STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 18-1848MPI

HCR MANOR CARE SERVICES OF FLORIDA, LLC, d/b/a HEARTLAND HOME HEALTH CARE,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a formal hearing was held in this matter on November 28 and 29, 2018, in Tallahassee, Florida, before Administrative Law Judge Yolonda Y. Green of the Division of Administrative Hearings ("Division").

APPEARANCES

For Petitioner: Brittany Adams Long, Esquire
Radey Law Firm, P.A.
Suite 200
301 South Bronough Street
Tallahassee, Florida 32301

For Respondent: Bryan K. Nowicki, Esquire
Reinhart Boerner Van Deuren, S.C.
Suite 600
22 East Mifflin Street
Madison, Wisconsin 53701-2018

STATEMENT OF THE ISSUES

The issues in this case are:

1. Whether Petitioner, Agency for Health Care Administration ("Petitioner" or "AHCA"), is entitled to recover Medicaid funds paid to Respondent, HCR Manor Services of Florida, LLC, d/b/a Heartland Home Health Care and Hospice ("Respondent" or "Heartland"), for hospice services Respondent provided during the audit period between July 1, 2011, through December 31, 2014;

2. Whether Heartland should be required to pay an administrative fine, pursuant to Florida Administrative Code Rule 59G-9.070(7)(e); and

3. The amount of any investigative, legal, and expert witness costs that AHCA is entitled to recover, if any.

PRELIMINARY STATEMENT

On June 19, 2017, AHCA issued a Final Audit Report ("FAR") in which it asserted that Respondent, an authorized Medicaid services provider, had been overpaid $127,015.43 for the claim period July 1, 2011, through December 31, 2014 ("Audit Period"). The FAR also sought to impose an administrative fine of $25,403.09; assessed costs of $75.55 for conducting the audit; and sought to recover investigative, legal, and expert witness costs associated with this matter.

On September 1, 2017, Respondent timely requested an administrative hearing challenging Petitioner's determination of overpayments and imposition of fines and costs. On April 9, 2018, this matter was referred to the Division for assignment to an administrative law judge. This matter was then assigned to the undersigned.

On April 19, 2018, the undersigned scheduled the formal hearing for August 21 through 23, 2018. On August 15, 2018, the undersigned granted AHCA's Unopposed Motion to Continue Final Hearing to enable new counsel to prepare for the hearing, and rescheduled the hearing for October 9 and 10, 2018. Following a continuance due to Hurricane Michael, the undersigned rescheduled this matter for November 28 and 29, 2018.

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

The final hearing convened November 28, 2018, as scheduled. At the final hearing, Joint Exhibits 1 through 48 were admitted into evidence.

AHCA presented the testimony of four witnesses: Robert Reifinger, FCCM, a program administrator of AHCA's Medicaid Program Integrity program ("MPI"); Terry Satchell, the medical review manager for Health Integrity, LLC ("HI"); and Ibrahim Saad, M.D., and Patrick Weston, M.D., AHCA's experts in internal

medicine. Respondent presented the testimony of two witnesses: Brian Stephens, M.D., team physician at Heartland; and Michael Shapiro, M.D., Heartland's expert in family medicine and hospice medicine.

The parties ordered a copy of the hearing transcript. The two-volume Transcript was filed with the Division on December 12, 2018. At the conclusion of the final hearing, the parties requested a deadline of January 18, 2019, for filing post-hearing submittals, which was granted. The parties timely filed Proposed Recommended Orders ("PROs"). Although, Respondent's PRO exceeded the page number allotment of 40 pages, both PROs have been considered in preparation of this Recommended Order.

Except as otherwise indicated, citations to the Florida Statutes or rules of the Florida Administrative Code refer to the 2016 versions, which were in effect during the time the alleged overpayments were made.

FINDINGS OF FACT

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

Parties

1. 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.

2. Heartland is a provider of hospice and end-of-life services in Florida. During the Audit Period, Heartland maintained a hospice program headquartered in Jacksonville, Florida. The program is enrolled as a Medicaid provider and has a valid Medicaid provider agreement with AHCA.

3. As a hospice care provider, Heartland has an inter-disciplinary team ("IDT"), which includes persons with medical, psychosocial, and spiritual backgrounds to provide comfort, symptom management, and support to patients and their families. Each patient is reviewed in a meeting of the IDT every two weeks.

4. 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, Heartland is subject to statutes, rules, and Medicaid handbooks incorporated by reference into rule, which were in effect during the Audit Period. See, e.g., Florida Medicaid Hospice Services Coverage and Limitations Handbook, 2007 (“Handbook”), adopted by Fla. Admin. Code R. 59G-4.140(2)(2007).

Audit Process

5. The Handbook contains six bullet points for a physician to consider when making a determination regarding a patient's initial certification for hospice eligibility. While those six bullet points provide factors for consideration by the certifying physician, each recipient is not required to meet each bullet point to be eligible for hospice care.

6. The six bullet points are as follows:

a. Terminal diagnosis with life expectancy of six months or less if the terminal illness progresses at its normal course;

b. Serial physician assessments, laboratory, radiological, or other studies;

c. Clinical progression of the terminal disease;

d. Recent impaired nutritional status related to the terminal process;

e. Recent decline in functional status; and

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

7. The initial certification for hospice applies for a 90-day period. The patient can then be recertified for a second 90-day period. Thereafter, all subsequent recertifications apply for a 60-day period so long as the patient meets the requirements to receive hospice benefits.

8. To determine eligibility, the Handbook provides:

> 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.

9. The U.S. Department of Health & Human Services, Centers for Medicare and Medicaid Services ("CMS"), contracted with HI, a private vendor, to perform an audit of Heartland. HI retained Advanced Medical Reviews ("AMR") to provide physician reviews of claims during the audit process in order to determine whether the patients met the criteria for Medicaid Services.

10. HI notified Heartland of the audit on or about June 30, 2016. The audit was conducted between August 25, 2016, and December 20, 2016.

11. The scope of the audit was limited to Medicaid recipients that received hospice services from Heartland during the period of July 1, 2011, through December 31, 2014, the Audit Period. The files were identified for review using the following criteria:

a. The recipient was not dually eligible (eligible for both Medicaid and Medicare);

b. Heartland provided hospice services for 182 days or longer, based on the recipient's first and last day of service within the Audit Period; and

c. HI excluded recipients who had at least one malignancy (cancer) primary diagnosis and had a date of death less than one year from the first date of service with Heartland.

12. Thus, the objective of the audit was to determine whether certain Medicaid patients were, in fact, and pursuant to

applicable law, eligible for hospice benefits provided by Heartland.

13. When HI applied the audit criteria to the Medicaid claims paid by AHCA to Heartland, HI determined that Heartland had provided hospice services to five Medicaid recipients for 182 days or longer during the Audit Period.

14. 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.

15. HI employed claims analysts who performed an initial review of Heartland's patient records to determine if the recipients were eligible for Medicaid hospice benefits. All HI claims analysts are registered nurses.

16. If the HI claims analyst was able to assess that the patient's file contained 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 pursuant to the audit process and, thus, the claim was not evaluated further.

17. If the HI claims analyst was unable to assess whether the patient's file contained sufficient documentation to determine eligibility for hospice benefits, or if only a portion

of the patient's stay could be justified by the HI claims analyst, the file was forwarded to an peer review physician to make the ultimate determination as to eligibility for Medicaid hospice benefits and whether an overpayment was due the Florida Medicaid program.

18. HI contracts with peer review organizations that provide physicians to perform the peer review. One of those organizations was AMR, which provided peer review services for the Heartland audit.

Heartland Audit

19. Regarding the Heartland audit, HI staff members identified the physicians who provided care to the recipients at Heartland. The physicians at Heartland had an active specialty in family medicine. Because HI did not have any family physicians on staff at the time of the audit, HI identified physicians specializing in internal medicine. Internal medicine was selected because the nature of the practice involves treatment of various medical conditions. The peer reviewers selected to review recipient records to determine eligibility for hospice were, to the maximum extent possible, of the same specialty as the Heartland physicians.

20. The HI claims analysts reviewed Heartland's patient records for five recipients and determined that no further action was warranted with respect to two recipients. The claims

analysts were registered nurses. As a result, three files were referred for physician peer review by AMR.

21. AMR maintains a secure portal ("AMR Portal") that HI personnel access to transmit all received provider files to AMR. AMR's peer review physicians use the AMR Portal to review the totality of the provider's submitted documentation, including all patient records, and provided their comments.

22. Initially, AHCA selected Ankush Bansal, M.D., to review the patient files identified for physician review. Dr. Bansal determined that all three recipients were ineligible for hospice services.

23. HI prepared a Draft Audit Report ("DAR"), which identified overpayments of Medicaid claims totaling $127,015.43, relating to three recipients. On March 7, 2017, HI presented the DAR to Heartland for comment and response.

24. The alleged overpayments for the three recipients were for the time periods as follows[1/]:

a. Patient P.C., for service dates 03/13/2012 – 9/11/2012.

b. Patient S.L., for service dates 03/02/2013 – 9/22/2013; and

c. Patient V.P, for service dates 11/13/2012 – 2/28/2014;

25. During the pendency of the audit, but after the DAR was provided to Heartland, Dr. Bansal became unavailable for

further work on the audit. Thus, AMR retained two new physicians (Ibrahim Saad, M.D., and Patrick Weston, M.D.) to perform the re-reviews of the patient records.

26. After Heartland responded to the DAR, Heartland's response was provided to the two new AMR peer review physicians, who, after reviewing Heartland's response to the audit, reevaluated the medical documentation in light of the additional information and argument provided by Heartland. The new peer reviewers, Drs. Saad and Weston, agreed with the original peer reviewer, Dr. Bansal, that the three recipients were not eligible for hospice services. As a result of that comment and review process, no claims were adjusted.

27. Once approved by CMS and AHCA, the DAR became the FAR. The FAR set forth an overpayment amount of $127,015.43 in Medicaid overpayments owed to AHCA based upon the three Medicaid recipients serviced by Heartland during the Audit Period.

28. HI submitted the FAR to CMS. CMS provided the FAR to AHCA with instructions that AHCA furnish the FAR to Heartland and initiate the state recovery process.

29. The FAR contains the determinations made by the AMR peer review physicians finding that each of the three patients identified therein were ineligible for hospice coverage as the documentation did not support the eligibility requirement of

having a terminal illness with a life expectancy of six months or less if the illness ran its normal course.

30. AHCA sent the FAR to Heartland. In the Notice letter, AHCA explained that a fine of $25,403.09 had been applied and costs were assessed in the amount of $75.55. The total amount due for the alleged overpayment, fines, and costs was $152,494.07.

Experts

31. Due to the nature of the review and re-review process, the final hearing primarily focused on the testimony of each parties' experts regarding whether particular recipients met the criteria of Medicaid hospice benefit eligibility.

32. The undersigned notes that Heartland did not offer testimony regarding the patients' eligibility from the physician who actually evaluated the recipients in dispute or certified any of the recipients as terminally ill during the Audit Period. Dr. Stevens, the certifying physician for at least two of the three patients, testified but did not offer specific testimony about the respective patients' Medicaid hospice eligibility.

33. The experts presented by AHCA and Heartland in this matter did not examine the recipients. For each patient, an AHCA and the Heartland expert reviewed the patient records and provided an opinion as to whether the six bullet points of the Handbook were satisfied to determine whether the recipient was

"terminally ill with a life expectancy of six months or less if the disease runs its normal course."

34. In performing their respective peer reviews, the peer review physicians were instructed to use their clinical experience and the Handbook.

35. As set forth above, the Handbook, adopted by Florida Administrative Code Rule 59G-4.140, requires a recipient to have a terminal diagnosis with a life expectancy of six months or less if, the terminal disease follows its normal course in order to be eligible for Medicaid hospice services. It also requires that the hospice maintain documentation supporting that prognosis at initial certification and for every recertification.

AHCA's Experts

Dr. Ibrahim Saad

36. Dr. Saad, board-certified in internal medicine, was actively practicing in Florida at the time of the audit. Dr. Saad regularly sees and treats patients with liver disease and congestive heart failure as part of his practice. Dr. Saad reviewed and rendered his opinion as to the hospice eligibility of two recipients in the FAR, patients P.C. and V.P.

37. Dr. Saad is a physician licensed under chapter 458, Florida Statutes, who has been regularly providing medical care

and treatment within the past two years and within the two years prior to the audit as explained above.

38. Dr. Saad began practicing medicine in Florida in August of 2015. Prior to practicing in Florida, he completed a three-year residency in Michigan, during which he actively treated patients. He was the chief resident his last year of the residency. The last two years of his medical school consisted of clinical rotations, during which he actively treated patients.

39. In its PRO, Heartland argued that Dr. Saad did not have "five years full-time equivalent experience providing direct clinical care to patients." However, there is no statutory requirement for a peer reviewer to have five years of experience. Although attesting to the statement is a requirement established by AMR, it has no bearing on whether Dr. Saad met the criteria for a peer reviewer under Florida law. Dr. Saad qualifies as a peer reviewer under the Florida Statutes.

40. When weighing the testimony of Dr. Saad, the undersigned considered material factors regarding Dr. Saad's qualifications. Dr. Saad has not certified a patient as being terminally ill. However, Dr. Saad regularly sees and treats hospice patients and patients with end-stage diseases. Based

upon his experience, Dr. Saad understands what factors are properly considered when estimating a patient's life expectancy. Dr. Saad also routinely makes life expectancy prognostications for his patients.

41. Based on the factors above, Dr. Saad was accepted as an expert in internal medicine.

Dr. Patrick Weston

42. Dr. Weston has been actively practicing as a physician since 2009, meaning he had been in practice for 10 years at the time of the hearing. Prior to 2009, Dr. Weston completed a three-year cardiovascular fellowship, and prior to that, he completed a two-year residency in internal medicine. Dr. Weston often sees and treats patients with cancer. Dr. Weston has referred patients to hospice. Dr. Weston reviewed and rendered his opinion as to the hospice eligibility of one recipient in the FAR, patient S.L.

43. Dr. Weston was board-certified in internal medicine in 2007. He was also board-certified in cardiology in 2010 and nuclear cardiology in 2011. Cardiology is a subspecialty of internal medicine.

44. Dr. Weston's internal medicine certification expired on December 31, 2017. However, he anticipates obtaining the certification again, and at the time of the hearing, was planning to take the test in a few months. Although his

certification lapsed, Dr. Weston continued to actively treat patients, spending approximately 50 percent of his time practicing internal medicine. More importantly, the certification was active when he performed the audit.

45. Dr. Weston treats hospice patients and refers patients to hospice on a regular basis. Based upon his experience, Dr. Weston understands what factors are properly considered when estimating a patient's life expectancy. Dr. Weston routinely makes life expectancy prognostications for his patients.

46. Based on the factors above, Dr. Weston was accepted as an expert in internal medicine.

47. When weighing the testimony of Dr. Weston, the undersigned considered material factors regarding Dr. Weston's qualifications. Dr. Weston has not certified a patient as being terminally ill. Dr. Weston is not board-certified in hospice or palliative care.

48. After the audit, but before the hearing, Dr. Weston moved to a new practice, in which he has a flexible schedule, sometimes working no hours per week and sometimes working 60 hours per week. However, he testified that on average, he works about 100 hours per month.

Heartland's Expert

Dr. Michael Shapiro

49. Dr. Shapiro attended the Ross University School of Medicine, performed his residency at the Medical Center of Central Georgia and Mercer University, and performed a fellowship at the University of South Florida in hospice and palliative medicine.

50. Dr. Shapiro was first exposed to hospice medicine during his residency, where there was both a palliative care service and a hospice service. After his residency, Dr. Shapiro spent a year as a junior faculty member at Mercer University where he performed palliative rounds on a weekly basis, in addition to practicing both general inpatient and outpatient medicine.

51. Dr. Shapiro's fellowship provided training on both the clinical and significant administrative aspects of hospice and palliative medicine, as well as hospice benefits. As part of this training, Dr. Shapiro learned how to appropriately evaluate patients to determine if they are eligible for the Medicaid hospice benefit.

52. After completing his fellowship, Dr. Shapiro began working full time in hospice with Cornerstone Hospice ("Cornerstone") as a team physician. In that role, Dr. Shapiro performed patient visits, held admission phone calls for new

patient certifications, and performed other tasks as the physician member of the IDT. Dr. Shapiro also assessed patients to determine whether they were eligible for the Medicaid hospice benefits and executed written certifications for patients who were terminally ill and eligible for hospice benefits.

53. Dr. Shapiro is currently the hospice medical director and chief medical officer of Cornerstone. In that role, he oversees all the physicians and hospice clinical practitioners, and actively participates in training.

54. Dr. Shapiro also provides hospice physician training to new Cornerstone employees regarding the hospice benefit beyond the organization's educational requirements.

55. Dr. Shapiro estimates that, during his time at Cornerstone, he has assessed well over 1,000 patients to determine whether they have a terminal illness of six months or less if, the illness runs its normal course. He has determined eligibility by taking the history and performing a physical examination of patients, as well as by evaluating a patient based strictly on the medical records.

56. Dr. Shapiro is board-certified in family medicine, hospice and palliative medicine, and as a hospice medical director. He also serves as the chair of the National Partnership for Hospice Innovation Medical Affairs Forum, which

is a collaborative group of larger, not-for-profit hospices who focus on improving the clinical aspects of hospice.

57. Based on the findings set forth above, Dr. Shapiro was accepted as an expert in hospice medicine, family medicine, and as a hospice medical director.

58. When weighing the testimony of Dr. Shapiro, the undersigned took note of several factors regarding Dr. Shapiro's qualifications. Dr. Shapiro testified that during his time at Cornerstone, he assessed more than 1,000 patients. He also acknowledged that Cornerstone underwent an audit in 2016, similar to the one at issue in this case, while he was medical director of the facility. The outcome of that audit resulted in Cornerstone being required to pay AHCA more than $700,000 in overpayments. While this factor does not disqualify Dr. Shapiro as an expert, the significant overpayment is a factor when weighing his testimony regarding the eligibility of recipients for Medicaid hospice services.

Patient Review

Patient P.C.

59. Patient P.C. was a 54-year-old female who was admitted to hospice with a terminal diagnosis of end-stage congestive heart failure on March 13, 2012.

60. P.C. presented with a secondary history of chronic obstructive pulmonary disease (asthma), GERD, and back pain.

She had been hospitalized in the prior three years and was dependent regarding six of six activities of daily living (ADLs), including ambulating, toileting, transferring, dressing, feeding, and bathing. The claim period in question is March 13, 2012, through September 11, 2012.

61. At the time of admission, P.C.'s most recent hospitalization, on March 7, 2012, was for a primary diagnosis of acute renal injury, lower extremity pain, and headache with a noted history of cardiomyopathy. During the admission, tests were conducted to rule out an acute kidney injury versus chronic kidney disease. The records noted that cardiology was only following her for her cardiomyopathy condition. Thus, the hospital admission was not related to her hospice-admitting diagnosis of congestive heart failure.

62. Prior to admission, the most recent report from her primary cardiologist was dated December 9, 2011. At that time, the doctor noted that she was "doing generally well from a cardiac standpoint" and that she "appears to be stable from a heart failure standpoint." Moreover, in the most recent record from her primary electrophysiologist, dated November 11, 2011, it was noted that she had New York Heart Association ("NYHA") Class II symptoms.

63. Her initial nursing assessment on March 15, 2012, showed that P.C. was able to ambulate 30 feet, she had no

complaints of chest pain, no edema noted, she did not need oxygen, and she was independent with activities of daily living. Her ejection fraction was 20 percent at the time, her PPS was 50 percent, and her level of consciousness was not altered.

64. The initial nursing assessment also indicated that P.C. was independent in all six ADLs. The follow-up assessment five days later on March 20, 2012, noted "none" for the ADL dependent category.

65. NYHA's functional classification is incorporated into the Heartland guidelines for determining prognosis for heart disease. The criteria for Class IV (terminally ill) patients with heart disease include "patients with cardiac disease resulting in inability to carry on physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

66. Dr. Saad testified that the NYHA classifications are based primarily on the level of ambulation and whether the patient has significant chest pain at rest. Dr. Saad testified that a patient classified as being in Class II is someone with mild symptoms with ambulation. There may be some shortness of breath or chest pain. P.C.'s records reflect that she was able to ambulate 30 feet, she did not require oxygen, and she did not

have chest pain. Based on P.C.'s records, she should have been classified as a Class II cardiac patient.

67. Although the heart disease guideline form in her records indicated she was initially designated as NYHA Class IV, both Drs. Shapiro and Saad agreed that P.C. did not meet the criteria for NYHA Class IV, but rather, she met the criteria for Class II.

68. In addition, patient P.C. was not using any oxygen when she was admitted to hospice and she was on room air. Dr. Saad credibly testified that a patient with end-stage heart failure would need to be on oxygen.

69. During her stay in hospice, P.C.'s PPS was 50 percent and it increased to 60 percent in the second period. Her weight fluctuated between 160 and 170 pounds. Dr. Shapiro's testimony that P.C.'s weight fluctuation could be attributed to fluid retention was not supported by the patient records.

70. Based on P.C.'s patient records, there was not sufficient evidence to demonstrate that she had six months or less to live. Between the visit at which her cardiologist found her to be stable and her entry into hospice, there was no evidence of any additional complications with her heart disease. Moreover, there was no evidence of functional decline, impaired nutritional status, or overall progression of her heart disease during the recertification periods.

71. Respondent's expert noted that the patient experienced chronic leg and back pain and had chronic opioid dependency. However, this factor is not sufficient to support hospice eligibility.

72. Dr. Shapiro pointed to several factors to support his contention that P.C.'s condition had progressed and her functionality had declined. During the recertification period with dates of March 13, 2012, through June 10, 2012, P.C. developed symptoms and progression of her underlying condition, including, shortness of breath with ambulation, tiring easily, and experiencing confusion about her medications. She was hospitalized on May 15, 2012, where she presented with oxygen saturations in the low 80s and a chest x-ray finding pulmonary congestion and opacities. During the hospital stay, P.C. was found to have anemia, with a hemoglobin measurement of 9.7. Dr. Shapiro testified that the lowered hemoglobin increased mortality by about 32 percent, and when coupled with untreated arrhythmias and underlying stage II heart disease, P.C.'s mortality at one year was almost 70 percent.

73. During the certified period June 11, 2012, through September 8, 2012, P.C. began using supplemental oxygen for shortness of breath and fatigue and was suffering from orthopnea.

74. The records reflect that P.C. was using a cane to ambulate upon admission to hospice due to vertigo. There was insufficient evidence of her nutritional decline; her weight fluctuated between 160 to 170 pounds; and her eating ranged from 25 to 75 percent. She was also independent regarding six of six ADLs.

75. During the period September 9, 2012, through November 7, 2012, P.C. elected to revoke hospice on September 11, 2012, only three days into the final benefit period at issue.

76. The patient records do not support a finding that P.C. met the Medicaid hospice eligibility standard during the disputed period of March 13, 2012, through September 11, 2012. The greater weight of the evidence supports a finding that P.C. was not eligible for Medicaid services and, thus, AHCA is entitled to recover an overpayment of $28,866.27.

Patient S.L.

77. Patient S.L. was a 56-year-old female, admitted to hospice on March 2, 2013, with a terminal diagnosis of squamous cell head and neck cancer. The claim periods at issue are March 2, 2013, through September 22, 2013.

78. Based on her patient records, it is noted that S.L. had a history of cancer in the neck and upper lip. She had a wide local resection of her upper lip to remove the cancer on

July 28, 2011. In May 2012, a CT scan of her neck showed evidence concerning cervical metastases. She then had a left neck dissection on May 10, 2012.

79. The patient records did not show any recurrence of cancer after the dissection. In January 2013, her patient records showed that she had complaints of neck and jaw pain. However, her appearance was noted as "[o]therwise healthy looking, well nourished, in mild distress." Upon discharge, the recommendation was that she continues medications as prescribed by the primary care physician and follow up in three months.

80. On March 1, 2013, the day before she entered hospice, she visited Shands complaining of pain in the neck on the left side. The record noted that she is a "poor historian and emotionally unstable." The record also noted that she was "sitting comfortably in the chair in no pain or distress" and her vital signs were within normal limits. The report found no evidence of the source of pain on the clinical exam so she was referred for a CT scan for further imaging. There was no referral for hospice services. In fact, there is no referral for hospice treatment by a physician in S.L.'s records.

81. S.L. self-reported a 20-pound weight loss at the time of admission, in addition to increased symptoms of fatigue and shortness of breath. Dr. Shapiro testified that these symptoms, in conjunction with metastatic cancer, demonstrated a clinical

need and appropriateness for hospice. However, there were no records to support a current diagnosis of cancer or a 20-pound weight loss.

82. The information in the records that was used to admit S.L. for hospice services was unreliable and at times, inaccurate. There is no evidence to support that S.L. had a current diagnosis of cancer at the time of her admission. Her records reflect a history but no recurrence. There is no evidence to support S.L.'s self-reported 20-pound weight loss at the time of admission. The record demonstrates that within the prior year, S.L.'s weight had a range between 120 to 130 pounds. In addition, in the initial certification assessment, the hospice physician stated in his narrative that the cancer had metastasized to the lungs. However, there is no evidence that demonstrates that cancer was in S.L.'s lungs and, thus, the record does not support this statement. Further, there is a note on the recertification document that "MD visit Mar 2013 pt informed cancer has grown." However, as stated above, S.L. was referred for a CT scan during her March 1, 2013, visit, but there is no mention of her cancer growing.

83. Based on the foregoing, S.L.'s patient records do not support a finding that S.L. met the Medicaid eligibility standards for hospice services.

84. During the recertification period of March 3, 2013, through May 30, 2013, S.L. was hospitalized for a possible overdose attempt. After this hospitalization, it was found that S.L. was experiencing lower extremity neuropathy, in addition to continued complaints of back and neck pain. However, none of these factors relate to her initial admitting diagnosis of cancer. Further, neither of the factors is noted as comorbidities that would warrant hospice services. A CT scan revealed nodal involvement, which Dr. Shapiro testified that literature suggests results in a 50-percent decrease in the rate of survival. However, follow-up testing was ordered to confirm the nature of the nodal mass, which is not sufficient documentation to demonstrate progression of cancer.

85. S.L. experienced anxiety and she was becoming easily tearful, frustrated, and paranoid. A visit to her maxillofacial surgeon on August 20, 2013, revealed a palpable neck mass, which required further investigation. More importantly, however, the treating physician noted that "[s]he has referred herself to hospice . . . it is not at all clear that she should be a hospice patient at all."

86. Both a positron emission tomography ("PET") scan conducted on August 30, 2013, and a biopsy performed by S.L.'s maxillofacial surgeon returned negative.

87. The medical records contained in S.L.'s file do not support a finding that the Medicaid hospice eligibility standard was met during the disputed period. Based upon the greater weight of evidence, it is determined that S.L. was not eligible for Medicaid hospice services at the initial assessment or for the recertification periods. As a result, AHCA is entitled to recover an overpayment of $29,601.95.

Patient V.P.

88. Patient V.P. was a 45-year-old male with a history of end stage liver disease with comorbidities of alcoholic cirrhosis and Hepatitis C. His other comorbidities included esophageal varices grade III, hypertension, portal tension, anemia, anxiety, and polysubstance abuse. The claim period at issue is November 13, 2012, through February 28, 2014.

89. V.P. had been admitted to the hospital seven times in the year prior to being admitted into hospice, the most recent of which was six weeks prior to his hospice admission. V.P. was admitted at that time for acute gastrointestinal hemorrhage and anemia due to the hemorrhage. He also had noted cirrhosis, very low blood counts, varices, and portal hypertension. Dr. Shapiro testified that these were significant clinical indicators of decompensated liver cirrhosis and findings suggestive of progressed liver disease. Based on this information,

Dr. Shapiro opined that V.P. was appropriately admitted to hospice.

90. Over a month before entering hospice, V.P. had an endoscopy, which showed grade III varices, but no bleeding, which meant that the disease was not active. Dr. Saad testified that this was significant because when looking at a terminal diagnosis, you are looking at a disease that is not responsive to treatment.

91. Dr. Saad testified that the two main factors that are considered in determining the function of the liver are the INR and the albumin levels. V.P. had an international normalised ratio ("INR") of 1.3 on October 3, 2012, and at admission, which is elevated and shows that he has liver disease, but it had not progressed to become end stage. Similarly, a normal albumin level is 3.5 and his was 3.0, which shows it is slightly decreased. The lower albumin level of 3.0 suggests that V.P. had liver disease, but that the level had not decreased to the point of end stage. More importantly, the patient records reflect that V.P.'s albumin level was 3.5 on September 27, 2012, and it decreased to 3.0 on September 28, 2012.

92. According to the Heartland guidelines, an INR of greater than 1.5 and an albumin level of less than 2.5 coupled

with other indicators of progression support a diagnosis of end-stage liver disease.

93. During the recertification period of November 12, 2012, through February 10, 2013, V.P. suffered from increased abdominal pain requiring medication management changes, shortness of breath on walking, dizziness with associated elevated blood pressure, and muscle atrophy, all signs of the severity of his underlying liver disease. V.P. also experienced a fall on November 15, 2012. Due to these factors, Dr. Shapiro opined that V.P. continued to be appropriate for hospice.

94. V.P. experienced abdominal pain during the recertification period of February 11, 2013, through May 11, 2013, which resulted in another medication regimen modification. V.P. was also transferred to a skilled nursing facility due to increased daily care needs. During this period, V.P. also began experiencing increased anxiety and depression. V.P.'s laboratory findings demonstrated an elevated INR of 1.5 from the previous month (of 1.3), which could lead to spontaneous bleeding. Dr. Shapiro also testified that V.P. experienced another fall, demonstrating his general weakness and continued functional decline.

95. During the recertification period of May 12, 2013, through July 10, 2013, the records show increased drowsiness and lethargy, which were found to not be related to his medication

but rather to his disease. V.P. experienced increased pain and ineffective control near the end of May, resulting in yet another medication modification. V.P. also had swelling and fluid retention in his lower extremities, which Dr. Shapiro opined illustrated muscle mass wasting in advancing liver disease.

96. V.P.'s alkaline phosphatase increased from 136 to 178, and an ultrasound showed ascites in his abdomen, hepatomegaly, and a renal stone. V.P. also exhibited non-verbal signs of pain, as well as a significant and sharp increase in shortness of breath. The shortness of breath occurred while V.P. was speaking and led to the presence of intermittent orthopnea, which is commonly found in terminal liver patients and demonstrates disease progression.

97. V.P. had documented pancytopenia, when combined with swelling and fluid retention, shows an advancing disease state where a patient is more susceptible to infection. V.P. experienced such an infection during this period, and he was treated with antibiotics for cellulitis. V.P. also suffered an additional fall in September and had continued decline in appetite, consuming only 25 percent to 50 percent of his meals.

98. On December 17, 2013, V.P. was examined by a team physician who noted that V.P. exhibited confusion, forgetfulness, slurred speech, muscle atrophy, frailty,

depressed mood, anxiousness, ascites, and moderate dependence in his activities. Other hospice team members also witnessed V.P.'s progressive symptoms, including confusion and repetitive speech. V.P. experienced another fall that resulted in a head injury, followed by slurred speech and lethargy. Despite another change in his medication, V.P.'s clinical symptoms progressed. He started suffering from hypoxia, abdominal tenderness, and ascites. A chest x-ray showed congestive heart failure. V.P. also developed a urinary tract infection requiring antibiotic treatment. Dr. Shapiro testified that these were clear findings that demonstrated V.P. was appropriate for hospice.

99. During the recertification period of January 7, 2014, through February 28, 2014, V.P. required additional nursing needs and visits. V.P. developed crackles (persistent fluid and congestion) in his lungs and had increased abdominal girth, at one point measured as a 1.5-inch increase over a two-week period. In addition, V.P. experienced two separate falls, suffered from increased fatigue and weakness, and had recurrent cellulitis (bacterial infection). A chest x-ray dated February 5, 2014, showed that V.P. developed pneumonia. In the radiology report, it is noted that the exam was overall worse compared to the January 1, 2014, exam.

100. V.P. died on February 11, 2016.

101. Dr. Saad testified that individuals can have good days and bad days and that they can wax and wane, but you look at whether they return to their baseline. While, there were some exacerbations, or infections, each issue may have ultimately resolved. However, V.P.'s records, including his lab results, x-rays which showed development of pneumonia within slightly more than a month, multiple reoccurring falls, a number of infections, increasing ADL dependence, and worsening confusion support a finding that V.P. was eligible for hospice services. The evidence does not support by a preponderance of evidence that V.P. was not entitled to hospice services and as a result, AHCA is not entitled to recover overpayment for patient V.P.

Overpayment Calculation

102. Based on the Findings of Fact above, AHCA is entitled to recover overpayment for hospice services to P.C. and S.L. in the amount of $58,468.22.

Fine Calculation

103. 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). The formula involves multiplying the number of claims in violation of the rule by $1,000 to calculate the total fine. The final

total may not exceed 20 percent of the total overpayment of $58,468.22, which results in a fine of $11,693.64.

CONCLUSIONS OF LAW

104. 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).

105. 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).

106. 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."

107. 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.

108. 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.

109. 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.

110. In this case, AHCA seeks reimbursement of overpayments based upon the lack of eligibility, in whole or in part, of the three patients at issue. In this proceeding,

eligibility is based in part on medical necessity as determined by peer review of the patient records.

111. 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.

112. In light of the totality of all the evidence presented in this case, and based upon the Findings of Fact above, AHCA should recover the overpayment as modified herein.

113. As required by the statute, AHCA, to the "maximum extent possible," through the CMS contractor, used well-qualified peer review physicians to make the critical medical decisions in this matter. Dr. Saad and Dr. Weston, being licensed in Florida with active practices and being experts in their respective area, were so qualified.

114. Heartland suggested at the hearing that Dr. Weston did not qualify as a peer reviewer because he worked only part time at the time of the hearing. Section 409.9131(2)(a) defines "active practice" and states that "a physician must have regularly provided medical care and treatment to patients within the past 2 years." Under the plain language of the statute, there is no requirement that the physician have worked full time in the past years. Instead, the physician must have "regularly provided" medical care "within" the past two years.

115. Dr. Weston testified that the he worked an average of over 100 hours per month seeing patients at his current

employment. This is sufficient to demonstrate that Dr. Weston regularly provided medical care and treatment to patients.

116. 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 and at the final hearing, Heartland did not pursue this argument. In addition, there is no evidence in the record nor did Heartland elicit any testimony that AHCA applied any unadopted rule in any regard in this matter. The evidence in the record supports the finding that AHCA complied with and utilized the applicable statutes, rules, and the Handbook, duly adopted by rule throughout the process. The physicians based their opinions on their review of records and clinical experience. Therefore, those allegations will not be further addressed in this Order. Section 120.57(1)(e), Florida Statutes, does not apply to this proceeding.

117. Section 409.913(16) requires AHCA to impose a fine for each violation of subsection (15) of up to $5,000 per violation. Rule 59G-9.070(7) further outlines AHCA's authority and states:

> 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:
>
> * * *
>
> (e) For failure to comply with the provisions of the Medicaid laws: For a first offense, $1,000 fine per claim found to be in violation.

118. Notwithstanding the provisions of rule 59G-9.070(7), rule 59G-9.070(4)(a) provides, in pertinent part, that:

> (4) Limits on sanctions.
>
> (a) Where a sanction is applied for violations of Medicaid laws (under paragraph (7)(e) of this rule), . . . and the violations are a "first offense" as set forth in this rule, if the cumulative amount of the fine to be imposed as a result of the violations giving rise to that overpayment exceeds 20% of the amount of the overpayment, the fine shall be adjusted to 20% of the amount of the overpayment.

119. As indicated in the Findings of Fact above, Heartland violated the provisions of section 409.913(15) by admitting and recertifying patients who were not eligible for Medicaid hospice services.

120. Each monthly period that Heartland billed for services for these patients that were determined to be ineligible for Medicaid reimbursement, Heartland is liable for a $1,000 fine, save for the provision of rule 59G-9.070(4)(a), that caps the fine at 20 percent of the overpayment. The fine

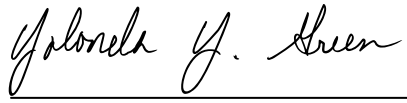
of $11,693.64, as modified in the Findings of Fact above and per the fine worksheet provided by AHCA is appropriate in this case.

121. 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. Because it has prevailed regarding two of the three claims, this tribunal reserves jurisdiction to enter an Order on costs. AHCA is ordered, within 30 days of the date of this Order, to serve Heartland and provide the undersigned with its evidence of the investigative, legal, and expert witness costs it incurred in this proceeding. If Heartland disputes this evidence, it shall have 10 days thereafter to file a pleading to contest AHCA's claim.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order directing Heartland to pay $58,468.22 for the claims found to be overpayments and a fine of $11,693.64. The undersigned reserves jurisdiction to award investigative, legal, and expert witness costs.

DONE AND ENTERED this 7th day of March, 2019, in Tallahassee, Leon County, Florida.



YOLONDA Y. GREEN
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of March, 2019.

ENDNOTE

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

COPIES FURNISHED:

Steven Alfons Grigas, Esquire
Akerman, LLP
Suite 1200
106 East College Avenue
Tallahassee, Florida 32301
(eServed)

Joseph G. Hern, Esquire
Agency for Health Care Administration
Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308
(eServed)

Bruce D. Platt, Esquire
Akerman, LLP
Suite 1200
106 East College Avenue
Tallahassee, Florida 32301
(eServed)

Kimberly Murray, Esquire
Agency for Health Care Administration
Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308
(eServed)

Bryan K. Nowicki, Esquire
Reinhart Boerner Van Deuren, S.C.
Suite 600
22 East Mifflin Street
Madison, Wisconsin 53701-2018
(eServed)

Joshua D. Taggatz, Esquire
Reinhart Boerner Van Deuren, S.C.
Suite 600
22 East Mifflin Street
Madison, Wisconsin 53701-2018

Brittany Adams Long, Esquire
Radey Law Firm, P.A.
Suite 200
301 South Bronough Street
Tallahassee, Florida 32301
(eServed)

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Stefan Grow, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Mary C. Mayhew, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Shena L. Grantham, Esquire
Agency for Health Care Administration
Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308
(eServed)

Thomas M. Hoeler, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

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.