded on April 25, 2017. At final hearing, Joint Exhibits 1 through 17 were admitted into evidence.

AHCA presented the live testimony of three witnesses: Robert Reifinger, a program administrator in the AHCA Medicaid Program Integrity Program ("MPI"); Mike Armstrong, the auditor in charge for Health Integrity, LLC; and Dr. Alan Heldman, AHCA's expert in internal medicine and cardiology. AHCA also presented by deposition Dr. Todd Eisner, AHCA's expert in internal medicine and gastroenterology. Halifax presented live testimony of Raul Laurence Zimmerman, M.D., medical director for Halifax.

The parties ordered a copy of the hearing transcript. The four-volume Transcript of the final hearing was filed with the Division on May 11, 2017. At the end of the final hearing, the

parties stipulated that their proposed recommended orders would be filed within 20 days of filing of the hearing transcript. The parties timely submitted Proposed Recommended Orders on May 31, 2017, which have been considered in preparation of this Recommended Order.

Except as otherwise indicated, citations to Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect during the time in which the alleged overpayments were made.

FINDINGS OF FACT

Based upon the stipulations of the parties and the evidence presented at hearing, the following relevant Findings of Fact are made.

Parties

1. Petitioner, AHCA, is the state agency responsible for administering the Florida Medicaid Program. § 409.902, Fla. Stat. (2016). Medicaid is a joint federal and state partnership to provide health care and related services to certain qualified individuals.

2. Respondent, Halifax, is a provider of hospice and end-of-life services in Volusia and Flagler counties. During the audit period of September 1, 2009, through December 31, 2012, Halifax was enrolled as a Medicaid provider and had a valid Medicaid provider agreement with AHCA.

Hospice Services

3. Hospice is a form of palliative care. However, hospice care is focused upon patients at the end-of-life-stage while palliative care is for any patient with an advanced illness. Both hospice and palliative care patients are amongst the sickest patients, generally.

4. Hospice is focused upon serving the patient and family to provide symptom management, supportive care, and emotional and spiritual support during this difficult period when the patient is approaching their end-of-life. Hospice care, as with Halifax, uses an inter-disciplinary team (IDT) to provide comfort, symptom management, and support to allow patients and their families to come to terms with the patient's terminal condition, i.e., that the patient is expected to die. Each patient is reviewed in a meeting of the IDT no less than every two weeks.

5. For hospice, a terminally-ill patient must choose to elect hospice and to give up seeking curative care and aggressive treatments.

6. At all times relevant to this proceeding, Petitioner was authorized to provide hospice services to Medicaid recipients.

AHCA Audit

7. A Medicaid provider is a person or entity that has voluntarily chosen to provide and be reimbursed for goods or services provided to Medicaid recipients. As an enrolled Medicaid provider, Halifax was subject to federal and state statutes, regulations, rules, policy guidelines, and Medicaid handbooks incorporated by reference into rule, which were in effect during the audit period.

8. AHCA is required to oversee the integrity of the Medicaid program. Among other duties, AHCA is required to conduct (or cause to be conducted) audits to determine possible fraud, abuse, overpayments, or recipient neglect in the Medicaid program. § 409.913(2), Fla. Stat. Under Florida law, "overpayment" is defined as "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." § 409.913(1)(e), Fla. Stat.

9. The federal Department of Health & Human Services, Centers for Medicare and Medicaid ("CMS"), contracted with Health Integrity, LLC ("HI"), a private vendor, to perform an audit of Halifax on behalf of AHCA. HI, in turn, retained a company called Advanced Medical Reviews ("AMR") to provide

physician reviews of claims during the audit process to determine whether an audited claim was eligible for payment.

10. The audit in this matter was conducted to determine whether Medicaid recipients met eligibility for hospice services. To establish the scope of the audit, HI identified patients that had greater than six months of service, and then, excluded recipients with cancer diagnoses and patients who were dual eligible for Medicaid and Medicare. All the claims at issue, along with patient medical records, were first reviewed by a claims analyst, who is a nurse consultant, to determine whether the claims met the criteria for hospice services.

11. The patient records and the nurse consultant's summary for each patient were then forwarded to a peer reviewer, a physician who used his or her medical expertise to determine the medical necessity of the hospice services provided.

12. In this case, AHCA employed the services of two peer reviewers: Dr. Alan Heldman was the peer reviewer who specializes in internal medicine and cardiology, and Dr. Todd Eisner, who specializes in gastroenterology. The peer reviewers prepared reports that offered their opinion as to whether a patient was qualified for hospice services.

13. A draft audit report ("DAR") was prepared by HI, which initially identified overpayment of Medicaid claims totaling $694,250.75, relating to 12 patients. Halifax provided a

response to the DAR, and contested the overpayments for each of the 12 patients. Halifax's response was provided to the peer review physicians, who, after reviewing the response, maintained their original conclusions.

14. HI then prepared the FAR, upholding the overpayments identified in the DAR, and submitted it to CMS. CMS provided the FAR to AHCA with instructions that AHCA was responsible for initiating the state recovery process and furnishing the FAR to the provider.

15. The FAR contains the determinations of the peer review physicians, specifically, whether each of the 12 patients at issue had a terminal diagnosis with a life expectancy of six or less months if their disease progressed at its normal course.

16. After the FAR had been issued, upon further review, of certain patient files at issue, AHCA determined that four of the original 12 patients were eligible for Medicaid hospice services, and revised the amount of overpayment it seeks to $529,906.88, with a reduction in the fine it seeks to $105,981.38.

17. Halifax is challenging the eligibility determination, i.e., the medical necessity of services provided, regarding the following patients[1/]: Patient D; Patient H; Patient P; Patient Q; Patient S; Patient U; Patient V; and Patient O.

18. The Florida Medicaid Hospice Services Coverage and Limitations Handbook, the January 2007 edition ("Handbook"), governs whether a service is medically necessary and meets certification criteria for hospice services. MPI instructs each peer reviewer to review the criteria set forth in the Handbook to determine whether services provided to a patient are eligible for Medicaid coverage.

19. To qualify for the Medicaid hospice program, all recipients must:

- Be eligible for Medicaid hospice;
- Be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course;
- Voluntarily elect hospice care for the terminal illness;
- Sign and date a statement electing hospice care;
- Disenroll as a participant in a Medicaid or Medicare health maintenance organization (HMO), MediPass, Provider Service Network (PSN), Medicaid Exclusive Provider Organization, MediPass Pilot Programs or the Children's Medical Services Network;
- Disenroll as a participant in Project AIDS Care; and
- Disenroll as a participant in the Nursing Home Diversion Waiver.

20. The Handbook also provides certification of terminal illness requirements as follows:

> For each period of hospice coverage, the hospice must obtain written certification from a physician indicating that the recipient is terminally ill and has a life expectancy of six months or less if the terminal illness progresses at its normal course. The initial certification must be signed by the medical director of the hospice or a physician member of the hospice team and the recipient's attending physician (if the recipient has an attending physician). For the second and subsequent election periods, the certification is required to be signed by either the hospice medical director or the physician member of the hospice team.

21. Certification documentation requirements used by the peer review physicians are as follows:

> Documentation to support the terminal prognosis must accompany the initial certification of terminal illness. This documentation must be on file in the recipient's hospice record. The documentation must include, where applicable, the following:
>
> - Terminal diagnosis with life expectancy of six months or less if the terminal illness progresses at its normal course;
> - Serial physician assessments, laboratory, radiological, or other studies;
> - Clinical progression of the terminal disease;
> - Recent impaired nutritional status related to the terminal process;
> - Recent decline in functional status; and

- Specific documentation that indicates that the recipient has entered an end-stage of a chronic disease.

22. The Medicaid hospice provider must provide written certification of eligibility for hospice services for each patient. The certification is also required for each election period. A patient may elect to receive hospice services for one or more of the election periods. The election periods include: an initial 90-day period; a subsequent 90-day period; and subsequent 60-day time periods.

23. The Handbook further provides guidance regarding the election periods as follows:

> The first 90 days of hospice care is considered the initial hospice election period. For the initial period, the hospice must obtain written certification statements from a hospice physician and the recipient's attending physician, if the recipient has an attending physician, no later than two calendar days after the period begins. An exception is if the hospice is unable to obtain written certification, the hospice must obtain verbal certification within two days following initiation of hospice care, with a written certification obtained before billing for hospice care. If these requirements are not met, Medicaid will not reimburse for the days prior to the certification. Instead, reimbursement will begin with the date verbal certification is obtained . . . .
>
> For the subsequent election periods, written certification from the hospice medical director or physician member of the interdisciplinary group is required. If written certification is not obtained before

> the new election period begins, the hospice must obtain a verbal certification statement no later than two calendar days after the first day of each period from the hospice medical director or physician member of the hospice's interdisciplinary group. A written certification must be on file in the recipient's record prior to billing hospice services. Supporting medical documentation must be maintained by the hospice in the recipient's medical record.

Peer Review Physicians

24. The two peer reviewers assigned to review claims in this matter were Florida-licensed physicians, who were matched by specialty or subspecialty to the claims they were reviewing. Each physician testified as to his medical education, background, and training. Petitioner offered each physician as an expert, and the undersigned accepted each expert as such.

25. Dr. Heldman has been licensed to practice medicine in the state of Florida for 10 years. While in Florida, he worked as a professor and practitioner within the University of Miami Medical School and Health System until 2015. Since 2015 he has maintained an independent private practice. Before practicing in Florida, Dr. Heldman practiced at Johns Hopkins Hospital in Baltimore, Maryland, for 19 years. Dr. Heldman received his training at Johns Hopkins in cardiology and interventional cardiology. He has been board-certified in cardiovascular disease since 1995, and board-certified in interventional cardiology since 1999. Both cardiology specialties are

subspecialties of the board of internal medicine. Dr. Heldman was previously board-certified in internal medicine in 1992 but was not certified in that area when he reviewed the claims in this matter.[2/] Dr. Heldman has referred patients to hospice.

26. Dr. Eisner, who is board-certified in gastroenterology, has seen numerous patients with liver disease throughout his career and, based upon his experience, Dr. Eisner understands what factors are properly considered when estimating a patient's life expectancy.

27. He also refers patients to hospice on a regular basis, which routinely requires him to make the type of prognosis determination such as those at issue in this matter. Although Dr. Eisner has some experience dealing with patients who have Chronic Obstructive Pulmonary Disease ("COPD"), he does not have board-certification in pulmonary disease. Also, Dr. Eisner has never provided expert testimony regarding pulmonology conditions.

Halifax Hospice Providers

28. Dr. Zimmerman, Halifax's medical director, authored the provider response to the eight patients at issue and testified at the final hearing in that regard. Although he is board-certified in hospice and palliative medicine, he is not and has never been certified in internal medicine, gastroenterology, or cardiology.

29. Halifax did not elicit testimony from Dr. Zimmerman that he had any experience in examining and treating patients with liver disease, COPD, dementia, or end-stage lung disease. Likewise, none of the other Halifax physicians testified at hearing and there was no evidence of their respective experience in examining and treating patients with the illnesses involved in this case.

30. Additionally, although Dr. Zimmerman initially certified the patients selected for the audit for hospice services, and attempted to support the other Halifax hospice physicians when they repeatedly recertified the patients as eligible, Dr. Zimmerman admitted he never examined any of these patients himself and was unable to attest that any of his in-house physicians ever personally examined any of the patients.

31. In addition to Dr. Zimmerman, the hospice physicians involved in the certification of the eight patients at issue in this audit were as follows:

- Dr. Richard C. Weiss: board-certified in internal medicine, oncology, and hospice & palliative medicine
- Dr. John Bunnell: board-certified in family medicine and hospice & palliative medicine
- Dr. Arlen Stauffer: board-certified in family medicine and hospice & palliative medicine

- Dr. Susan Howard: board-certified in family medicine and hospice & palliative medicine

- Dr. Lyle E. Wadsworth: board-certified in internal medicine, geriatrics, and hospice & palliative medicine

- Dr. Gregory Favis: board-certified in internal medicine, with subspecialty certification in hematology and oncology; and

- Dr. Justin Chan: board-certified in family medicine

Specific Patient Review

32. At the time of the hearing, the hospice service claims related to eight patients remained at issue. The findings of fact regarding eligibility of each patient for hospice services are set forth below in the following order: D, H, P, Q, S, U, V, and O.

Patient D

33. Patient D, a 53-year-old male, was first admitted to Halifax Hospice on February 25, 2011, with a terminal diagnosis of hepatocellular cancer and cirrhosis secondary to hepatitis C. He was discharged on May 29, 2012, and then readmitted on June 13, 2012, through December 31, 2012 (audit period). He had previously been in various hospices for six to seven years.

34. Dr. Eisner noted there was no recent decline in functional status. In June 2011, a nurse noted the patient was ambulating well and went fishing, but he experienced frequent

falls. He continued to experience falls (from his couch and bicycle) and also had mild to moderate arm and hand tremors. His weight decreased from 176 to 162 over seven months. Thus, the patient records reflected some indication of functional decline.

35. However, as Dr. Eisner credibly testified, even considering the alleged terminal diagnosis, the patient showed no evidence of having refractory ascites, hepatic encephalopathy nor gastrointestinal bleeding. Further, he indicated there was no documentation of variceal bleeding, hepatorenal syndrome, or spontaneous bacterial peritonitis, which he would expect to see if the patient truly had six or less months to live.

36. The medical records support Dr. Eisner's conclusion that the patient did not meet the standard of six or less months to live. Throughout the period of the hospice stay, nursing notes indicate that the patient was stable, ambulating well, felt good, and was observed by an ER doctor after a fall off his bike, as "well-nourished, well-developed patient, [and] in no apparent distress."

37. Even Dr. Weiss, the hospice physician who worked with Patient D, noted in recertification that "It is a difficult case as he clearly has a terminal illness and at the same time is manipulative with no overt progression of disease."

38. Dr. Eisner credibly testified that the patient was not eligible for hospice services and, thus, the services provided were not eligible for Medicaid reimbursement.

39. The greater weight of the evidence proves that Patient D was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $98,776.63

Patient H

40. Patient H was admitted to Halifax on December 31, 2010, with a terminal diagnosis of end-stage liver disease secondary to chronic hepatitis C. Dr. Eisner determined that Patient H did not have a life expectancy of less than six months. Dr. Eisner opined that there was no clinical progression of the patient's terminal disease. The patient did not have impaired nutritional or functional status related to the terminal illness. The patient had weight loss but experienced increased abdominal girth.

41. The treating hospice physician was Dr. Wadsworth, who is board-certified in internal medicine. He noted that the patient had cirrhosis and variceal bleeding and hepatic encephalopathy. However, as correctly noted by Dr. Eisner, those conditions were the natural progression of the disease, but would not result in a life expectance of less than six months.

42. Dr. Eisner also testified that patients with chronic liver disease can live up to 10 years and patients with hepatic encephalopathy can live up to 15 years.

43. Patient H was ultimately discharged for drug diversion, and although her discharge note states: "Suspected drug diversion became evident over last 2 months when controlled medication was not available for nurses to check during visit," the patient records reflect that Halifax was aware of this problem throughout her stay, but did not discharge her for an additional 12 months.

44. The inconsistency of the medical records and Dr. Eisner's opinions indicate that this patient did not have a terminal diagnosis with a life expectancy of six months or less if her terminal disease progressed at its normal course at initial certification or at any recertification throughout her stay with Halifax. The medical records contained in this patient's file do not support a finding that the Medicaid hospice eligibility standard was met.

45. Based upon the greater weight of the evidence in this case, it is determined that Patient H was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $50,142.74.

Patient P

46. Patient P, a 48-year-old male, was admitted to Halifax on August 25, 2011, with a terminal diagnosis of end-stage liver disease. The first 11 months of his stay were denied, however, the last month was approved.

47. Dr. Eisner testified that although the patient had ascites requiring frequent paracentesis, he did not see documentation indicating there was a progression of the terminal disease until July 2012. Dr. Eisner also determined there was no documentation in the patient records of impaired nutritional status related to the disease or a decline in functional status. However, when the patient did show a decline in functional status, Dr. Eisner agreed the patient was eligible.

48. Further, because, during the denied period, there was no evidence of variceal bleeding, hepatorenal syndrome or recurrent spontaneous bacterial peritonitis, Dr. Eisner opined that the life expectancy of the patient would typically be one to two years, not six or less months.

49. There is also a discrepancy in the medical records for this patient. In the narrative for the recertification for November 24, 2011, Dr. Wadsworth indicates this is a "48 yo ES Dementia, and multiple comorbidities. Has had [hallucinations] has improved." Certainly this is in error and cannot be the

basis for a valid recertification--this patient did not have dementia nor were there reported hallucinations.

50. This patient did not have a terminal diagnosis with a life expectancy of six months or less if his terminal disease progressed at its normal course at initial certification or at any recertification throughout the first 11 months of his stay with Halifax. The medical records contained in this patient's file do not support a finding that the Medicaid hospice eligibility standard was met.

51. Based upon the greater weight of the evidence in this case, it is determined that Patient P was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $60,872.04.

Patient Q

52. Patient Q was a 56-year-old male admitted with end-stage lung disease. Per the FAR overpayment recalculations, he was deemed ineligible for the first three months of his hospice admission beginning on December 13, 2011, and was thereafter approved through the end of the audit period.

53. As Dr. Eisner reasoned, the medical records did not support hospice eligibility for the first three months that were billed. The patient was stable, using a walker, and had reasonable palliative performance scale scores, and showed no

decline in functional status and Transient Ischemic Attacks ("TIA), if any, were stable.

54. However, as Dr. Eisner noted, after three months, the records did contain evidence supporting a progressive deterioration of the patient's condition and functional status.

55. Much of the issue with this patient appears to be whether the patient actually had ongoing TIA episodes prior to and during the initial certification period.

56. The patient's medical record from a hospital visit six months prior to hospice admission, where he was seen for chest pains, made no mention of TIAs.

57. Further, Dr. Zimmerman admitted that none of his doctors or nurses had witnessed the patient having a TIA, and the records do not support that the patient had mini-strokes prior to the approved period.

58. While Dr. Zimmerman also attempted to justify his concerns with TIAs based upon one episode during the denied period where the patient reported being dizzy and short of breath, he admitted that these could have been caused by the extensive amount of opiates and other drugs the patient had been given.

59. For the denied period, the patient did not have a terminal diagnosis with a life expectancy of six months or less if his terminal disease progressed at its normal course at

initial certification. The medical records do not support a finding that the Medicaid hospice eligibility standard was met.

60. Based upon the greater weight of the evidence, it is determined that Patient P was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $12,716.10.

Patient S

61. Patient S, a 51-year-old patient, was admitted to Halifax with a terminal diagnosis of end-stage liver disease. Dr. Eisner determined that hospice services were not appropriate for Patient S. Specifically, he determined that the patient's disease, while terminal, did not result in a life expectancy of six months or less. In refuting Dr. Zimmerman's response, Dr. Eisner stated, "In the absence of recurrent, untreated, variceal bleeding, hepatorenal syndrome or recurrent spontaneous bacterial peritonitis, the life expectancy of patients with cirrhosis, ascites, and hepatic encephalopathy is typically 1 to 2 years." There was no clinical progression of the disease.

62. The Halifax treating physician, Dr. Weiss, noted that the patient's condition included cirrhosis and hepatic encephalopathy. However, as noted by Dr. Eisner, the condition was the natural progression of the disease.

63. The greater weight of the evidence supports that Patient S was not eligible for hospice services for the period

September 1, 2009, through December 1, 2010, and that Petitioner is entitled to recover an overpayment of $63,235.91.

Patient U

64. Patient U, a 61-year-old female, was admitted with a terminal diagnosis of dementia. She was first admitted to Halifax hospice in October 2010, however, the claims audit period for this patient did not begin until January 1, 2011. Dr. Heldman indicated that she was not eligible through the end of her initial stay in hospice on January 31, 2012. Dr. Heldman approved her second stay in hospice beginning on May 19, 2012.

65. Dr. Heldman, who indicated he had dealt with dementia patients many times, testified that there were discrepancies throughout her medical records and that the file did not contain documentation showing serial physician assessments, clinical progression of the terminal disease, a decline in functional status, nor of the end stage of a terminal disease.

66. Dr. Zimmerman, in his provider response after the DAR, focused on what he claimed was a significant weight loss with this patient over the period she remained in hospice care.

67. As Dr. Zimmerman stated in the provider response: "when certifying physicians saw consistent weight gain/stabilization they became comfortable that the improvement was not a brief 'honeymoon' in her failing nutritional status and they no longer believed that her 'normal course' would

result in a life expectancy of six months or less and they appropriately discharged her." It is clear Dr. Zimmerman relied on the patient's alleged dramatic weight loss to justify continued provision of hospice services to the patient.

68. However, at the final hearing, Dr. Zimmerman conceded that the dramatic weight loss upon which he relied (and his physician who was recertifying the patient relied on) in evaluating this patient, was a mistake.

69. The factor upon which Dr. Zimmerman relied upon to support the patient's stay in hospice, including his initial certification and at least two recertifications, did not actually exist.

70. Dr. Heldman likewise provided credible testimony regarding the inconsistencies in Halifax's records for Patient U's file and that the records did not contain sufficient documentation to support the initial certification and recertifications.

71. The preponderance of the evidence proves that Patient U was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $47,159.40.

Patient V

72. Patient V, a 56-year-old male, was initially admitted to Halifax on May 22, 2012, with a terminal diagnosis of end-stage liver disease.

73. Dr. Eisner testified that although this patient did have ascites, they are part of the normal progression of the disease and the condition was appropriately treated with paracentesis. Further, he indicated that throughout the course of the patient's stay, there was no documentation to show a clinical progression of the terminal disease. Dr. Eisner also noted there was no evidence of impaired nutritional status related to the terminal disease or any decline in functional status. More importantly, Dr. Eisner opined that there was no evidence that the patient had entered the end stage of a chronic disease. Finally, he saw no evidence that the patient had variceal bleeding, hepatorenal syndrome, or recurrent spontaneous bacterial peritonitis, which would have indicated six months or less to live.

74. Dr. Zimmerman testified that his team was extremely worried about the patient's prior episode of ventricular tachycardia and the chance of another episode that would be fatal, and that this chance supported keeping him in hospice.

75. Dr. Zimmerman highlighted this grave concern repeatedly through his written response to the DAR. However, on

cross-examination, he admitted that the patient did not have a history of the tachycardia but rather had one episode that lasted 20 beats or less and that Halifax did not send the patient to be further evaluated by a cardiologist. He also admitted that the opiates Halifax treatment providers were giving Patient V could have caused the dizziness that prompted their concern and allegedly supported the prognostication of limited life expectancy.

76. Patient V did not have a terminal diagnosis with a life expectancy of six months or less if his terminal disease progressed at its normal course at initial certification or at any recertification throughout his stay with Halifax during the audit period. The medical records contained in this patient's file do not support a finding that the Medicaid hospice eligibility standard was met.

77. Based upon the greater weight of the evidence in this case, it is determined that Patient V was not eligible for Medicaid hospice services and that Petitioner is entitled to recover an overpayment of $38,769.20.

Patient O

78. Patient O, a 57-year-old female, was first admitted to Halifax on October 16, 2009, with a terminal diagnosis of COPD, a common breathing disorder. She was discharged November 9,

2012, because Halifax determined she did not meet the criteria for hospice.

79. Although Patient O had COPD, Halifax never presented her for a FEV1 test which would have been a good indicator of the degree of COPD and would have assisted in properly obtaining a prognosis of life expectancy.

80. Patient O was recertified for hospice 16 times, with little or no narrative from the recertifying Halifax physician present in the medical records. Patient O also regularly showed oxygen saturation levels within the normal range for a COPD patient.

81. In May 2010, seven months into her hospice stay, there was no evidence of impaired nutritional status, no signs or symptoms of respiratory distress, no change in chest pain, residual weakness, fair appetite, no swallowing difficulties and her pain was well controlled.

82. Additionally, in September 2010, there were notes that the patient's lungs were clear, she had been removed from oxygen for activities, and had showered without difficulty.

83. Between December 2010 through September 2012, the nurse's notes reflect that patient O stated that she was doing better and had not experienced shortness of breath.

84. It appears from the medical records that while the patient may have had COPD, it was not progressing.

85. Dr. Eisner testified that other than intermittent upper respiratory infections, the patient's pulmonary status remained stable and showed no progression over the course of time. Further, he saw no proof that her coronary heart disease or diabetes deteriorated over the three years and that, although she had some weight loss, there was no documentation of a decline in her functional status.

86. However, Dr. Eisner provided an opinion regarding this patient outside his expertise. That a COPD terminal diagnosis was beyond his experience was made clear when Dr. Eisner could not identify the specific indicators for when a COPD patient was decompensating. Although Dr. Eisner may have treated patients with COPD, his primary practice treating patients was related to gastroenterological conditions. He was not board-certified in pulmonology and was not trained in the specialty.

87. Therefore, AHCA has not met its burden by the greater weight of the evidence that Patient O was not eligible for Medicaid hospice services, and Petitioner is not entitled to recover an overpayment of $158,234.66.

Fine Calculation

88. When calculating the appropriate fine to impose against a provider, MPI uses a formula based on the number of claims that are in violation of rule 59G-9.070(7)(e). Specifically, the formula involves multiplying the number of

claims in violation of the rule by $1,000 to calculate the total fine.[3/] The final total may not exceed 20 percent of the total overpayment, which resulted in a fine of $64,981.38.

Summary of Findings of Fact

89. At the time of the hearing, AHCA sought from Respondent overpayments in the amount of $529,906.88 for eight patients who received hospice services at Halifax during the audit period. The findings of fact above upheld AHCA's denial of hospice services for patients: D, H, P, Q, S, U, and V. The Respondent rebutted the evidence regarding eligibility of Patient O. Therefore, AHCA is entitled to recover overpayment of $371,672.22.

90. Each expert credibly testified as to when each patient was admitted and the certification for each patient. The experts provided the requisite support to both the DAR and FAR for the patients where there was a finding of ineligibility for hospice services.

CONCLUSIONS OF LAW

91. The Division of Administrative Hearings has jurisdiction over the parties and subject matter of this proceeding pursuant to sections 120.569, 120.57(1), and 409.913(31), Florida Statutes (2016).

92. The burden of proof is on the Agency to prove the material allegations by a preponderance of the evidence.

S. Med. Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440 (Fla. 3d DCA 1995); Southpoint Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992). The sole exception regarding the standard of proof is that clear and convincing evidence is required for fines. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996).

93. Section 409.902 provides, in pertinent part:

> (1) The Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. These payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law. This program of medical assistance is designated the "Medicaid program."

94. To meet its burden of proof, the Agency may rely on the audit records and report. Section 409.913(21), (22) provides:

> (21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon

contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.

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

95. The term "overpayment" is defined as "any amount that is not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." § 409.913(1)(e), Fla. Stat.

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

97. In this case, AHCA seeks reimbursement of overpayments based upon the lack of eligibility, in whole or in part, of the eight patients at issue. In this proceeding, eligibility is based in part on medical necessity as determined by peer review of the patient records.

98. Section 409.9131(2) provides, in pertinent part:

> (a) "Active practice" means "a physician must have regularly provided medical care and treatment to patients within the past two years."
>
> (b) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or

> services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.
>
> (c) "Peer" means a Florida licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice.
>
> (d) "Peer review" means an evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health care standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

99. Respondent alleged in its Petition that AHCA applied unadopted rules in the audit process, by providing peer reviewers with criteria that is not supported by statute and rule and calculating the fines improperly. In the Prehearing Stipulation, Respondent appears to have limited its allegations to "AHCA utilized unadopted rules in its adoption of the Health Integrity Audit as part of its issuing the FAR." However, there

is no evidence in the record nor did Respondent elicit any testimony that AHCA applied any unadopted rule in any regard in this matter or that there was any statement of "general applicability" involved.

100. In a proceeding challenging an unadopted rule, the burden of proof is on the party challenging the rule to prove the agency statement is an unadopted rule. Since Petitioner offered no evidence at the final hearing, the undersigned finds Halifax abandoned this issue.

101. Respondent also argued in its Proposed Recommended Order that the peer review physicians retained by AHCA were not qualified to perform the reviews and render their respective opinions on the eligibility of the eight patients at issue.

102. The primary medical decisions in this matter concerned whether each patient was eligible for Medicaid hospice services at initial certification and each recertification with a terminal diagnosis with a life expectancy of six or less months to live if their terminal disease followed its normal course.[4/] The primary conditions for each patient involved gastroenterology- and cardiology-related conditions. Both peer review physicians were board-certified in internal medicine as a prerequisite of their sub-specialty certifications in gastroenterology and cardiology, respectively. Thus, they were

qualified to the extent possible to perform review of the patient claims for patients: D, H, P, Q, S, U, and V.

103. However, the peer review physician for patient O, Dr. Eisner, was not qualified to the extent possible to perform a review for a patient who experienced extensive pulmonary conditions.

104. The DAR and subsequent FAR support and constitute evidence of the overpayments claimed. In light of the totality of all the evidence presented in this case, AHCA should recover the overpayment as modified herein based upon the findings of fact above.

105. The rule that addresses sanctions, rule 59G-9.090(7)(e), underwent amendments during the audit period. The version of rule Rule 59G-9.070(7)(e) in effect between September 1, 2009 and September 7, 2010 provides that:

> SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed for the following:
>
> * * *
>
> (e) Failure to comply with the provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, the requirements and provisions in the provider's Medicaid provider agreement, or the certification found on claim forms or transmittal forms

> for electronically submitted claims by the provider or authorized representative. § 409.913(15)(e), Fla. Stat.

106. The version of rule Rule 59G-9.070(7)(e) which was in effect September 7, 2010 through the end of the audit period provides that:

> (7) SANCTIONS: Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed for the following:
>
> * * *
>
> (e) Failure to comply with the provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, the requirements and provisions in the provider's Medicaid provider agreement, or the certification found on claim forms or transmittal forms for electronically submitted claims by the provider or authorized representative. [Section 409.913(15)(e), F.S.]
>
> * * *
>
> (10) GUIDELINES FOR SANCTIONS.
> (a) The Agency's authority to impose sanctions on a provider, entity, or person shall be in addition to the Agency's authority to recover a determined overpayment, other remedies afforded to the Agency by law, appropriate referrals to other agencies, and any other regulatory actions against the provider.
>
> * * *
>
> (i) A $500 fine per provision, not to exceed $3,000 per agency action. For a pattern: a $1,000 fine per provision, not to exceed $6,000 per agency action.

107. Each monthly period that Halifax billed for services for these eight patients that were determined to be ineligible for Medicaid reimbursement, Halifax is liable for a $1,000 fine, per claim for the time period of September 7, 2010 through December 31, 2012, which is capped at 20 percent of the repayment amount. Halifax is liable for a $500 fine, per claim for the time period of September 1, 2009 through September 6, 2010, which is capped at $3,000 per action. Therefore, AHCA should impose a fine of $64,981.38 in this case.

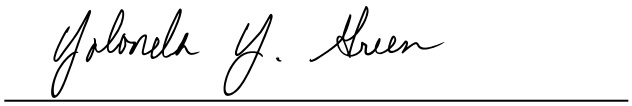
108. The FAR should be revised consistent with the findings herein, to arrive at a final overpayment amount of $371,672.22 and fine of $64,981.38.

109. AHCA reserved its right to amend its cost worksheet in this matter and, pursuant to section 409.913(23), to file a request with the undersigned to seek all investigative and legal costs, if it prevailed.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that that the Agency for Health Care Administration enter a final order directing Halifax to pay $371,672.22 for the claims found to be overpayments and a fine of $67,981.38. The undersigned reserves jurisdiction to award costs to the prevailing party.

DONE AND ENTERED this 30th day of June, 2017, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of June, 2017.

ENDNOTES

[1/] For confidentiality reasons, including the requirements of HIPPA, the parties have agreed to reference the patients in dispute by letter, representing the first letter of the last name of the patient.

[2/] While Dr. Heldman was not board-certified when he reviewed the claims, the statute requires that he be certified at the time of the dates of service.

[3/] Under rule 59G-9.070, AHCA may impose a fine of $1,000 per claim for a first offense.

[4/] At the hearing, Petitioner raised the issue of whether the peer reviewers were unduly influenced by having the records for the patients' post-audit period. Both Dr. Heldman and Dr. Eisner credibly denied any such influence.

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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.