STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 19-3666MPI

ZENITH PSYCHOLOGICAL SERVICES, INC.,

Respondent.
_____/

RECOMMENDED ORDER

A hearing was conducted in this case pursuant to sections 120.569 and 120.57(1), Florida Statutes (2019)[1/], before Cathy M. Sellers, an Administrative Law Judge ("ALJ") of the Division of Administrative Hearings ("DOAH"), on November 13, 2019, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Susan Sapoznikoff, Esquire
Ryan McNeill, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308—5403

For Respondent: No Appearance

STATEMENT OF THE ISSUES

The issues presented in this proceeding are: (1) whether, Petitioner, Agency for Health Care Administration, is entitled to repayment of an alleged Medicaid overpayment to Respondent,

Zenith Psychological Services, Inc., and, if so, the amount of the overpayment to be repaid; (2) whether an administrative fine should be imposed against Respondent, and, if so, the amount of that fine; and (3) if warranted, the amount of any investigative, legal, and expert witness costs to be assessed against the Respondent.

PRELIMINARY STATEMENT

Petitioner performed an audit of Medicaid-related records for the period of November 1, 2017, through October 31, 2018, to determine whether Respondent had sufficient documentation to establish that the behavior analysis and behavior assistant services providers it employed possessed the qualifications required by the October 2017 Florida Medicaid Behavior Analysis Services Coverage Policy ("Behavior Analysis Policy") to be eligible to provide such services during the Audit Period.

On or about March 12, 2019, Petitioner issued the Final Audit Report ("FAR"), which constitutes the challenged agency action in this proceeding. The FAR concluded that Petitioner overpaid Respondent for services that, in whole or part, were not authorized under the Medicaid program. Additionally, Petitioner sought to impose a sanction for failure to comply with Medicaid rules, and costs incurred as a result of the audit.

Respondent, through counsel, timely requested an administrative hearing, challenging the findings made and amounts

assessed in the FAR.[2/] The matter was referred to DOAH to conduct a final hearing. The final hearing was initially scheduled for September 9 through 11, 2019, but pursuant to Petitioner's motion, was continued to November 12 through 14, 2019. On October 22, 2019, the undersigned issued an Amended Notice of Hearing setting the hearing for November 13, 2019.

Shortly after this matter was referred to DOAH, Respondent filed a Motion to Withdraw, requesting that its counsel of record be granted permission to withdraw as counsel in this proceeding[3/]; that motion was granted. The motion identified another attorney as the new contact on behalf of Respondent; however, that attorney advised Petitioner by electronic mail that he was not representing Respondent in this proceeding, and he did not enter a notice of appearance. No other attorney or representative appeared on Respondent's behalf. All pleadings, motions, notices, and other documents entered onto the docket of this proceeding were sent by U.S. Mail to Respondent in care of its principal, Dr. Marie Cheour, at Respondent's address of record; however, all of the mailings were returned as undeliverable. DOAH also mailed a copy of the Amended Notice of Hearing to another address that had been obtained for Respondent, and that mailing also was returned as undeliverable. Additionally, DOAH made numerous attempts to contact Cheour by electronic mail at various email addresses; all emails sent to her were refused as undeliverable. In any event,

Respondent received notice of this proceeding, as evidenced by UPS tracking information showing that it received the FAR and by its having initially retained counsel to represent it in this proceeding.

Because Petitioner has the burden in this proceeding to establish that it is entitled to reimbursement, by Respondent, for the alleged Medicaid overpayments and to payment of an administrative fine and costs, a final hearing was conducted on November 13, 2019. Petitioner presented the testimony of Robi Olmstead and Donald Burdick, and Petitioner's Exhibits 1 through 9 were admitted into evidence without objection. Respondent did not appear, so did not present any testimony or tender any exhibits for admission into evidence.

The one—volume Transcript was filed on December 16, 2019. Proposed recommended orders were due on or before December 27, 2019. Petitioner's timely filed Proposed Recommended Order has been duly considered in preparing this Recommended Order.

FINDINGS OF FACT

The Parties

1. Petitioner is the state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. This program of medical assistance is designated the "Medicaid Program." Petitioner is responsible for administering the Florida Medicaid Program in

accordance with state and federal law. See section 409.902, Fla. Stat. As part of its statutory responsibilities, Petitioner is charged with operating a program "to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate." § 409.913, Fla. Stat.[4/]

2. During the audit period of November 1, 2017, through October 31, 2018 ("Audit Period"),[5/] Respondent was a Medicaid provider enrolled to provide behavior analysis services, and had a valid Non-Institutional Medicaid Provider Agreement with Petitioner, as Medicaid Provider No. 019521800. Respondent voluntarily contracted to be a Medicaid provider and was subject to the applicable federal and state statutes, regulations, rules, policy guidelines, and Medicaid handbooks adopted by rule that were in effect during the Audit Period. As a condition of being an authorized Medicaid provider, Respondent agreed to retain all Medicaid and Medicaid-related records to satisfy all necessary inquiries by Petitioner.

The Audit

3. As part of its duties in overseeing the integrity of the Medicaid program, Petitioner investigates and audits Medicaid providers regarding services rendered to Medicaid recipients.

Pursuant to this authority, Petitioner conducted an audit of Respondent.

4. The audit was conducted to determine whether Respondent had sufficient documentation to establish that the persons it employed as behavior analysts and behavior assistants possessed the qualifications required by section 3.2 of the Behavior Analysis Policy, and, therefore, were eligible to provide services during the Audit Period, and to verify that claims paid to Respondent for behavior analysis services qualified for payment under the Medicaid program.

5. During the Audit Period, Respondent submitted claims for services rendered by 139 employees for which Medicaid paid Respondent a total of $3,732,173.05. Of these employees, Petitioner identified 46 who had rendered behavioral analysis services during the Audit Period but were not qualified to do so.

6. Based on the audit, Petitioner determined that Respondent had been overpaid for providing behavior analysis services in the amount of $880,617.59.

7. Petitioner prepared and sent a Preliminary Audit Report ("PAR") to Respondent. The PAR notified Respondent that 46 of its employees had been determined not qualified to provide behavior analysis services and set forth the amount of overpayment associated with each of those employees.

Respondent was given the opportunity to reimburse Petitioner for overpayment or submit additional records to substantiate the qualifications of the employees Respondent had determined unqualified to render behavior analysis services under the Medicaid program.

8. Respondent neither paid the amount calculated as due in the PAR, nor sent any additional records to Petitioner to substantiate the qualifications of its employees.

9. Based on Respondent's failure to respond to the PAR, Petitioner issued a FAR dated March 12, 2019, MPI Case ID No.: 2017-0008498, finding that Respondent had been overpaid $880,617.59 for certain behavior analysis services that were performed by behavior assistants who did not meet the qualifications specified in section 3.2 of the Behavioral Analysis Policy. In addition, the FAR informed Respondent that Petitioner sought to impose a sanction of $176,123.52, pursuant to Florida Administrative Code Rule 59G-9.070(7)(e), and to recover costs of $643.50 pursuant to section 409.913(23)(a). In sum, Petitioner asserted in the FAR that Respondent owed Petitioner a total of $1,057,384.61.

Evidence Adduced at the Final Hearing

10. Section 1.0 of the Behavior Analysis Policy states: "[b]ehavior analysis services are highly structured interventions, strategies, and approaches provided to decrease maladaptive

behaviors and increase or reinforce appropriate behaviors." Persons who receive these services have mental health disorders or developmental or intellectual disabilities. To ensure that appropriate services are provided to these vulnerable individuals, behavior analysts and the behavior assistants who work with them are required to have specified levels of education and training.

11. Section 3.2 of the Behavior Analysis Policy sets forth the qualifications required for behavior assistants to provide behavior analysis services. Specifically, behavior assistants must work under a lead analyst and must meet one of the following qualification categories: (1) have a bachelor's degree from an accredited university or college in a related human services field; be employed by or under contract with a group, billing provider, or agency that provides Behavior Analysis; and agree to become a Registered Behavior Technician ("RBT") credentialed by the Behavior Analyst Certification Board by January 1, 2019; or (2) be 18 years old or older with a high school diploma or equivalent; have at least two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities; and complete 20 hours of documented in-service trainings in the treatment of mental health, developmental or intellectual disabilities, recipient rights, crisis management strategies, and confidentiality. To be qualified to provide services under the Medicaid program, behavior

assistants must either meet both requirements of the first qualification category in section 3.2, or all four requirements of the second qualification category in section 3.2.

12. Respondent's records show that 46 behavior assistants on its staff had not received a bachelor's degree in a related human services field, and none of them had received RBT certification.

13. Additionally, Respondent failed to provide records showing that any of those same behavior assistants met the qualifications in the second category in section 3.2.

14. Respondent failed to submit any records substantiating that two behavior assistants, Maulaire Seme and Patricia Charles, met the requirements of either qualification category.

15. Respondent's records also failed to show that ten behavior assistants had obtained a high school diploma or equivalent. These behavior assistants are: Chantal Simeon, Francia Joanis, Lisa Pederson, Maria Rouco, Marie Cherismat Laguerre, Monique Rowe, Pierre Merzier, Rodeline Joseph, Sabine Exy, and Wideline Thelemaque-Claire.

16. Respondent's records also failed to establish that 32 of the 46 behavior assistants had received the required training in section 3.2. These behavior assistants are: Abigail Gamez, Carol Charles, Chenelle Weaver, Claire Siffrant, Crescentia Stephen, Dayan D'Haiti, Denisse Paz, Diose Sylvain, Eva Platt, Ginette Mindor, Jorge Pirella, Julian Luhtanen, Khandker Ahmed, Lens

Descius, Luis Velasquez, Lyse Pierre Paul, Madda Saintard Simon, Maidely Diaz Caro, Makenson Mathias, MaryMagdelen Cohen, Natacha Beauge, Natacha Charles, Nord Voltaire, Rolando Gallegos, Shantal Donovan, Sol M. Santana Ortiz, Stephanie Pierre Louis, Tarisha Hartsfield, Vania Valdes, Whenzdjyny Simon, Yarisley Echevarria, and Yvena Justabe.

17. Respondent also failed to provide records for 15 of these 32 behavior assistants showing that they had at least two years of experience providing direct services to recipients with mental health disorders, developmental or intellectual disabilities.

18. In sum, Respondent failed to demonstrate that these 46 behavior assistants met the qualifications to render behavior analysis services under the Medicaid program during the Audit Period. Accordingly, the claims for their services must be denied.[6/]

19. Based on the foregoing, it is determined that Respondent was overpaid in the amount of $880,617.59 for the provision of behavior analysis services that did not qualify for payment under the Medicaid program.

CONCLUSIONS OF LAW

20. DOAH has jurisdiction over the parties to, and subject matter of, this proceeding, pursuant to sections 120.569 and 120.57(1).

Burden and Standard of Proof

21. Petitioner bears the burden of proof in this proceeding, by a preponderance of the evidence, to demonstrate that Respondent was overpaid by Medicaid for the claims billed. See South. Med. Servs. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharm. v. Dep't of HRS, 596 So. 2d 106 (Fla. 1st DCA 1992).

22. Additionally, in order for Petitioner to impose a fine, it must establish the factual grounds for doing so by clear and convincing evidence. § 120.57(1)(j), Fla. Stat.; see Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854 (Fla. 2015)(disciplinary action by agency must be supported by clear and convincing evidence).

Establishment of Overpayment

23. Pursuant to section 409.913, Petitioner is authorized to recover Medicaid program overpayments from Medicaid providers.

24. An "overpayment" is defined in section 409.913(1)(e) 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."

25. "Abuse" is defined, in pertinent part, as "[p]rovider practices that are inconsistent with generally accepted business

. . . practices and that result in an unnecessary cost to the Medicaid program." § 409.913(1)(a), Fla. Stat.

26. The statutes, rules, and handbooks in effect during the period for which the services being audited were provided apply in a proceeding in which Petitioner seeks to recover an overpayment of Medicaid claims. See Toma v. Ag. for Health Care Admin., Case No. 95-2419 (Fla. DOAH July 26, 1996; Fla. AHCA Sept. 24, 1996).

27. The record keeping provisions of the 2008 and 2012 Florida Medicaid Provider General Handbooks require, in pertinent part, that all providers maintain "all business records as defined in 59G-1.010(30) F.A.C., medical-related records as defined in 59G-1.010(154) F.A.C., and medical records as defined in 59G-1.010(160)."

28. The failure of a Medicaid provider to document that its employees meet the applicable qualifications to provide services in accordance with the applicable Medicaid handbooks and the Provider Enrollment Agreement is inconsistent with generally accepted business practices.

29. The 2008 Florida Medicaid Provider General Handbook, Incomplete Records section, states that "[p]roviders who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments.

Medicaid payments for services that lack required documentation or appropriate signatures will be recouped."

30. The 2012 Florida Medicaid Provider General Handbook, Incomplete or Missing Records section, similarly states: "[i]ncomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid shall recover payment for services or goods when the provider has incomplete records or does not provide the records."

31. Sections 409.913(7)(e) and (f) require providers to present claims for reimbursement in accordance with all Medicaid rules, regulations, and handbooks, and to appropriately document all goods and services provided.

32. Section 409.913(21) states: "[w]hen making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of the overpayment."

33. Section 409.913(22) states: "[t]he audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Consistent with this provision, Petitioner can establish a prima facie case of overpayment by proffering a properly supported audit report, which must be received in evidence. See Colonial Cut-Rate Drugs, Inc. v. Ag. for Health Care Admin., Case No. 03-1547MPI (DOAH Mar.

14, 2005; AHCA May 27, 2005); Full Health Care, Inc. v. Ag. for Health Care Admin., Case No. 00-4441 (DOAH June 25, 2001; AHCA Oct. 4, 2001).

34. In this case, Petitioner established a prima facie case of overpayment by tendering its audit report, which was admitted into evidence. Additionally, Petitioner presented credible, unrefuted documentary and testimonial evidence establishing that Respondent was overpaid for behavior analysis services performed by unqualified behavior assistants, so that Petitioner must be reimbursed for the claims paid for those services.

35. Based on the foregoing, the undersigned concludes that Petitioner proved, by a preponderance of the evidence, that Respondent was overpaid for claims that failed to comply with the laws, rules, and regulations governing Medicaid providers during the Audit Period.

36. Accordingly, it is concluded that Petitioner is entitled to reimbursement from Respondent for those claims in the amount of $880,617.59.

Administrative Fine

37. Petitioner is authorized to impose administrative sanctions as appropriate. § 409.913(16), Fla. Stat.

38. Rule 59G-9.070, titled "Administrative Sanctions on Providers, Entities, and Persons," establishes, among other

things, the requirements for imposing administrative fines. The rule provides, in pertinent part:

> (7) 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. For a second offense, $2,500 fine, per claim found to be in violation. For a third, or subsequent offense, $5,000 fine, per claim found to be in violation.

39. Here, Petitioner's witness testified that in calculating the administrative fine to be imposed in this case, Petitioner

> applied a sanction of $1,000 per claim that was in violation[7/] and that would have come out to $14,792 and no cents. However, the statute allows us to cap 70 violations at 20 percent of the overpayment. So that's what was done in this instance. So the overpayment was $880,617.59, capped at 20 percent, that gave us the sanction of $176,123.52 for (7)(e).

40. In determining this fine amount, Petitioner apparently relied on rule 59G—9.070(4), which states, in pertinent part:

> (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.

Fla. Admin. Code R. 59G—9.070(4)(a)(emphasis added).

41. However, Petitioner's witness testified that the amount of the fine calculated under subsection (7)(e) of the rule was $14,492. This amount is substantially less than 20 percent of the amount of the overpayment, which equals $176,123.52.

42. By its plain terms, rule 59G—9.070(4)(a)——which is titled "Limits on sanctions"——only applies when the fine exceeds 20 percent of the amount of the overpayment. Because the amount of the fine determined under rule 59G—9.070(7)(e) does not exceed 20 percent of the overpayment amount, rule 59G—9.070(4)(a) does not apply in this case to determine the amount of the administrative fine to be imposed.

43. Petitioner did not present evidence establishing that, pursuant to section 409.913(17), any circumstances exist that warrant an enhanced penalty exceeding the amount determined pursuant to rule 59G—9.070(7)(e).

44. Accordingly, the undersigned concludes that Petitioner has presented clear and convincing evidence to support the

imposition of an administrative fine of $14,492, pursuant to rule 59G—9.070(7)(e).

Entitlement to Recovery of Costs

45. As the prevailing party in this proceeding, Petitioner is entitled to recover "all investigative, legal, and expert witness costs." § 409.913(23)(a), Fla. Stat. A party prevails when it prevails on "significant issues in the litigation." See e.g., Zhang v. D.B.R. Asset Mgmt., 878 So. 2d 386 (Fla. 3rd DCA 2004).

46. At the time Petitioner issued the FAR, it sought to recover costs in the amount of $643.50. Petitioner has since incurred additional costs in preparing for and attending the final hearing and preparing and filing its Proposed Recommended Order, and it may incur additional costs related to this proceeding.

Conclusion

47. Based on the foregoing, it is concluded that Petitioner is entitled to reimbursement from Respondent for Medicaid overpayments totaling $880,617.59; payment by Respondent of an administrative fine in the amount of $14,492; and recovery from Respondent of its costs, in a final amount to be determined.

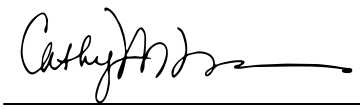
RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that Petitioner, Agency for Health Care Administration:

A. Enter a final order requiring Respondent, Zenith Psychological Services, Inc., to reimburse Petitioner the amount of $880,617.59 for Medicaid overpayments and imposing an administrative fine in the amount of $14,492.

B. Pursuant to section 409.913(23)(a), Petitioner, as the prevailing party in this proceeding is entitled to recover all of its investigative, legal, and expert witness costs.

DONE AND ENTERED this 14th day of January, 2020, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 14th day of January, 2020.

ENDNOTES

[1/] All references to sections 120.569 and 120.57, Florida Statutes are to the 2019 version.

[2/] Petitioner mailed the FAR to Respondent's business address at 11770 Leeward Place, Boca Raton, 33428—5680, in care of Dr. Marie Cheour Gordon, Respondent's principal, who also went by the name Dr. Marie Cheour. The FAR was successfully delivered to this address.

[3/] The Motion to Withdraw stated "Respondent, Zenith, has advised that it no longer wishes to retain counsel to represent its interests in this proceeding and has authorized Ms. Schrader and Mr. Findley to file this Motion to Withdraw."

[4/] The audit giving rise to this proceeding addressed services rendered by Respondent between November 1, 2017, when the 2017 version of Florida Statutes was in effect, and October 31, 2018, by which time the 2018 version of Florida Statutes was in effect. The provisions of section 409.913 pertinent to this proceeding were not amended during the 2018 legislative session. Thus, for expediency purposes, all references to section 409.913 are to the 2018 version.

[5/] The audit period consists of the range of dates during which services that were billed and paid by Medicaid were rendered. As discussed in note 4 above, the services that are the subject of this proceeding were rendered between November 1, 2017, and October 31, 2018.

[6/] Some of the behavior assistants who did not initially qualify to provide behavior analysis services subsequently became qualified during the Audit Period. In calculating the total overpayment amount of $880,617.59, Petitioner prorated the overpayment amounts assigned to those behavior assistants, to only deny the claims for services that were rendered during the portion of the Audit Period when the behavior assistants were not qualified. Those behavior assistants are: Monique Rowe, Sabine Exy, Wideline Thelemaque—Claire, Abigail Gamez, Chenelle Weaver, Claire Siffrant, Julian Luhtanen, Khandker Ahmed, Maidely Diaz Caro, Makenson Mathias, and Yarisley Echevarria.

[7/] The evidence shows that this proceeding entails Respondent's first offense of failure to comply with Medicaid laws.

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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.