STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 17-4641MPI

COVENANT HOSPICE, INC.,

Respondent.
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RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this matter on March 19 through 23, 2018, in Tallahassee, Florida, before Administrative Law Judge Yolonda Y. Green of the Division of Administrative Hearings ("Division").

APPEARANCES

For Petitioner: Bryan K. Nowicki, Esquire
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For Respondent: Rex D. Ware, Esquire
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STATEMENT OF THE ISSUES

The issues are whether Petitioner, Agency for Health Care Administration ("Petitioner" or "AHCA") is entitled to recover Medicaid funds paid to Respondent, Covenant Hospice, Inc.

("Respondent" or "Covenant"), pursuant to section 409.913(1), Florida Statutes, for hospice services Respondent provided during the audit period between January 1, 2011, through December 31, 2012; and the amount of sanctions, if any, that should be imposed pursuant to section 409.913(15) and (17).

PRELIMINARY STATEMENT

Respondent, an authorized provider of Medicaid services, was audited by Petitioner's Office of Medicaid Program Integrity ("MPI") for the claims period January 1, 2011, through December 31, 2012 ("Audit Period"), and found to be in violation of certain Medicaid provider policies. Petitioner prepared a Final Audit Letter on August 9, 2016, informing Petitioner that it was overpaid $714,518.14 for services provided during the Audit Period and imposing fines in the amount of $142,903.63 and costs in the amount of $131.38, as a sanction in accordance with section 409.913(15), (16), (17) and to recoup investigative, legal, and expert witness costs.

On August 29, 2017, Respondent timely requested an administrative hearing challenging Petitioner's determination of overpayments and imposition of fines and costs. The undersigned scheduled this matter for a final hearing on October 23 through 25, 2017. On October 5, 2017, the parties filed a Joint Motion for Continuance and the hearing was rescheduled for February 5 through 9, 2018.

On December 18, 2017, Respondent filed its Petition for Formal Hearing to Challenge Agency Statements Defined as Rules ("Rule Challenge"). On December 20, 2017, the undersigned entered an Order consolidating the Rule Challenge with the instant case.

The parties twice filed a Motion for Continuance, which the undersigned granted. This matter was rescheduled for hearing on March 19 through 23, 2018.

The parties filed a Joint Pre-hearing Stipulation, which contains facts that have been incorporated into the Findings of Fact below, to the extent relevant.

On March 19, 2018, the final hearing convened as scheduled and concluded on March 23, 2018. At the final hearing, Joint Exhibits 1 through 121, 124 through 167, and 169 were admitted into evidence.

AHCA presented the live testimony of four witnesses: Robert Reifinger, FCCM, a program administrator of AHCA's MPI; Mike Armstrong, the auditor in charge for Health Integrity, LLC ("Health Integrity"); Nada Boskovic, M.D., AHCA's expert in hospice and palliative care; and Charles D. Talakkottur, M.D., AHCA's expert in internal medicine. AHCA also presented by deposition Dr. Todd Eisner, AHCA's expert in internal medicine and gastroenterology. Covenant presented live testimony of David McGrew, M.D., FAAHPM, HMFC, Covenant's expert in hospice

and palliative care; and James Smith, DO, Covenant's interim chief medical officer and corporate medical director for Covenant.

The parties ordered a copy of the hearing transcript. The seven-volume Transcript of the final hearing was filed with the Division on April 6, 2018, after which the parties filed a Joint Motion Regarding Deadlines and Page Limits for Proposed Orders. The undersigned granted the motion, thereby increasing the page limit for the proposed recommended orders ("PROs") to 50 pages and extending the deadline for submittal of the PROs to May 18, 2018. The parties timely filed PROs, 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 the alleged overpayments were made.

FINDINGS OF FACT

Based on the evidence presented at the final hearing and the record in this matter, the following Findings of Fact are made.

Parties

1. Covenant is a provider of hospice and end-of-life services and at all times relevant to this matter, the program

was an authorized provider of Medicaid services pursuant to a valid Medicaid provider agreement with AHCA.

2. AHCA is the state agency responsible for administering the Florida Medicaid Program. Medicaid is a joint federal/state program to provide health care and related services to qualified individuals, including hospice services.

3. AHCA is authorized to recover Medicaid overpayments, as deemed appropriate. § 409.913, Fla. Stat.

Medicaid Audit Process

4. The U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services ("CMS"), contracted with Health Integrity, a private vendor, to perform an audit of Covenant. Health Integrity retained a company called Advanced Medical Reviews ("AMR") to provide peer physician reviews of claims to determine whether an overpayment occurred.

5. On or about December 3, 2013, Health Integrity commenced the audit of Covenant. The scope of the audit was limited to Medicaid recipients that received hospice services from Covenant during the period of January 1, 2011, through December 31, 2012. Generally speaking, the files were identified for review using the following criteria: a) the recipient was not dually eligible (eligible for both Medicaid and Medicare); and b) Covenant provided hospice services for 182 days or longer, based on the recipient's first and last day

of service within the Audit Period. Thus, the objective of the audit was to determine whether certain Medicaid patients were eligible for hospice benefits provided by Covenant.

6. When Health Integrity applied the audit criteria to the Medicaid claims paid by AHCA to Covenant, Health Integrity determined that Covenant had provided hospice services to 62 Medicaid recipients for 182 days or longer during the Audit Period.

7. Covenant provided Health Integrity with medical and related financial records ("Covenant's Records") in order to support the eligibility of these 62 patients for Medicaid benefits paid by AHCA.

8. To qualify for the Medicaid hospice program, all recipients must, among other things: a) be certified by a physician as terminally ill with a life expectancy of six months or less if the disease runs its normal course; and b) voluntarily elect hospice care for the terminal illness. See Florida Medicaid Hospice Services Coverage and Limitations Handbook, January 2007 ed. ("Handbook") at page 2-3, as adopted by Fla. Admin. Code R. 59G-4.140 (effective Dec. 24, 2007); see also § 400.6095(2), Fla. Stat. (2010-2012).

9. Health Integrity employs claims analysts who performed an initial review of Covenant's medical records to determine if

the recipients were eligible for Medicaid hospice benefits. All Health Integrity claims analysts are registered nurses.

10. If the Health Integrity claims analyst is able to assess that the patient's file contains sufficient documentation to justify eligibility for hospice benefits for the entire length of stay under review in the audit, there was no imposition of an overpayment for that file and, thus, the claim is not evaluated further.

11. If the Health Integrity claims analyst is unable to assess whether the patient's file contains sufficient documentation to determine eligibility for hospice benefits, or if only a portion of the patient's stay could be justified by the Health Integrity claims analyst, the file is then forwarded to an AMR physician to make the ultimate determination as to eligibility for Medicaid hospice benefits and whether an overpayment is due the Florida Medicaid program.

12. With respect to the Covenant audit, the Health Integrity claims analysts reviewed Covenant's medical files for the 62 initially identified recipients and determined that no further action was warranted with respect to 10 recipients. As a result, 52 files were referred for physician peer review by AMR.

13. AMR maintains a secure portal ("AMR Portal") that Health Integrity personnel access to transmit all received

provider files to AMR. AMR's peer review physicians, in turn, use the AMR Portal to review the totality of the provider's submitted documentation, including all medical case records, and provide their comments.

14. As required by section 409.9131, AHCA referred Petitioner's records for peer review to determine whether there was a medical necessity for a hospice program.

15. Section 409.9131(2) sets forth the following definitions:

> (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.
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> (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.

Peer Review

16. Each AMR peer reviewer retained to review the respective recipient’s patient records prepared a written report, which was based on the reviewer’s opinion regarding whether the patient had a terminal diagnosis, with a life expectancy of six months or less to live if the recipient’s terminal illness followed its natural course.

17. The peer reviewers formulated their opinions based on their own training, experience, and the generally accepted standards in the medical community within the respective specialty. After the AMR peer review physicians reviewed the 52 Covenant recipient files loaded into the AMR Portal, the AMR physicians determined that 25 recipients were eligible for Medicaid hospice services and 29 patients were ineligible. The peer review physicians determined that 29 patients were ineligible for Medicaid hospice services.

18. On February 12, 2016, Health Integrity presented the Draft Audit Report ("DAR") to Covenant for comment and response. Covenant provided a response to the DAR and contested the overpayments for each of the 29 recipients. Covenant's response was provided to the AMR peer physicians, who, after reviewing the response, revised their opinions for four recipients. Therefore, the number of recipients in dispute was reduced to 25 patients.

19. Health Integrity then prepared a Revised Draft Audit Report ("RDAR"), which assessed an overpayment amount of $714,518.14, relating to 25 recipients. Health Integrity presented the RDAR to CMS and AHCA for approval.

20. Once the RDAR was approved by CMS and AHCA, Health Integrity then prepared and issued the Final Audit Report ("FAR"), upholding the overpayments identified in the RDAR and submitted it to CMS. CMS provided the FAR to AHCA with instructions for AHCA to initiate the state recovery process and to furnish the FAR to Covenant.

21. The FAR determined that Petitioner was overpaid $714,518.14 for services provided to the 25 recipients during the Audit Period. The FAR also imposed a fine of $142,903.63 and assessed costs of $131.38. Prior to the final hearing, the parties reduced the number of ineligible patients from 29 to 17 patients. As a result, AHCA is seeking a revised amount of

overpayment in the total amount of $677,023.44, with a corresponding revised fine amount of $135,404.68, for the remaining patients in dispute.

22. To be eligible for Florida Medicaid hospice services, a recipient must be certified by a physician as terminally ill with a life expectancy of six months or less, if the disease runs its normal course. The Handbook also requires:

> 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:
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> • Terminal diagnosis with life expectancy of six months or less if the terminal illness progresses at its normal course;
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> • Serial physician assessments, laboratory, radiological, or other studies;
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> • Clinical progression of the terminal disease;
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> • Recent impaired nutritional status related to the terminal process;
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> • Recent decline in functional status; and
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> • Specific documentation that indicates that the recipient has entered an endstage of a chronic disease.

Experts

AHCA Peer Reviewers

23. The four peer review physicians 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 or her medical education, background, and training. Petitioner offered each physician as an expert, and the undersigned accepted each expert in their field of specialty.

24. Todd Eisner, M.D., is an expert in Internal Medicine and Gastroenterology. He is a physician licensed in Florida and maintains an active practice. He has been actively practicing in Florida for more than 22 years and treats patients with liver disease daily as part of his practice. He has seen thousands of patients with liver disease over his career and, based upon his experience, Dr. Eisner understands what factors are properly considered when estimating a patient's life expectancy. Dr. Eisner reviewed and rendered his opinion as to the hospice eligibility of two patients remaining at issue.

25. Charles Talakkottur, M.D., practices in the area of internal medicine. He is a physician licensed in Florida, who is board-certified in Internal Medicine, and maintains an active practice in internal medicine. Dr. Talakkottur has more than 13 years of practice, where he evaluates and treats patients

with a variety of illnesses including: leukemia, cancer, heart disease, lung disease, chronic liver disease, and respiratory disease. In addition, Dr. Talakkottur routinely makes prognoses related to whether a patient has a terminal disease. Dr. Talakkottur rendered his opinion as to the hospice eligibility of 11 patients remaining at issue.

26. Nada Boskovic, M.D., is an expert in internal medicine and hospice and palliative care. She is licensed in Florida and maintains an active practice. She is currently a hospice medical director for VITAS, a large hospice provider in Florida. Dr. Boskovic has certified or recertified approximately 1,000 patients in a hospice setting throughout her career. Dr. Boskovic reviewed and rendered her opinion regarding three of the patients remaining at issue.

27. Finally, Kelly Komatz, M.D., is an expert in hospice and palliative care. She is a physician licensed in Florida and maintains an active practice. Dr. Komatz has been an associate medical director of a Florida hospice and has evaluated patients for hospice initial certification and recertification. Dr. Komatz reviewed one patient’s claim in dispute.

28. The AHCA peer reviewers used their clinical experience, generally accepted medical standards, and the eligibility standards set forth in the Handbook.

Covenant Expert

29. Covenant offered one expert at hearing, David McGrew, M.D. Dr. McGrew reviewed the medical records and provided reports for each of the 17 patients at issue. Like the AHCA peer reviewers, Dr. McGrew did not examine or provide certification for the 17 patients at issue.

30. Dr. McGrew has been a hospice medical director since 1985. Dr. McGrew has practiced in the hospice and palliative medicine for approximately 23 years and has experience with overseeing over 5,000 hospice certifications. Dr. McGrew is a certified hospice medical director who trains other physicians in hospice care. Dr. McGrew's distinguished career in palliative medicine is highlighted by his membership on the board for the American Academy of Hospice and Palliative Physicians for 12 years, where he served as president in 2013.

Specific Patient Review

31. At the time of the hearing, the hospice service claims related to 17 patients remained at issue. The Findings of Fact regarding eligibility of each patient for hospice services are set forth below in the following order: 1, 2, 3, 5, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 20, 22, and 23.[1/]

Patient 1 (C.S.)

32. Patient C.S., a then 53-year-old female, was admitted with a terminal diagnosis of lung cancer with suspected

metastasis to the liver. The audit period dates reviewed were January 1, 2011, through August 29, 2011. The dates in dispute are January 1, 2011, through April 5, 2011.

33. Patient C.S. had an abnormal palliative performance scale ("PPS") score of 30 percent, had severe ascites, experienced significant fatigue, required oxygen, had possible low levels of encephalopathy, had a significant edema, low appetite, and shortness of breath. Dr. McGrew opined that the Patient C.S. had a life expectancy of six months or less, if the disease ran its normal course based on his determination that the symptoms did not show improvement, stability, or a reason for discharge. However, there was no evidence of decline in her condition.

34. The preponderance of evidence demonstrates that Patient C.S. was not eligible for hospice services for the period of January 1, 2011, through April 5, 2011. Thus, Petitioner is entitled to recover an overpayment of $12,692.00 for hospice services rendered during the disputed period.

Patient 2 (J.R.)

35. Patient J.R., a 55-year-old female at the time she was admitted to hospice on September 14, 2011, had a terminal diagnosis of end-stage leukemia and pulmonary hypertension. The disputed period for Patient J.R. is September 14, 2011, through December 12, 2011.

36. Dr. McGrew opined that Patient J.R. had both a terminal illness and a terminal prognosis based on records showing a gastrointestinal bleed, an anemia from the leukemia, a very low white blood cell count, a depressed platelet count, ongoing chest pain, and need for substantial oxygen during her hospitalization.

37. Dr. Talakkottur, on the other hand, focused on the combination of pulmonary hypertension and leukemia and noted that the condition of the combination of leukemia and pulmonary hypertension demonstrated improvement of her condition.

38. The undersigned finds Dr. McGrew more persuasive and finds that the preponderance of the evidence supports that Patient J.R. was eligible for hospice during the disputed period of September 14, 2011, through December 12, 2011. Thus, AHCA is not entitled to repayment of $12,206.50 for hospice services rendered to Patient J.R.

Patient 3 (D.M.)

39. Patient D.M., a 45-year-old female, was admitted to Covenant on December 20, 2011. Patient D.M. was admitted to hospice with a diagnosis of HIV/AIDS with Kaposi's sarcoma, coupled with complications of psychosocial issues and addiction problems. The disputed period for D.M. is June 17, 2012, through December 31, 2012.

40. Dr. McGrew opined that Patient D.M. had a low CD4 cell count, was suffering from Kaposi's sarcoma, and was experiencing continued infections. Dr. Fitzgerald, the referring oncologist for Patient D.M., noted that she was appropriate for hospice based on her condition.

41. While there was no documented confirmation of the Kaposi's sarcoma in the record by lab results, such as a biopsy, the patient's records reflect that Dr. Fitzgerald, an oncologist, confirmed the diagnosis. Furthermore, Patient D.M.'s treating nurse at Covenant noted that the patient had multiple lesions on her face and extremities. While Kaposi's sarcoma is more common in certain aged males, it is a common condition for patients who suffer from HIV/AIDS.
Dr. Talakkottur testified that a simple biopsy could have been completed to confirm the diagnosis, but the patient did not submit to the biopsy. Although the diagnosis of Kaposi's sarcoma was not confirmed by a biopsy, a preponderance of the evidence supports a finding that the patient suffered from the condition. The HIV/AIDS terminal diagnosis, coupled with Kaposi's sarcoma, supports a finding that Patient D.M. had a documented terminal illness with a life expectancy of six months or less, if the disease ran its normal course during the disputed period.

42. Thus, the undersigned finds that AHCA is not entitled to repayment of $26,843.84 for hospice services rendered to Patient D.M. during the disputed period of June 17, 2012, through December 31, 2012.

Patient 5 (P.W.)

43. Patient P.W., a 54-year-old male upon admission to Covenant, was admitted on October 24, 2011. The patient presented to hospice with a diagnosis of metastatic squamous cell cancer of the pharynx. The disputed period for Patient P.W. is October 24, 2011, through January 21, 2012. Dr. McGrew opined that if a patient was diagnosed with squamous cell cancer of the pharynx and was not being treated, hospice would be appropriate for that patient.

44. Dr. Talakkottur testified as follows: (a) the patient was highly functional, ambulatory, and not using any assistive devices; (b) the patient only used oxygen as needed, and not continuous; and (c) the patient had no nutritional impairment. The more telling picture of the patient's condition was that the patient had no reported or demonstrated mass presence or growth, and there were no medical records to support the patient's claim that his cancer had metastasized.

45. The preponderance of the evidence demonstrates that Patient P.W. was not eligible for hospice services during the disputed period of October 24, 2011, through January 21, 2012.

Thus, AHCA is entitled to repayment of $12,249.00 for hospice services rendered to Patient P.W.

Patient 7 (J.B.)

46. Patient J.B., a 62-year-old male at the time of his admission to hospice, was admitted with a diagnosis of end-stage liver disease with a medical history of hepatitis C and ascites. The disputed recertification period is January 1, 2011, through June 3, 2011. Based on the records, the patient had stabilized during the recertification period. He was independent with self-care and activities of daily living. One of the physician assessments reflected that the patient had shown slow, steady improvement to the point of riding his bicycle. In addition, the records reflect that during the disputed period, nursing documentation indicated that the patient was able to ambulate independently, without shortness of breath, and had no residual apparent ascites. While Dr. McGrew noted that Patient J.B. experienced multiple urinary tract infections, reported dizziness and fatigue, and had very poorly controlled blood sugars during the disputed period, the records consistently reflect that Patient J.B.'s condition had improved during the disputed period.

47. The records presented at hearing did not support a finding that Patient J.B. was eligible for hospice services during the disputed period of January 1, 2011, through June 3,

2011. Thus, AHCA is entitled to repayment of $20,574.40 for hospice services rendered to Patient J.B.

Patient 8 (E.H.)

48. Patient E.H., a 59-year-old male at the time of his admission, was admitted to Covenant on January 27, 2011. Patient E.H. was admitted to hospice with a diagnosis of adult failure to thrive and a medical history of schizophrenia and bipolar disorder. The disputed period for E.H. is January 22, 2012, through March 21, 2012. Dr. McGrew opined that Patient E.H. was eligible for hospice services on the basis that the patient presented to Covenant with history of significant weight loss and a PPS score of 30 percent, which was complicated by underlying conditions, including schizophrenia and bipolar disorder. Dr. Talakkottur opined that the patient gained weight, was ambulatory, was oriented to self, had no recurrent or retractable infections, and had normal vital signs. In addition, the patient had gained 18 pounds since his original admission in hospice and had a body mass index ("BMI") of 21.

49. The greater weight of the evidence demonstrates that Patient E.H. was not eligible for hospice services during the disputed period of January 22, 2012, through March 21, 2012. Thus, AHCA is entitled to repayment of $6,029.66 for hospice services rendered to Patient E.H.

Patient 9 (K.W.)

50. K.W., a 53-year-old male at the time of his admission to hospice, was admitted with a terminal diagnosis of heart disease. The disputed period for K.W. is October 31, 2011, through June 26, 2012. The patient records reflect that Patient K.W. was still smoking, taking drugs, breathing room air, only had shortness of breath with exertion, was highly functional and ambulatory, could perform most of his activities of daily living, and traveled regularly. K.W. reported nine previous myocardial infarctions in the past 11 months; ejection fractions measured at six percent on one occasion and under 20 percent on a separate occasion, was hypotensive, short of breath, had a low heart rate and sodium level, and had elevated liver function tests consistent with hepatic stasis. Dr. Talakkotur noted that the patient's nine alleged heart attacks were self-reported by the patient.

51. Based on the evidence presented at hearing, Dr. Talakkotur credibly opined that Patient K.W. was not eligible for hospice treatment during the disputed period of October 31, 2011, through June 26, 2012. Thus, AHCA is entitled to repayment of $32,664.00 for hospice services rendered to Patient K.W. during the disputed period.

Patient 10 (K.H.)

52. Patient K.H. was a 58-year-old male when he was admitted to Covenant on October 15, 2010, with a terminal diagnosis of chronic airway pulmonary obstruction disease ("COPD.") The disputed period is August 11, 2011, through December 9, 2011. The patient was involved in a car accident in 2008, which caused significant injuries. He also suffered a closed-brain injury and COPD. Dr. Talakkottur opined that the records contained no evidence of progression of the diagnosed terminal condition. Dr. Talakkottur testified that the medical records reflected that Patient K.H. was improving during the disputed period. Additionally, the patient was receiving physical therapy and occupational therapy.

53. Dr. Talakkottur credibly testified that Patient K.H. was not eligible for hospice services during the disputed period of August 11, 2011, through December 9, 2011. Thus, AHCA is entitled to recover overpayment of $16,240.60 for the hospice services rendered to Patient K.H. during the disputed period.

Patient 12 (T.O.)

54. Patient T.O., a 57-year-old male, was admitted to hospice on September 9, 2011, with a terminal diagnosis of end-stage chronic heart failure. The patient's diagnosis was based on two separate echocardiograms reflecting a 53-percent and 55-percent ejection fraction.

55. Dr. Talakkottur opined that the echocardiogram readings would be considered normal. At one point during the disputed period, Edward Fletcher, M.D., a Covenant physician, changed Patient T.O.'s hospice diagnosis from end-stage chronic heart failure to debility. In addition, Dr. Fletcher noted that the patient had no heart palpitations or chest pain and had a good appetite and normal respiratory exam. The greater weight of the evidence demonstrates that Patient T.O. was not eligible for hospice during the disputed period of September 9, 2011, through November 14, 2011. Thus, AHCA is entitled to recover overpayment of $9,063.70 for the hospice services rendered to Patient T.O. during the disputed period.

Patient 13 (M.L.)

56. Patient M.L., a then 39-year-old female, had a diagnosis of end-stage liver disease. The patient also had a medical history of esophageal varices, ascites, and paracentesis. However, Dr. Talakkottur credibly testified that Patient M.L. was not eligible for hospice services. Patient M.L. had no recurrent or intractable infections nor any encephalopathy or peritonitis, and showed no progression of her disease. Patient M.L. was also highly functioning and ambulatory. The greater weight of the evidence demonstrates that Patient M.L. was not eligible for hospice services during the disputed period of January 1, 2011, through January 11,

2011. Thus, AHCA is entitled to recover an overpayment of $1,469.60 for the hospice services rendered to Patient M.L. during the disputed period.

Patient 14 (D.K.)

57. Patient D.K. was a 59-year-old man when admitted to Covenant with a terminal diagnosis of end-stage liver disease on August 6, 2010. The disputed period is January 1, 2011, through April 2, 2011. The patient had a fair to good appetite, exhibited no real pain or discomfort, and showed no signs of a significant decline. Dr. Boskovic further indicated that although the patient had some ascites, the condition was being well managed, and the patient showed no signs of encephalopathy because he remained alert and oriented. Finally, Dr. Boskovic opined, and the records support, the patient generally had a good nutritional status with no sign of the patient’s disease progressing.

58. Respondent contends that Dr. Boskovic's testimony supported Covenant's position because she admitted that the hospice physician could reasonably disagree with her conclusion regarding D.K. and neither physician would be wrong. Here, however, the undersigned finds that Dr. Boskovic’s opinion is more persuasive and demonstrates that Patient D.K. was not eligible for hospice services during the disputed period of January 1, 2011, through April 2, 2011.

59. Thus, AHCA is entitled to recover an overpayment of $12,291.20 for hospice services rendered during the disputed period.

Patient 15 (S.S.)

60. Patient S.S. was a 52-year-old female at the time of her readmission to Covenant. On December 26, 2009, Patient S.S. was admitted with a terminal diagnosis of COPD. Dr. Komatz opined that Patient S.S. was not eligible for hospice services during the denied period on the basis that the patient’s illness was not progressing, she was stable and did not demonstrate decline, and she had experienced weight gain over the period in dispute. She also noted that the patient remained ambulatory and took outings with her family.

61. To the contrary, Dr. McGrew contended that the patient was eligible for hospice due to the progression of her illness that led to hospitalization during her hospice admission. The most telling of the patient’s condition was that the physician who treated the patient during a hospital admission noted that Patient S.S. did not suffer from end-stage COPD.

62. Based on the foregoing, the greater weight of the evidence demonstrates that Patient S.S. was not eligible for hospice services during the disputed period of February 19, 2011, through December 15, 2011. Thus, AHCA is entitled to

recover an overpayment of $40,270.00 for hospice services rendered during the disputed period.

Patient 16 (R.W.)

63. Patient R.W., a 53-year-old male at the time of his admission to Covenant Hospice, had an initial terminal diagnosis of adult failure to thrive. The patient's diagnosis was changed to HIV/AIDS in May 2012. The disputed period for R.W. is April 29, 2012, through June 27, 2012. Dr. Talakkottur opined that Patient R.W. was not eligible for hospice and relied upon medical records that showed the patient was not losing weight, he was ambulatory, had adequate nutrition, and did not show any infections that would demonstrate terminal progression of his disease. Dr. McGrew noted that the patient suffered from an episode of toxoplasmosis, and experienced weight loss and lack of appetite. However, he also noted that, during the disputed period, the patient was getting better and gaining weight.

64. The preponderance of the evidence supports a finding that Patient R.W. was not eligible for hospice services during the disputed period. Thus, AHCA is entitled to recover an overpayment of $8,166.00 for hospice services rendered during the disputed period.

Patient 17 (E.M.)

65. Patient E.M. was a 60-year-old female at the time of her admission to Covenant on April 28, 2010, with a terminal

diagnosis of debility. The disputed period was January 1, 2011, through February 21, 2011. Dr. Boskovic opined that the patient did not have refractory edema, her chest pain was well managed, there was no evidence of impaired nutritional status (no weight loss or low BMI), her albumin level was good, she ambulated with a walker or wheelchair, and her overall condition was stable. Dr. McGrew opined that the patient was eligible for hospice services and noted that the patient was taking a high daily dosage of Lasix. The undersigned finds Dr. Boskovic's testimony more persuasive regarding whether Patient E.M. was eligible for hospice services during the disputed period.

66. Dr. Boskovic credibly testified that Patient E.M. was not eligible for hospice services during the disputed period. Thus, AHCA is entitled to recover an overpayment of $6,947.20 for hospice services rendered during the disputed period.

Patient 20 (P.G.)

67. Patient P.G. was a 53-year-old female at the time of her admission to Covenant on June 8, 2010. Patient P.G. had a terminal diagnosis of end-stage liver disease. The denied dates at issue are January 1, 2011, through February 2, 2011. Dr. Eisner, a gastroenterologist for more than 20 years, testified that Patient P.G. had measured albumin and INR scores within the normal range for liver function. During the denied

period, the patient also maintained a stable weight and her ascites were controlled. Dr. Eisner also noted that the patient's nutritional status remained stable.

68. The greater weight of the evidence establishes that the patient was not eligible for hospice services during the disputed period. Thus, AHCA is entitled to recover an overpayment of $4,408.80 for hospice services rendered during the disputed period.

Patient 22 (C.D.)

69. Patient C.D. was an 8-year-old male when he was admitted to hospice following a hospitalization for respiratory distress with an underlying diagnosis of spina bifida. The disputed period of hospice services was April 25, 2011, through November 25, 2011.

70. Dr. Talakkottur, who is board-certified in pediatrics, opined that Patient C.D. had a chronic condition but was not terminal. He noted that the patient's weight had increased, his PPS was 50 percent, and he was playing ball with his siblings. In addition, the patient was receiving physical therapy and active rehabilitation, both of which are inconsistent with hospice palliative care. The patient did not show any signs of being at the end-stage of his chronic disease. Finally, Patient C.D. remained oriented to self and had no

recurrent or intractable infections. Although Patient C.D. was at risk for pneumonia or sepsis as noted by Dr. McGrew, he did not show any symptoms of the two conditions.

71. The greater weight of the evidence establishes that Patient C.D. was not eligible or hospice treatment during the disputed period of April 25, 2011, through November 25, 2011. Thus, AHCA is entitled to recover an overpayment of $30,827.69 for hospice services rendered during the disputed period.

Patient 23 (C.M.)

72. Patient C.M., a 59-year-old female, was admitted to Covenant on November 15, 2010. The patient was admitted with a terminal diagnosis of malignant neoplasm of the liver. The period in dispute is January 1, 2011, through April 1, 2011. Dr. Talakkottur opined that Patient C.M. was not eligible for hospice service because there was no progression of her disease. Dr. Talakkottur noted that the patient had cancer, but she was functioning well, was ambulatory, and stable enough to take a long-distance trip with her family. Dr. Talakkottur also noted that the patient had a PPS of 60-70 percent at times, and her vital signs remained stable.

73. The greater weight of the evidence establishes that the patient was not eligible for hospice services during the disputed period. Thus, AHCA is entitled to recover an

overpayment of $12,157.60 for hospice services rendered during the disputed period.

Summary of Findings of Fact Regarding Overpayment

74. At the time of the hearing, the parties had stipulated that AHCA was entitled to overpayment of $411,571.65. The Findings of Fact above upheld AHCA's entitlement to additional overpayment of hospice services as indicated. Respondent rebutted the evidence regarding eligibility of Patients 2 and 3. Therefore, in addition to the amount the parties agreed upon, AHCA is entitled to recover an additional overpayment of $226,060.50 for services rendered to patients who were not eligible for hospice services during the Audit Period. Thus, AHCA is entitled to recover a total overpayment of $637,632.15.

75. As indicated in the Findings of Fact above, each expert provided the requisite support to both the RDAR and FAR for the patients where there was a finding of ineligibility for hospice services.

Fine Calculation

76. 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 Florida Administrative Code Rule 59G-9.070(7)(e). The formula involves multiplying the number of claims in violation of the rule by $1,000 to calculate

the total fine.[2/] The final total may not exceed 20 percent of the total overpayment, which results in a fine of $127,526.43.

CONCLUSIONS OF LAW

77. 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).

78. The burden of proof is on AHCA 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).

79. 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."

80. To meet its burden of proof, AHCA may rely on the audit records and report. Section 409.913(21) and (22) provide:

> (21) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments. The agency's determination must be based solely upon information available to it before issuance of the audit report and, in the case of documentation obtained to substantiate claims for Medicaid reimbursement, based solely upon contemporaneous records. The agency may consider addenda or modifications to a note that was made contemporaneously with the patient care episode if the addenda or modifications are germane to the note.
>
> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude

> consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

81. 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.

82. 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.

83. In this case, AHCA seeks reimbursement of overpayments based upon the lack of eligibility, in whole or in part, of the 17 patients at issue. In this proceeding, eligibility is based in part on medical necessity as determined by peer review of the patient records.

84. 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.

85. Respondent alleged in a separate Petition that AHCA applied unadopted rules in the audit process, which was addressed in the Rule Challenge case.

86. 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 17 patients at issue.

87. 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. The undersigned finds that each expert was qualified to perform review of the patient claims for the respective patients.

88. 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.

89. Rule 59G-9.070(7)(e) 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.

90. Each monthly period that Covenant billed for services for these 17 patients that were determined to be ineligible for Medicaid reimbursement, Covenant is liable for a $1,000 fine, which is capped at 20 percent of the overpayment. The fine of $135,404.68, per the revised fine worksheet, should be recalculated to impose a fine of $127,526.43 in this case.

91. The FAR should be revised consistent with the findings herein, to reflect a final overpayment amount of $637,632.15 and fine of $127,526.43.

92. 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 Covenant to pay $637,632.15 for the claims found to be overpayments and a fine

of $127,526.43. The undersigned reserves jurisdiction to award costs to the prevailing party.

DONE AND ENTERED this 15th day of August, 2018, in Tallahassee, Leon County, Florida.

YOLONDA Y. GREEN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 15th day of August, 2018.

ENDNOTES

[1/] For confidentiality reasons, including the requirements of HIPPA, the patients in dispute are referenced in the Findings of Fact by number and by the first letter of the first and last name of the patient.

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

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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.