STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 17-3268MPI

GREEN CROSS HOME CARE SERVICES,

Respondent.
_____/

RECOMMENDED ORDER

Administrative Law Judge John D. C. Newton, II, of the Division of Administrative Hearings (Division) conducted the final hearing in this matter on August 29, 2017, and September 25, 2017, in Tallahassee, Florida; and on October 25, 2017, and November 6, 2017, by video teleconference with locations in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: James B. Countess, Esquire
Alexandra M. Marshall, Esquire
Office of the General Counsel
Agency for Health Care Administration
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For Respondent: Aline LaFortune, RN, ARNP
Green Cross Home Care Services, Inc.
15383 Northwest 7th Avenue
Miami, Florida 33169

STATEMENT OF THE ISSUES

A. Did Respondent, Green Cross Home Care Services (Green Cross), submit unsupported or unauthorized claims for treatment of Medicaid patients to Petitioner, Agency for Health Care Administration (Agency), causing the Agency to overpay some claims during the audit period, July 1, 2009, through June 30, 2013 (audit period)?

B. If so, what amount is Green Cross required to reimburse to the Agency?

C. If the Agency overpaid Green Cross, should it assess costs and sanctions against Green Cross; and, if so, in what amount?

PRELIMINARY STATEMENT

The Agency sent Green Cross a letter dated May 16, 2014, with a Preliminary Audit Report asserting that the Agency overpaid Green Cross $30,255.14 for claimed services during the audit period that were not covered by Medicaid. The Agency attached the work papers for its claims to the report. The Agency also provided Green Cross an opportunity to submit information or documents disputing the claims. Later the Agency sent Green Cross an Amended Final Audit Report (audit report). The audit report asserted that the Agency overpaid Green Cross $23,432.78. It also sought a fine of $4,686.56 and costs of $849.01, for a total of $28,968.35.

Green Cross contested the claims and requested an administrative hearing. The Agency conducted an informal hearing. When Green Cross raised disputed issues of material fact, the Agency hearing officer closed the case, and the Agency referred the dispute to the Division of Administrative Hearings (Division) on June 6, 2017.

On June 22, 2017, the Division issued a Notice of Hearing for August 29, 2017. The undersigned convened the hearing. Green Cross representatives did not appear. Co-owners Aline LaFortune, R.N., and Joseph LaFortune, M.D., called the office of the undersigned about 15 minutes after the scheduled start time claiming that they did not receive notice of the hearing. The undersigned continued the hearing and rescheduled it to September 25, 2017, in Tallahassee, Florida.

The undersigned re-convened the hearing on that date. The court reporter scheduled by the Agency did not appear, and the Agency was unable to locate a substitute. The hearing was continued again and rescheduled to be held by video teleconference with locations in Miami and Tallahassee for October 25, 2017. The hearing convened as scheduled. The hearing was not completed. It was continued to November 6, 2017, in Tallahassee, Florida. The hearing convened as scheduled.

At the hearings, Agency Exhibits 1, 3 through 7, and 9 through 17 were accepted into evidence. Mary Canfield and Sonya Graves testified on behalf of the Agency.

Green Cross Exhibits 1 through 3 were admitted into evidence. Aline LaFortune, a co-owner of Green Cross, testified on behalf of Green Cross.

December 6, 2017, Ms. LaFortune filed a letter referring to a 20-day time period and a "unified agreement." With that letter Ms. LaFortune filed a letter from Dr. Lafortune stating: "It is with all due respect, may I retain your attention with the opportunity given me to properly express myself as per the law require." On December 7, 2017, Dr. and Ms. Lafortune filed a letter that read partially like a proposed recommended order and partially like a discussion of factual matters beyond the record. It was treated as a proposed recommended order. On December 22, 2017, Dr. Lafortune, who was not the designated representative of Green Cross, filed a letter discussing timing of orders.

The parties obtained a transcript that was filed January 4, 2018. On January 16, 2018, the Agency filed its proposed recommended order. On February 6, 2018, Dr. and Ms. LaFortune filed a document titled "Petition's [sic] Proposed Recommended Order." On February 27, 2018, the undersigned rendered an Order Accepting Respondent's Late-Filed Proposed Recommended Order in light of the fact that Green Cross was not represented by

counsel. The multiple untimely filings of Green Cross waived all deadlines created by chapter 120, Florida Statutes (2017),[1/] and Florida Administrative Code Chapter 28-106.

The arguments presented in the parties' pleadings have been considered in preparation of this Recommended Order. The factual assertions of matters beyond the record have not been considered.

FINDINGS OF FACT

Participants and Process

1. This case arises from an Agency Medicaid audit of Green Cross claims for services submitted and paid during the audit period.

2. The Agency does not claim that Green Cross provided poor quality of care. It also does not claim that the billings of Green Cross are fraudulent.

3. The Florida Legislature has designated the Agency as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act (Medicaid program). The Agency oversees and administers the Medicaid program for the State of Florida. § 409.913(11), Fla. Stat. (2017).[2/] The Agency investigates and audits Medicaid providers to identify and recoup overpayments for services rendered to Medicaid recipients and the costs of recovery. The Legislature also empowered the Agency to impose

sanctions and fines against providers that received overpayments. § 409.913, Fla. Stat.

4. In the Medicaid program, providers bill the Agency for services rendered and the Agency pays the bills, also called claims. Later the Agency audits the claims. The audit includes examination of whether the services were proper, whether the amounts billed were correct, and whether Medicaid covers the services provided. If the Agency determines that it overpaid a provider, the Agency seeks recoupment of the funds.

5. The Medicaid program follows a process of record collection, records analysis, provider input, and rebuttal from the provider before reaching its final determination of amounts overpaid. The Agency first issues a Preliminary Audit Report to which the provider may respond and submit rebuttal documents. The Agency issues a Final Audit Report, sometimes amended, stating its determination and the reasons for it. If the provider disputes the Agency's final determination, the provider may request a formal administrative hearing.

6. Green Cross is a home health care service provider. During the audit period, Green Cross was an enrolled Medicaid provider subject to the requirements of the Medicaid provider agreement that it executed on July 11, 2000.

7. The Medicaid provider agreement is a contract between the Agency and the provider. It requires the Medicaid provider

to comply with all state and federal laws establishing and regulating the Medicaid program. This includes Medicaid Provider General Handbooks (Handbook) that are incorporated by reference into rules.[3/] By executing the agreement, Green Cross agreed to maintain medical records and make those records available to the Agency in a systematic and orderly manner for review. The contract required that the records be accessible, legible, and comprehensive.

8. The Agency audited Green Cross's claims and Agency payments made during the audit period. The Agency used a data program to screen for claims of Green Cross that were outliers worthy of further examination by audit. The Agency issued a Preliminary Audit Report stating and explaining a determination that it had overpaid Green Cross $30,255.14.

9. After communications with Green Cross representatives and consideration of additional documents, the Agency issued its Amended Final Audit Report setting forth its determination that it had overpaid Green Cross $23,432.78. The Amended Final Audit Report also asserted that Green Cross should pay a fine of $4,686.56 and costs.

10. This proceeding followed. During the activities and proceedings that occurred after Green Cross requested a hearing, the Agency adjusted its claims downward. It now seeks $22,739.96 in overpayments and $4,547.99 in sanctions, as well as costs.

11. The Agency categorizes the claimed overpayments as: (1) failure to submit records or notes to support a claim; (2) failure to submit sufficient records or notes to support a specific claim; (3) impermissible claims for a period when the patient was in a hospital; (4) claims for excluded services; and (5) claims improperly billed for consecutive days. For each claim that the Agency deemed unsupported or unauthorized, it proposed recouping the amount paid for the claim. For the most part, the Agency proved the overpayments that it asserts. It did not prove most of the alleged overpayments based solely upon a claimed overlapping hospital stay.

Claims With No Supporting Records or Notes

12. The July 2008 Medicaid Handbook, at 2-55, and the July 2012 Medicaid Handbook, at 2-61, require providers to maintain and provide upon request medical records and documentation to support each claim. Providers must retain the records for at least five years after the date of service. Upon the Agency's request, providers must send legible copies of all Medicaid-related information to authorized state and federal agencies. Id.

13. Records that do not document that all requirements or conditions for services are incomplete records. Jul. 2008 Handbook, at 5-8; Jul. 2012 Handbook, at 5-9.

14. Providers who do not comply with the documentation, record retention, and record production requirements of the handbooks and section 409.913 may be subject to payment recoupment and administrative sanctions. Jul. 2008 Handbook, at 2-57; Jul. 2012 Handbook, at 2-62. Incomplete records do not satisfy the requirements.

15. The Agency's Preliminary Audit Report gave Green Cross notice of its preliminary determination of overpayment and asked Green Cross for any "documentation in support of the claims identified as overpayments" in the Preliminary Audit Report.

16. Green Cross submitted documentation to support some claims and signed a Certification of Completeness of Records on July 17, 2014. In March of 2017, Green Cross submitted additional documents, which the Agency considered.

17. The preponderance of the competent and substantial evidence proved that Green Cross did not submit documents sufficient to support claims identified as "no records sent" or "no notes submitted" in the audit papers admitted as Agency Exhibit 7. Specifically, Green Cross did not submit records to support claims for Recipients (Rec.) 2, 4, 9, 18, 23, 24, 40, 50, 53, 54, 56, 57, 61, 62, 63, 65, 68, 78, 80, 82, 89, 94, 99, 102, 108, 110, and 115.

18. Green Cross also did not submit records sufficient to support specific claims for the following recipients on the dates shown, as identified in the papers admitted as Agency Exhibit 7.

Rec.	Date of claims
38	4/17/2010, 6/28/2011-7/1/2011
45	5/17/2012
109	4/17/2012
112	9/9/2011, 10/1/2011, 10/11/2011

19. Green Cross also did not submit notes sufficient to document its claims for payment for services to recipients 16, 30, 46, 73, 75, 86, and 90, as identified in the papers admitted as Agency Exhibit 7.

20. Furthermore, Green Cross did not submit notes sufficient to support the specific claims for the following recipients and dates of service, as identified in the papers admitted as Agency Exhibit 7.

Rec.	Date of claims
06	10/15/2009
14	11/28/2009, 12/15/2009
27	7/7/2012
28	8/26/2009, 12/17/2009
29	3/16/2012
31	2/8/2013, 3/22/2013, 5/30/2013

35	11/2/2009-11/7/2009, 12/14/2011, 12/18/2011, 5/15/2003-5/18/2013
37	11/10/2009, 11/11/2009, 11/16/2009, 12/11/2009
38	7/2/2011
48	3/9/2010, 5/17/2010, 5/28/2010
60	2/10/2010
83	6/19/2013
84	8/19/2009, 3/12/2010
101	1/30/2011, 1/31/2011
105	11/24/2010
107	8/29/2010, 6/5/2011
114	7/24/2011, 6/29/2012, 9/11/2012, 9/12/2012

21. The Agency correctly identified the claims identified in paragraphs 18, 19, and 20 as overpayments. Green Cross is responsible for repaying these claims.

Excluded Services

22. Medicaid rules exclude specific services from reimbursement as a Medicaid home health service. Medicaid does not reimburse for "nursing assessments related to the plan of care" under the home health services program. Jul. 2008 Handbook, at 2-11 & 2-12; Dec. 2011 Handbook, at 2-11 & 2-12; Mar. Handbook 2013, 2-11 & 2-12.

23. Green Cross billed, and Medicaid paid, reimbursement claims for nursing assessments provided Medicaid recipients. Those services are excluded from Medicaid payment.

24. The claims are identified below, as presented in Agency Exhibit 7.

Rec.	Date of Service
6	9/28/2009
39	12/4/2011
49	7/10/2009
51	1/16/2013
64	2/23/2010
69	3/5/2010
77	3/20/2010
91	6/10/2010
92	4/15/2010

25. Competent and substantial evidence proved that the payments for the claims identified in paragraph 24 were overpayments.

Improper Billing (Overlap Days)

26. Medicaid rules specify how providers must bill hours when the period of services begins on one day and ends on the next day. The Medicaid Handbooks require that when private duty nursing services begin one day and end on the next day, billing should reflect the total number of care hours provided on each

day. Jul. 2008 Handbook, at 2-21; Dec. 2011 Handbook, at 2-23; Mar. 2013 Handbook, at 2-22.

27. Green Cross billed Medicaid, and the Agency paid for, claims where Green Cross claimed reimbursement for private duty nursing services to Medicaid recipients provided during a period that spanned two days but were billed as if provided on a single day.

28. The claims, as described in Agency Exhibit 7, are identified below by Recipient and date of service.

Rec.	Date of Service
31	8/23/2012, 9/10/2012, 11/22/2012, 12/18/2012, 2/22/2013
37	8/11/2009
66	4/26/2010
72	4/11/2013, 4/23/2013
75	3/23/2010, 4/9/2012
107	8/29/2010, 3/17/2011, 6/6/2011
111	10/3/2011, 11/7/2011, 4/20/2011
114	5/11/2011, 6/7/2011, 12/4/2011, 11/5/2012
116	8/29/2012, 9/14/2012
117	10/22/2012

29. Competent and substantial evidence proved that payments for the claims identified in paragraph 28 were overpayments.

Claims for Services Allegedly Provided Hospital Patients

30. The Agency seeks to recoup repayment for 28 claims based upon its assertion that the claims were for home health services provided to a hospital patient and are therefore unauthorized.

31. Medicaid rules exclude reimbursement for home health services, billed as T1021 (home health aide visits), T1030 (home health services provided by a registered nurse), or T1031 (home health services provided by a licensed practical nurse), when provided to a recipient in a hospital or nursing facility. Jul. 2008 Handbook, 2-13; Dec. 2011 Handbook, 2-14; Mar. 2013 Handbook, 2-14.

32. The documents submitted by Green Cross for two of the 28 claims, for Recipients 1 and 45, indicate that the patient was in the hospital. Green Cross also did not provide documents describing services rendered to Recipient 45. These claims and the payments for them were unauthorized and overpayments.

33. The Agency's Proposed Recommended Order describes claims for services to Recipient 71 as being provided to a hospital patient. The Agency's work papers (Agency Ex. 7), however, establish that Green Cross billed the claims as services performed by a registered nurse (RN). But, a licensed practical nurse (LPN) provided the services. For this reason, the Agency properly adjusted these claims to the lower LPN rate.

34. The Agency denied the remaining claims, which it categorizes as "hospital days excluded." For this determination, the Agency depends on its claim that Green Cross provided the services in a hospital.

35. The sole basis for that claim is the Agency's record of claims for Medicaid reimbursement submitted by a hospital. The documents relied upon by the Agency are printed "UB Claims" of a hospital. They simply show that a hospital claimed payment for services for a patient during a time period when Green Cross also claimed payment for services provided the patient.

36. In short, the information from the hospital that the Agency relies upon is no different from the information provided in the claims filed by Green Cross that the Agency disputes. Both are simply claims for payment. Using this "analysis," the Agency could have as easily relied upon the payment claims of Green Cross to conclude that the hospitals submitted unauthorized claims for hospital services while the patient was actually at home receiving services from Green Cross. The record offers no reason to give more credence to the hospitals' bills than to the bills of Green Cross.

37. The evidence does not permit identifying what hospital made the claim or where the hospital is located. The evidence does not identify the person who submitted the claim on the

hospital's behalf, or the information source that the hospital relied upon in making the claim for payment.

38. The evidence does not include testimony or certification by a document custodian or officer of the hospitals showing that the UB Claims are documents or data compilations made at or near the time of the alleged services by, or from information transmitted by, a person with knowledge about the alleged provision of services. The record does not prove how the hospitals obtained the information underlying the UB Claims, who prepared the claims, or what the hospitals' regular practices were in preparing the claims. There is no persuasive evidence that the hospitals' UB Claims are records created contemporaneously with the alleged provision of services. There is, in fact, no evidence from any hospital representative providing any information about how the claims are prepared and transmitted to the Agency. The UB Claims do not satisfy the business record hearsay exception requirements of section 90.803(6), Florida Statutes (2017).

39. There are also no documents, such as nurse's notes, from the hospital tending to prove that the patient received services in the hospital on the dates and at the times claimed.

40. In stark contrast, the papers include detailed notes from Green Cross home health aides and nurses documenting the services Green Cross provided patients, when they were provided,

and who provided them. The notes are more credible and persuasive than the excerpts from data bases recording hospital claims for payment.

41. The UB Claims are not records, reports, or statements reduced to writing or data compilations setting forth the activities of a public agency or matters observed pursuant to a duty imposed by law as to matters for which there is a duty to report. They are hospital bills submitted to the Agency.

42. The UB Claims do not satisfy the public records hearsay exception of section 90.803(8), Florida Statutes.

43. The preponderance of the persuasive evidence does not prove that the practice of relying upon hospital payment claims to deny another providers' payment claims is an accepted and valid auditing, accounting, analytical statistical or peer-review method. The record does not present persuasive evidence that hospital UB Claims have any characteristics that make them more reliable or credible than payment claims of any other provider, including Green Cross.

44. For the claimed overpayments where the audit report relies solely on the hospital UB Claims in the work papers, the work papers do not support the audit report as required by section 409.913(22), Florida Statutes.

45. One further fact emphasizes why the Agency's process of relying upon untested, unevaluated UB Claims is not persuasive.

For denied claims for services to Recipients 33, 60, 95, and 105, the Agency work papers do not even include a UB Claim that is the ostensible basis for the Agency's determination that Green Cross provided the billed services while the patient was in a hospital. The fact that the Agency denied these claims with no basis at all further undermines the credibility of the Agency's process.

46. The chart below includes all of the claims that the Agency asserts are overpayments subject to recoupment because they were provided in a hospital. For each claim with a "No" in the "Recoup?" column, the Agency did not prove by a preponderance of the evidence that Green Cross's claim was improper or unauthorized.

Claimed Overpayments Due to Hospital Days Excluded				
Recipient	Date	Claim Amount	Additional Information	Recoup?
45	5/19/2012	$34.92	notes doc. hospital & do not doc. services	Yes
60	2/7/2010 through 2/9/2010	$52.38	No UB Claim	No
76	11/3/2012 through 11/8/2012	$104.76	No UB Claim; No Work Papers	No
101	1/13/2012 through 1/23/2012	$973.00		No
27	6/18/2012	$31.04		No
33	11/5/2010	$31.04		No
42	9/16/2012	$4.85	Not a Hospital basis; RN/LPN Discrepancy	Yes
60	7/18/2010	$52.38		No

71	7/31/2009	$31.04	RN/LPN Overlap	Yes
87	10/20/2012	$31.04		No
106	2/10/2010	$4.85	RN/LPN Discrepancy	Yes
1	9/4/2010	$26.19	Notes Document Rec. in Hospital	Yes
14	4/1/2010	$26.19		No
	5/2/2010	$52.38		No
	5/3/2010	$52.38		No
44	9/30/2009	$26.19		No
	10/21/2009	$52.38		No
71	7/31/2009	$52.38		No
96	1/30/2012	$26.19		No
104	6/30/2012	$26.19		No
95	4/15/2011 through 4/21/2011	$931.12	No UB Claim	No
105	2/17/2011	$116.40	No UB Claim	No
107	3/13/2011	$69.84		No
22	10/15/2010	$60.00		No
26	1/22/2010	$60.00		No
29	3/16/2012	$90.00		No
41	5/15/2010	$30.00		No
48	5/13/2010	$30.00		No
	5/31/2010	$30.00		No
	6/7/2010	$30.00		No
59	11/22/2009	$90.00		No
	11/23/2009	$180.00		No
66	4/10/2010 through 4/17/2010	$1,440.00		No
	4/22/2010 through 4/25/2010	$825.00		No
79	7/14/2009 through 7/16/2009	$330.00		No
	7/27/2010	$120.00		No
	7/28/2010	$60.00		No

47. The total value of the claims that the Agency failed to prove were improper is $6,082.28.

Claim That Reimbursement Has Already Been Paid

48. Green Cross argues that it has already repaid the alleged overpayments. It claims that Green Cross Exhibits 1 through 3 demonstrate payment in full. They do not.

49. The audit that is the subject of this proceeding is audit number C.I. 14-1787-000 or MPI Case number 2015-0002077.

50. Green Cross Exhibit 1, an Agency letter to Green Cross dated July 3, 2013, states that C.I. 12-1159-000 and C.I. 12-2368-000 are paid in full. Additionally, the undersigned took Official Recognition of the Agency's Final Orders closing each of those matters.

51. Neither C.I. 12-1159-000 nor C.I. 12-2368-000 are at issue in this proceeding. The audit in dispute here is number C.I. 14-1787-000.

52. Green Cross did not prove that any of the claims included in this proceeding were included in a prior audit.

53. In addition, the evidence demonstrated that the Agency takes reasonable measures to prevent the overlap of overpayment claims in subsequent audits.

CONCLUSIONS OF LAW

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

55. The Agency bears the burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

56. The statutes, rules, and Medicaid Provider Handbooks in effect during the period for which the services were provided apply in this dispute. Toma v. Ag. for Health Care Admin., Case No. 95-2419 (Fla. DOAH July 26, 1996; Fla. AHCA Oct. 28, 1996).

57. The Legislature authorized the agency to seek repayment of overpayments it may have made for goods or services reimbursed under the Medicaid program. §§ 409.913(1), 409.913(11), 409.913(15)(j), and 409.913(30), Fla. Stat.

Claims With No Supporting Records or Notes

58. The records and notes Green Cross submitted to support the claims identified in paragraphs 17, 18, 19, and 20 do not satisfy the supporting documentation requirements of the July 2008 Handbook, at 5-8; the July 2012 Handbook, at 5-9; the July 2008 Handbook, at 2-57; and the July 2012 Handbook, at 2-62.

Excluded Services (Nursing Assessments)

59. The preponderance of the evidence proved that the claims identified in paragraph 24 were for nursing assessments. The handbooks all prohibit payment for those assessments. Jul. 2008 Handbook, at 2-11 & 2-12; Dec. 2011 Handbook, at 2-11 & 2-

12; Mar. 2013, at 2-11 & 2-12. These are overpayments that the Agency is entitled to recoup.

Improper Billing (Overlapping Days)

60. The preponderance of the evidence proved that Green Cross improperly billed for services provided in two consecutive days by billing all the hours to one day instead of allocating them between the days, as the handbooks require. Jul. 2008 Handbook, at 2-21; Dec. 2011 Handbook, at 2-23; Mar. 2013 Handbook, at 2-22. The Agency proved that the paid claims identified in paragraph 28 are overpayments that it is entitled to recoup.

Hospital Days Excluded

61. The Agency's effort to recoup payments under the theory that Green Cross provided the services to patients in a hospital rests entirely on one document and its attachments. The document is titled "Home Health Care Services Institutional Analysis." (Agency Ex. 7). For the charges related to hospital stays, the "analysis" is only a compilation of copies of Green Cross's charges for a specific patient on a specific day and a hospital's charges for the same patient on the same day. The corresponding attachments are partial printouts of the Agency's record of claims from unidentified hospitals for payment for the same patient on the same day. These documents are hearsay and not

subject to any hearsay exception. They cannot support a finding of fact on their own. § 120.57(1)(c), Fla. Stat.

62. They only come into evidence by operation of section 409.913(22). It provides "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment."

63. The Agency attachments to the "analysis" do not support the report's conclusion that Green Cross billed for services provided hospital patients. The facts described in paragraphs 34 through 46 establish that the attachments for the claims based upon the theory that the patient was in the hospital do not support that determination and have no persuasive force. The Agency is doing nothing more than using the bills of one provider to invalidate the bills of another. The record provides no reason to find one provider's bills more credible or accurate than the other's. The requirement of section 409.913(22) that Agency work papers support the report has not been met.

64. The Agency audit "must use accepted and valid auditing, accounting, analytical, statistical or peer-review methods, or combinations thereof." § 409.913(20), Fla. Stat. The plain language of the statute governs. Fla. Birth-Related Neurological Injury Compensation Ass'n v. Fla. Div. of Admin. Hearings, 686 So. 2d 1349, 1354 (Fla. 1997). There is no reason to speculate or use statutory construction tools if a statute is clear.

Brown v. Comm'n on Ethics, 969 So. 2d 553, 559 (Fla. 1st DCA 2007). Section 409.913(20) is clear. It calls for use of "accepted and valid auditing, accounting, analytical, statistical or peer-review methods, or combinations thereof." The evidence does not establish that comparing two providers' billings and arbitrarily choosing to credit one over the other meets the standard of accepted and valid methods imposed by section 409.913(20).

65. This is not an analytical process, such as the statistical sampling methodology of cluster sampling that the First District Court of Appeal found proper in Agency for Health Care Administrative v. Custom Mobility, Inc., 995 So. 2d 984 (Fla. 1st DCA 2008). This is comparing billings from two providers and arbitrarily choosing to credit one over the other. The "analysis" and the report that depends upon it do not meet the standard imposed by section 409.913(20).

66. The Agency maintains that the report and attachments are prima facie evidence of overpayment. That is not what the statute says. "Prima facie" appears nowhere in section 409.913. The Legislature did not include in section 409.913(22) a direction that the Agency audit and work papers must be treated as prima facie evidence. The Legislature only required that they must be accepted as evidence. The determination of their persuasiveness and credibility lies with the trier of fact.

67. The lack of a statement that the audit report and "work papers" should be considered prima facie evidence precludes interpreting the statute to mean that they are prima facie evidence. If a statute is clear and unambiguous and conveys a clear and definite meaning, a tribunal must apply that unequivocal meaning without resort to rules of statutory interpretation and construction. Dep't of Rev. v. Graczyk, 206 So. 3d 157, 159 (Fla. 1st DCA 2016); Brown v. Comm'n on Ethics, 969 So. 2d 553, 559 (Fla. 1st DCA 2007). The plain and ordinary meaning of the statute's words must govern. Fla. Birth-Related Neurological Injury Compensation Ass'n v. Fla. Div. of Admin. Hearings, 686 So. 2d 1349, 1354 (Fla. 1997). The plain and ordinary meaning of the words of section 409.913(22) require that the Agency audit and "work papers" be admitted into evidence. The plain and ordinary meaning of the words does not confer some special power or persuasiveness upon the documents. They are evidence. Like all evidence, they must be persuasive and credible to support a finding of fact. They are not.

68. Interpreting the statute to make the papers prima facie evidence of overpayment requires adding words to the statute, words that change its effect. Knowles v. Beverly Enters.-Florida, Inc., 898 So. 2d 1, 7 (Fla. 2004)("The law is well settled that courts in this state are 'without power to construe an unambiguous statute in a way which would extend, modify, or

limit, its express terms or its reasonable and obvious implications.' Holly, 450 So. 2d at 219 (quoting Am. Bankers Life Assurance Co. of Fla. v. Williams, 212 So. 2d 777, 778 (Fla. 1st DCA 1968)"). Adding "prima facie" to section 409.913(22) dramatically alters the statute's express terms and reasonable and obvious implications. It changes the effect of the statute from making documents evidence to making them, on their own regardless of how flawed the reasoning or unsupported the conclusions in them, "sufficient to establish a fact unless and until rebutted." Dockswell v. Bethesda Mem'l Hosp., Inc., 210 So. 3d 1201, 1209 (Fla. 2017) (defining prima facie).

69. If the Legislature intended for the papers to be prima facie evidence it would have said so. State v. Chubbuck, 141 So. 3d 1163, 1171 (Fla. 2014). In other statutes, the Legislature has been explicit and specific when it intends for something to be accepted as prima facie proof of a fact. See § 810.07(1), Fla. Stat. (2017)("[P]roof of the entering of such structure . . . is prima facie evidence of entering with intent to commit an offense."); § 810.07(2), Fla. Stat. (2017) ("[P]roof of the attempt to enter . . . is prima facie evidence of attempting to enter with intent to commit an offense."); § 173.06(1), Fla. Stat. (2017) ("An affidavit . . . shall be received in evidence as prima facie proof of the facts so certified . . . ."); § 173.06, Fla. Stat. (2017) ("Tax certificates shall be

admissible in evidence and shall be prima facie valid."); § 766.102(2)(b), Fla. Stat. (2017) ("[D]iscovery of the presence of a foreign body, such as a sponge, clamp . . . or other paraphernalia commonly used in surgical examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider".

70. Statutes should not be construed to produce an unreasonable or absurd result. State v. Schell, 222 So. 2d 757, 759 (Fla. 2d DCA 1969). Construing section 409.913(22) to make any document that the Agency labels an audit report and attaches papers to, regardless of its facial deficiencies, prima facie evidence is unreasonable and absurd.

71. The fact that the Legislature did not declare that the Agency papers were "prima facie" evidence in section 409.913(22) requires a conclusion that the Legislature did not intend the Agency papers to be prima facie evidence. See Smith v. Smith, 224 So. 3d 740, 747 (Fla. 2017); State v. Chubbuck, 141 So. 3d 1163, 1171 (Fla. 2014); Dep't of Rev., 206 So. 3d 157, 161 (Fla. 1st DCA 2016).[4/]

72. In this case, the report and printouts of hospital billings are not persuasive or credible evidence that Green Cross improperly billed the Agency for services provided patients who were in a hospital. The Agency did not prove that it overpaid the claims identified in paragraph 46. Their value of $6,082.28

should not be included in the overpayment amount recouped by the Agency or penalty calculation.

73. The preponderance of the evidence proved that the Agency overpaid Green Cross $16,657.68 and is entitled to recoup that amount.

Sanctions and Costs

74. Florida Administrative Code Rule 59G-9.070(7), as in effect during the audit period, authorizes the Agency to impose an administrative fine when a provider does not comply with Medicaid requirements. It states in pertinent part:

> Sanctions: In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. 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 as follows[.]

75. The rule provides for imposition of a $1,000.00 fine per claim for a first offense. Rule 59G-9.070(4)(a) caps the fine at 20 percent of the overpayment amount. The Agency's fine should be adjusted using only the violations found in this Recommended Order. The undersigned finds no factual basis for enhancing the fine amount.

76. The authority under rule 59G-9.070 to impose sanctions on providers is clear. The meaning of the phrases "will impose" and "shall be imposed" are unambiguous and directory. Carmack v. State, 31 So. 3d 798, 800 (Fla. 1st DCA 2009)(holding that the

terms of a law or regulation should be given their plain meaning).

77. To impose a punitive administrative fine, the Agency must establish the factual grounds for doing so by clear and convincing evidence. Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854, 857 (Fla. 2015). The Agency presented clear and convincing evidence that Respondent failed to comply with state and federal law, rules, regulations, and policies of the Medicaid program for the violations found in this Order.

78. The Agency must reduce the fine amount to 20 percent of the overpayment after revising the overpayment amount in accordance with this Order. Fla. Admin. Code R. 59G-9.070(4)(a). The adjusted fine that the Agency is entitled to recover is $3,331.54.

79. The Agency seeks reimbursement of costs that it expended in the investigation of Green Cross and the litigation of the audit findings. § 409.913(23), Fla. Stat. The Agency incurred costs of $849.01 before hearing. It has incurred additional costs preparing for and attending the final hearing.

80. Since the hearing, the Agency has filed a Motion to Assess Costs seeking payment of its investigative and litigation costs.

81. The undersigned reserves jurisdiction of this issue. If the parties cannot agree upon the amount of additional costs,

upon proper application and proof, the Agency will be awarded appropriate and reasonable costs.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration, render a final order requiring Respondent, Green Cross Home Care Services to:

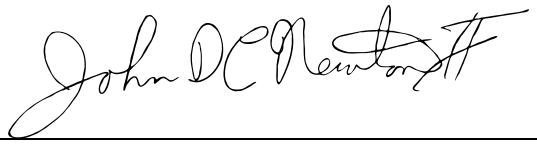
A. pay the overpayment amount of $16,657.68;

B. pay sanctions of $3,331.54; and

C. repay the recalculated and updated amounts for the Agency's investigative, legal, and expert witness costs.

If the parties do not stipulate to the amount of costs, the final order should permit Respondent, Green Cross Home Health Services, to request a hearing to contest the amount of costs.

DONE AND ENTERED this 25th day of April, 2018, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 25th day of April, 2018.

ENDNOTE

[1/] All citations to the Florida Statutes are to the 2017 compilation, unless noted otherwise.

[2/] The relevant portions of section 409.913, Florida Statutes, did not change materially during the audit period. Consequently, this Recommended Order refers to the statute number without identifying a year of statute compilation.

[3/] Various iterations of the handbooks apply during the audit period. This Recommended Order will identify them by year and month followed by the appropriate page number. The portions relevant here do not differ materially from handbook to handbook.

[4/] In a recent Recommended Order, adopted by Agency Final Order, the undersigned included a conclusion of law saying, "the Agency can make a prima facie case by proffering a properly supported audit report, which must be received in evidence." Ag. for Health Care Admin. v. Nakhla, Case No. 17-1825MPI (Fla. DOAH Feb. 21, 2018; Fla. AHCA Apr. 6, 2018). Some Recommended Orders have made similar statements. See e.g., Disney Med. Equipment, Inc. v. Ag. for Health Care Admin., Case No. 05-2277MPI (Fla. DOAH Apr. 11, 2006); Fla. AHCA Jun. 1, 2016). Some have not. See e.g., Ag. for Health Care Admin. v. JRM Pharmacy, Inc., Case No. 14-321MPI (Fla. DOAH Jan. 13, 2015; Fla. AHCA Feb. 2, 2015).

The facts of the cases reciting that the Agency work papers were prima facie evidence were such that whether the report and work papers were prima facie evidence did not determine the outcome. In Nakhla the issues were whether the dentist's records supported performing the procedures that he performed. The Agency presented expert testimony about what the records showed, what treatment the standard of care called for, and what the Medicaid rules permitted reimbursement for.

In Disney Medical Equipment, Inc., the evidence included summaries of the pharmacy records, undisputed facts, and expert testimony explaining the statistical analysis the Agency used. The Recommended Order, adopted by the Agency's Final Order, also noted that the directive to receive the audit report and

supporting papers as evidence did not require that the evidence be believed, no matter what. That is the situation here. The documents the Agency relies on are not persuasive or credible.

The facts of this case required examination of the statute and consideration of applicable authorities. The examination compels a conclusion that section 409.913(22) does not make the Agency's audit and supporting work papers prima facie evidence. The section similarly does not compel a conclusion that the evidence is credible or persuasive.

COPIES FURNISHED:

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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.