STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ORTHOPAEDIC MEDICAL GROUP
OF TAMPA BAY,

Petitioner,

vs.

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Respondent.

CASE NO. 04-4625MPI

AHCA’S PROPOSED RECOMMENDED ORDER

The parties having been provided proper notice, Administrative Law Judge D.M. Kilbride of
the Division of Administrative Hearings convened a formal hearing of this matter in Tallahassee,
Florida, on September 28, 2005.

APPEARANCES

For Petitioner: William M. Furlow, III, Esquire
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For Respondent: Grant P. Dearborn, Esq.
Agency for Health Care Administration
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I. BRIEF STATEMENT OF THE ISSUE

The issue for determination is whether the Petitioners, Orthopaedic Medical Group of Tampa
Bay/ Stuart A. Goldsmith, P.A., ("Petitioners"), violated State Medicaid policy and law. The
Agency for Health Care Administration (the “Agency” or “AHCA”), alleges that based upon the violations, petitioners were overpaid $81,682.06 by Medicaid between the time period of January 1, 2001, and January 1, 2003.

II. PRELIMINARY STATEMENT

AHCA is the State agency with responsibility for administering the Florida Medicaid Program. Petitioners were and are a Medicaid provider offering medical services. The Agency determined that during the period of time between January 1, 2001, and January 1, 2003 (the “Audit Period”), Petitioners violated Medicaid policy and law because documentation/medical records provided to AHCA by the petitioners reveals that: (1) some services for which the petitioners billed and received payment were not documented, (2) the documentation/medical records petitioners provided to AHCA support a lower level of office or hospital visit than the one for which petitioners billed and received payment, (3) petitioners billed for radiology services when a radiologist outside of the office/group previously billed the reading and interpretation, and (4) petitioners records indicate instances of double-billing Medicaid for services by using two CPT codes when one of these codes incorporates the elements of the other.

The Agency audited the petitioners’ paid Medicaid claims during the Audit Period and determined that the Medicaid program overpaid petitioners. Petitioners were provided the Agency’s findings via a Preliminary Agency Audit Report dated February 6, 2004. Thus, the Agency (based upon the documentation petitioners provided to the Agency, as well as the applicable law, rules, and regulations) preliminarily determined that petitioners were overpaid by the Medicaid program in the amount of $117,942.53. Subsequently, the petitioners sent AHCA additional documentation, and the Agency then prepared a final Agency audit report (AHCA
Exhibit 12). The Agency's action is memorialized in a Final Agency Audit Letter dated October 26, 2004 (the "FAAL").

Petitioners filed a Petition with the Agency requesting a formal administrative hearing (the "Petition"), which the Agency forwarded to the Division of Administrative Hearings. Petitioners deny that they violated Medicaid policy.

As a result, the Division of Administrative Hearings ("DOAH") opened this case, and scheduled a final administrative hearing for September 28, 2005. Prior to the Final Hearing, petitioners submitted additional documentation to the Agency. The Agency reviewed the documentation and reduced the alleged overpayment to $81,682.06. (p.75 line 13 to p.76 line 7). The Agency adjusted the worksheets attached to its FAAL to reference its adjusted overpayment determinations (AHCA exhibit 13). Both parties appeared at the Final Hearing.

The Agency introduced the following Exhibits into Evidence, without objection, Joint Exhibits No. 1 through 30. The Agency also introduced AHCA's exhibits 1-3 into evidence. The Agency called Blanca Notman, RN and (by deposition) Dr. Averbuch as its witnesses to support its determination.

Petitioners presented the testimony of Jeffrey Howard to support petitioners' position.

The transcript of the final hearing was ordered and submitted. The Agency has timely submitted its Proposed Recommended Order.

A. PARTIES

1. Petitioners are Medicaid providers in the State of Florida.
2. AHCA is the agency responsible for administering the Florida Medicaid Program. Florida Statutes Chapter 409. One of AHCA's duties is to recover Medicaid overpayments from physicians providing care to Medicaid recipients. Section 409.913, Florida Statutes.

**B. THE PROVIDER AGREEMENT**

3. During the audit period, Petitioners were authorized to provide services to eligible Medicaid patients. (AHCA Exhibit 2).

4. Petitioners was to provide services pursuant to Medicaid Provider Agreement with AHCA (AHCA Exhibit 2).

5. Pursuant to Section 409.907, Florida Statutes, all Medicaid providers are required to supply the services in accordance with the applicable Federal, State and local laws. The relevant requirements in this case are set forth in the Medicaid Reimbursement Handbook, HCFA 1500 (the “Reimbursement Handbook”), Physicians Handbook, the CPT and in Chapter 409, *Florida Statutes* and the Florida Administrative Code (See officially recognized documents).

**II. FINDINGS OF FACTS**

6. The AHCA offered the deposition of Dr. Averbuch as evidence/testimony. (p.14 line 9 to p.15 line 15). Petitioners did not object to the deposition transcript being admitted (p.15 lines 16-22). The Court accepted Dr. Averbuch as an expert in the areas of orthopedic practices and orthopedic coding (p.18 lines 3-11) and admitted the deposition into evidence (p.18 lines 10-11) as AHCA exhibit 1.

7. AHCA offered the testimony of Blanca Notman, RN. Ms. Notman is a registered nurse (p.20 line 10). Ms. Notman works for the AHCA as an investigator of Medicaid providers (p.20 line 12 to p. 21 line 7).

8. Dr. Averbuch reviewed the subject patient records (p.47 lines 16-19).
9. Blanca Notman prepared the preliminary audit letter in this audit (p.48 lines 1-4). The preliminary audit letter was sent to Dr. Goldsmith (p.48 lines 3-4).

10. The "provider information/FMMIS printouts", tab 31, was admitted as evidence and marked as AHCA exhibit 2 (p.49 lines 20-23).

11. The "Medicaid Provider Agreement", tab 32, was admitted as evidence and marked as AHCA exhibit 3. (p.50 lines 22-25).

12. "Audit information certificate", tab 34, was admitted as evidence and marked as AHCA exhibit 4 (p.55 lines 23 to p. 56 line 3).

13. "Adhoc request for sample", tab 35, was admitted as evidence and marked as AHCA exhibit 5. (p.59 lines 5-8).

14. "Initial professional medical review report", tab 36, was admitted as evidence and marked as AHCA exhibit 6 (p.60 lines 19-21).

15. "Overpayment calculation (initial review)", tab 37, was admitted as evidence and marked as AHCA exhibit 7 (p.63 lines 5-9).

16. The "provisional Agency Audit report", tab 38, was admitted as evidence and marked as AHCA exhibit 8 (p.64 lines 2-4).

17. "Provider correspondence", tab 39, was admitted as evidence and marked as AHCA exhibit 9 (p.64 lines 14-21)

18. "Medical Review Report", tab 40, was admitted as evidence and marked as AHCA exhibit 10 (p.65 lines 3-18).

19. "Overpayment Calculation Using Cluster Sampling", tab 41, was admitted as evidence and marked as AHCA exhibit 11 (p.67 lines 20-25).
20. Tab 42, “Final Agency Audit Report” dated October 26, 2004, was admitted as evidence and marked as AHCA exhibit 12 (p.70 lines 16-21).

21. AHCA offered the final calculation document as evidence and it was admitted as AHCA exhibit 13 (p.71 line 5 to p.72 line 9).

22. Petitioners submitted additional documentation to AHCA prior to the hearing (p.75 lines 4-7).

23. The current overpayment calculation as determined by AHCA is $81,682.06 (p.75 line 13 to p.76 line 7) (Exhibit 13).

24. The Agency presented Blanca Notman, RN (“Ms. Notman”) who testified that she conducted an audit of petitioners’ Medicaid billings during the Audit Period. Ms. Notman is employed by the Agency as a Medicaid Health Care Analyst, in the Medicaid Program Integrity unit.

25. Dr. Averbuch testified that the petitioners’ records/documents did not support the level of coding billed to AHCA (AHCA Exhibit 1). Also, Dr. Averbuch testified that petitioners’ claims contained an inordinate number of level 4 and 5 claims (AHCA Exhibit 1). Dr. Averbuch reported his coding opinions on page 1 of joint exhibits 1 to 30.

26. Even petitioners’ witness Mr. Howard agreed that some of the original codings were higher than appropriate. (p.198 lines 5-8).

27. As to patient #1, the petitioners in a document provided to AHCA stated, “However, in this particular case I can accept per your consultant a reduction from 99214 to 99213. However, I do not agree with it in principle”. (Joint exhibit 1, page 3).

28. As to patient #2, the petitioners stated that the visit included only “medical decision of moderate complexity”’. (Joint exhibit 2, page 4).
29. As to patient #3, the petitioners stated that the patient was told “that there is nothing I can offer her secondary to the fact of her ongoing problems for seven years”. (Joint Exhibit 3, page 4).

30. As to patient #4, the petitioner stated, “The reason for my billing was that my note, although short, does not reflect the amount of times that this patient had been to see me.” (Joint exhibit 4, page 2). Additionally, petitioners state, “Therefore, I am at fault and I admit that there is no documentation for the billing secondary to the fact that the note of April 3, 2001 does not state that”. (Joint exhibit 4, page 2).

31. As to patient #5, the petitioners referred the patient for tests. (Joint exhibit 5, page 4).

32. As to patient #6, the petitioners states, “Therefore, the patient was treated conservatively and although I did not place about the complexity of the injury…”. (Joint exhibit 6, page 2).

33. As to patient #6, for the visit of March 5, 2002, the petitioners billed for a level 4 even though the patient was “healed”. (Joint exhibit 6, page 4).

34. As to patient #7, the petitioners stated, “I do not argue with the down coding on this particular situation”. (Joint exhibit 7, page 2).

35. As to patient #8, the petitioners stated, “I would concur in this situation that the coding of 99243 is accepted instead of the 99245”. (Joint exhibit 8, page 2).

36. As to patient #9, the petitioners wrote “…I will concur that your consultant has billed it at 99243 and because of my review of the documentation of that visit I will agree to the lower code.” (Joint exhibit 8, page 2, lines 2-3).

37. As to patient #10, petitioners diagnosed this as a “classic gamekeeper’s thumb, yet
petitioners billed for a highest level complexity of 5". (Joint exhibit 10, page 3).

38. As to patient #11, for the 7-16-02, petitioners billed a level 4 for a patient who was "healed". (Joint exhibit 11, page 4).

39. As to patient #12, the patient on November 12 was sent for a MRI and AHCA was billed for a level 5. (Joint exhibit 12, pages 1 and 4).

40. As to patient #13, petitioners admit not documenting certain matters in the June 5, 2001 record (Joint exhibit 13, page 5, lines 10-11). Additionally, the August 7 visit was billed at a level 4 even thought the recommendation of surgery was the only decision (Joint exhibit 13, page 7).

41. As to patient #14, the petitioners billed for a level 5 for the January 15, 2002 visit even though the patient was previously diagnosed. (Joint exhibit 14, pages 1 and 4). Additionally, petitioners billed a level 4 for the February 12 visit for a patient who was "healed". (Joint exhibit 14, pages 1 and 5).

42. As to patient #15, the petitioners billed a level 5 for the June 11, 2002 visit even though the scoliosis was previously diagnosed. (Joint exhibit 15, page 3).

43. As to patient #16, for the March 26 visit, the patient was previously diagnosed and the petitioners billed AHCA for a level 5 (Joint exhibit 16, page 3). As to the April 9, 2002 visit, the patient was healed and yet petitioners billed AHCA for a level 4. (Joint exhibit 16, pages 1 and 4).

44. As to patient #17, petitioners stated, "I will accept the down code". (Joint exhibit 17, page 3).

45. As to patient #17, petitioners admitted that a down code should occur (Joint exhibit 17, pages 3, lines 5-6). For the May 14th visit, petitioners billed AHCA for a level 5 and the
patient had been previously diagnosed (Joint exhibit 17, pages 1 and 4). Additionally, petitioners billed the June 6th visit at a level 4 for a patient who was healing well or healed. (Joint exhibit 17, pages 1 and 5).

46. As to patient #18, petitioners stated that they agreed with the down code. (Joint exhibit 18, page 2, lines 12-13).

47. As to patient #19, for the July 9th visit, the petitioners billed a level 4 for a “healed” patient. (Joint exhibit 19, pages 5). The same is true for the August 12th visit. (Joint exhibit 19, pages 1 and 6).

48. As to patient #20, the petitioners placed the patient in a “heel cup” and billed AHCA at a level 5. (Joint exhibit 20, pages 1 and 3).

49. As to patient #21, the petitioners agreed to the down coding and admitted that the documentation “cannot establish the 99214”. (Joint exhibit 21, page 3, lines 12-13).

Additionally, the patient had been previously diagnosed. (Joint exhibit 21, page 4). For the June 21st visit, petitioners billed for a level 4 for a patient who had “an excellent resolution of her symptoms”. (Joint exhibit 21, page 6).

50. As to patient #22, petitioners agreed to the down coding. (Joint exhibit 22, page 2, lines 4-6).

51. As to patient #23, petitioners acknowledge problems in their documentation. (Joint exhibit 23, page 2, lines 17-18). The result of the January 29th visit was to recommend surgery on a gunshot victim. (Joint exhibit 23, page 4).

52. As to patient #24, the petitioners treated this patient who complained of back pain with pain medication and billed AHCA for level 5 and 4 visits. (Joint exhibit 24).

53. As to patient #25, the petitioners recommended that the patient change to “regular
last oxford" and the petitioners billed AHCA for a level 5. (Joint exhibit 25, page 3).

54. As to patient #26, the patient was previously diagnosed and petitioners concurred that it was a "classic" case of scoliosis curve. (Joint exhibit 26, page 3).

55. As to patient #27, for the April 11th visit, petitioners recommended a MRI and billed AHCA at a level 5. (Joint exhibit 27, pages 1 and 5). Additionally, for the April 23rd visit, the petitioners recommended surgery and billed AHCA for a level 4. (Joint exhibit 27, page 6).

56. As to patient #28, for the October 31st visit, the patient was progressing well and AHCA was billed for a level 4. (Joint exhibit 28, pages 1 and 4).

57. As to patient #29, petitioners stated that they would accept the "down coding". (Joint exhibit 29, page 2, lines 3-5).

58. As to patient #30, the petitioners stated that there was nothing that they could do for the patient (Joint exhibit 30, page 3) and billed AHCA for a level 5. (Joint exhibit 30, page 1).

59. The Court officially recognized the following: (1) The petitioners were a Medicaid provider during the subject audit period, (2) the petitioners had a Medicaid provider agreement in effect during the respective subject audit period, (3) the petitioners were paid for the claims which are the subject of this audit, and (4) the petitioners filed claims for the respective claims which are the subject of this audit (p.8 lines 11-24).

III. GENERAL MEDICAID LAW

60. During the Audit Period, Petitioner was subject to all of the duly enacted statutes, laws, and rules that generally governed Medicaid providers. (AHCA Exhibit 2 and F.S. 409).

61. During the Audit Period, Petitioner was required to follow all Medicaid Handbooks in effect. (AHCA Exhibit 2 and F.S. 409).
62. During the Audit Period, the applicable statutes, laws, rules and policy
guidelines in effect required Petitioner to maintain all "Medicaid-related Records" and information that supported any and all Medicaid invoices or claims made by Petitioner during the Audit Period.

63. During the Audit Period, the applicable statutes, laws, and rules in effect required Petitioners at AHCA's request, to provide AHCA (or AHCA's authorized representatives), all Medicaid-related Records and other information that supported all the Medicaid-related invoices or claims that Petitioner made during the Audit Period.

64. Section 409.907(3), Florida Statutes, requires Petitioners to maintain "all medical and Medicaid-related records for a period of 5 years".

65. The stated purpose behind the 5-year document retention requirement of Section 409.907(3), Florida Statutes, is so that Petitioners, "can satisfy all necessary inquiries by the agency."

66. Section 409.907(3), Florida Statutes, required Petitioners to allow AHCA (and AHCA's authorized representative) access to, "all Medicaid-related information which may be in the form of records, logs, documents, or computer files, and other information pertaining to the services and goods billed to the Medicaid Program, including access to all patient records . . . ."

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1 The term "Medicaid-related Records" used throughout this Request for Admissions, has the meaning that is used in Chapter 409, Florida Statutes, and Chapter 59G-1, F.A.C. The definition is set forth in §409.901(19), Florida Statutes, and Section 59G-1.010(154), F.A.C. It is described in more detail in §409.907(3), and §409.913(7), Florida Statutes. This term shall also encompass any and all computer stored data [i.e., electronic mail (E-mail), computerized billing records, computer spreadsheets, computer databases, etc.].
67. Section 409.913(7), *Florida Statutes*, imposed an affirmative duty on the Petitioner to comply with all the requirements as set forth in its subparagraphs (a), (b), (c), (d), (e), and (f).

68. Section 409.913(7)(f), *Florida Statutes*, imposed an affirmative duty on Petitioners to make sure that any claim for goods and services are, "documented by records made at the time goods and services were provided."

69. Section 409.913(7)(f), *Florida Statutes*, imposed an affirmative duty on Petitioners to make sure that any all the records documenting Medicaid goods and services demonstrate, "the medical necessity for the goods and services rendered."

70. Section 409.913(7)(f), *Florida Statutes*, authorized AHCA to investigate, review, or analyze the records, including Medicaid-related Records, that Petitioners were required to retain.

71. Section 409.913, *Florida Statutes*, makes AHCA the "final arbiter of medical necessity."

72. Section 409.913, *Florida Statutes*, states in part that, "Determinations of medical necessity . . . must be based upon information available at the time goods or services are provided."

73. Section 409.913(1)(d), *Florida Statutes*, defines "overpayment" 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."
74. Section 409.913(10), Florida Statutes, authorizes AHCA to require the
Petitioner to repay goods and services are "inappropriate, medically unnecessary, or
excessive".

75. Since AHCA performs audits after the services are performed, Medicaid Providers
are required to substantiate their billing in documentation they maintain. See Section
409.913(8), Florida Statutes.

76. AHCA through its “Motion for Official Recognition” requested official recognition
of the following:

C. Rule 59G-5.010, F.A.C., “Provider Enrollment”, 7-10-00
D. Rule 59G-5.020, F.A.C., “Provider Requirements”, 1-9-00, 4-24-01, 8-6-01
F. Physician Coverage and Limitations Handbook:
   1.) January 2001, p. 2-84
   2.) January 2000, p. 2-76
   3.) January 2000, p. 2-80
   4.) January 2001, p. 2-88
   5.) January 2001, p. 3-1
   6.) January 2000, p. 3-1
   7.) Update log
   8.) Update log
G. Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health

   Check-up 221:

   1.) Update log

   2.) July 1999, p. 2-19 to 2-21

   3.) May 2001, p. 2-45 to 2-47

H. Rule 59G-4.230, “Physician Services”, 4-23-00 and 8-05-01

I. “Documentation Guidelines for Evaluation and Management Services”, May
   1997, American Medical Association and Health Care Financing
   Administration.

   Association, (1999), attached pages.

77. The Court took official recognition without objection to attachments A, B, C, D, E, H
   and J of AHCA’s motion for official recognition (p. 7 lines 8-10). These are 409.907, Florida
   Administrative Code, rule 59G-5.020 and Florida Administrative Code, 59G-5.110 Florida
   Terminology Fourth Edition of the American Medical Association 1999. (p.7 line 20 to p.8 line
   4).

78. Ms. Notman identified tab F of AHCA’s motion for official recognition as the
   Physician Coverage and Limitations Handbook and explained that “F” regulates the
   reimbursement of Medicaid providers. (p.23 lines 8 to p.25 lines 11).
79. Ms. Notman identified tab I of AHCA’s motion for official recognition as “the
documentation guidelines for evaluation and management services put out by the American
Medical Association (p.31 lines 8-21).

80. The Court took official recognition of tabs F-1 through F-8 and G-1 through G-3 of
AHCA’s motion for official recognition (p.44 lines 19-21).

81. The Court took official recognition of tab I of AHCA’s motion for official
recognition (p.44 lines 5-22).

82. The Court accepted joint exhibits 1-30 in to evidence. (p.11 lines 9-14).

83. As one of its duties, the Agency must recover "overpayments . . . as appropriate".
The term "overpayment" being statutorily defined to mean "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." See Section
409.913(1)(e), Florida Statutes.

84. This case arises out of the Agency's attempt to recover overpayments made to
petitioners.

85. Section 409.913(7)(f), Florida Statutes, declares that Medicaid goods and
services are:

"excessive or medically unnecessary, unless both the medical basis and the
specific need for them are fully and properly documented in the recipient's
medical record."

86. Section 409.913(7)(f), Florida Statutes, required Petitioners to:

"retain medical, professional, financial and business records pertaining to
services and goods furnished to a Medicaid recipient and billed to Medicaid for a
period of 5 years after that date of furnishing such services or goods."
87. The Physician Coverage and Limitations Handbook states “Radiology Frequency:
Only one interpretation per radiology procedure is reimbursable”. [page 2-88 January 2001;
page 2-80 January 2000].

88. The Physician Coverage and Limitations Handbook states:

“Maximum fee: To be reimbursed the maximum fee for a radiology
service, the physician must provide both the technical and professional
components.

When a radiological study is performed in an office setting, either the
physician billing the maximum fee must have performed or directly
supervised the performance and interpreted the study; or if a group
practice, members of the group must perform all components of the
services”;

and

“Professional Component: A professional component service is the
physician’s interpretation and reporting of the radiological exam.....”.
[page 2-84 of January 2001; page 2-76 of January 2000].

89. Chapter 3 of the Physician Coverage and Limitations Handbook states:

Introduction: This chapter describes the procedure codes for services
reimbursable by Medicaid that must be used by physicians
providing services to eligible recipients.

Procedure and Diagnosis Code Origination: The procedure codes listed in
this chapter are Health Care Financing Administration
Common Procedure Coding System (HCPCS) levels 1, 2

16
and 3. These are based on the Physicians Current Terminology (CPT) book. [page 3-1 of January 2000; page 3-1 of January 2001].

90. The Medicaid Provider Reimbursement Handbook states:

Requirements for Medical Records:

Medical records must state the necessity for and the extent of services provided. The following requirements may vary according to the service rendered:

History; physical assessment; chief complaint on each visit; diagnostic tests and results; diagnosis; treatment plan, including prescriptions; medications, supplies, scheduling frequency for follow-up or other services; progress reports, treatment rendered; The author of each (medical record) entry must be identified and must authenticate his or her entry by signature, written initials or computer entry; dates of service; and referrals to other services. [pages 2-19 to 2-20 July 1999; pages 2-45 to 2-46 May 2001].

Incomplete records:

Providers 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.


91. The Medicaid Provider Reimbursement Handbook, HCFA-1500 requires that “The
provider must retain all medical, fiscal, professional, and business records on all services
provided to a Medicaid recipient”. [page 2-45 May 2001; page 2-19 July 1999].

92. The Physicians Coverage and Limitations Handbook, and the Medicaid Provider
Reimbursement Handbook HCFA-1500 and Child Health Check-Up 221 is incorporated into
rule through Florida Administrative Code 59G-5.020 and 59G-4.230. The handbooks are
binding when incorporated into rule.

93. After Ms. Notman’s investigation, she concluded that petitioners were in violation of
Medicaid law and regulations that were in effect during the Audit Period.

IV. CONCLUSIONS OF LAW

94. The Division of Administrative Hearings has jurisdiction over the parties and subject
matter of this proceeding pursuant to Chapter 120, Florida Statutes.

95. The Agency is responsible for administering the Florida Medicaid program, and is
required to “operate a program to oversee the activities of Medicaid recipients, and providers and
their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients
occur to the minimum extent possible.” Section 409.913, Fla. Stat.

96. In addition, the Agency need “conduct, or cause to be conducted by contract or
otherwise, reviews, investigations, analyses, audits, or any combination thereof, to determine
possible fraud, abuse, overpayment, or recipient neglect in the Medicaid program and shall report
the findings of any overpayments in audit reports as appropriate.” Section 409.913(2), Fla. Stat.
(2001). For purposes of this requirement, "overpayment" includes 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." Section 409.913, Fla. Stat.

97. The audit process which led to the determination of overpayment to Petitioner was initiated by the Agency in accordance with section 409.913, Florida Statutes.

98. The Agency has the burden of proving that Petitioner was overpaid for the Medicaid services delivered to recipients. See South Medical Services, Inc. v. Agency for Health Care Administration, 653 So.2d 440 (Fla. 3d DCA 1995). This proof must be by a preponderance of the evidence. See id.

99. As a result of section 409.913, Florida Statutes, the Agency's prima facie burden is easily met. See Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, DOAH Case No. 97-3791, 1998 WL 870139, *2 (Recommended Order issued Mar. 20, 1998). Section 409.913(21), Florida Statutes, provides that "[i]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." "Thus, the Agency can make a prima facie case without doing any heavy lifting: it need only proffer a properly-supported audit report, which must be received in evidence." Recommended Order, Full Health Care, Inc. vs. AHCA, DOAH Case No. 00-4441 (citing Maz Pharmaceuticals, DOAH Case No. 97-3791).

100. The Agency has offered proper support for its audit report. The Agency's work papers (AHCA's Exhibits), the relevant sections of the Handbooks and testimony of Ms. Notman, RN and Dr. Averbuch sufficiently support the Agency's audit conclusions.
101. When Petitioners decided to become a Medicaid provider, they executed a
document according to section 409.907, Florida Statutes, whereby they agreed to abide by the
provisions of the Florida Statutes and the policies, procedures, and manuals of the Florida
Medicaid program. This commitment continued throughout the audit period.

102. The statutes, rules, regulations, and handbooks in effect during the period for which
the services were provided govern the outcome of the dispute. See Toma v. Agency for Health
Care Administration, Case No. 95-2419 (Div. of Admin. Hearings 1996). Petitioners clearly
were required to comply with the Reimbursement Handbooks in effect during the Audit Period.
The Agency clearly established the Reimbursement handbook provisions. The testimony of Ms.
Notman and Dr. Averbuch, identified those of Petitioners’ claims that violated the billing
procedures.

103. Accordingly, the Agency has met its burden of proof in establishing the existence
of Medicaid overpayments to Petitioners. Simply put, there was more than enough evidence set
forth in the Findings of Fact above to prove that, more likely than not, the provider violated
Medicaid policy that prohibits petitioners from being reimbursed for Medicaid services at the
billed levels.

104. Section 409.913, Florida Statutes, specifically authorize AHCA’s audit report and
accompanying worksheets to come in as evidence. This section reads in part, “[t]he Audit
Report, supported by Agency work papers, showing an overpayment to the provider constitutes
evidence of the overpayment.” (Emphasis added). Pursuant to the plain meaning of the statute,
the Division of Administrative Hearings have consistently treated Section 409.913(21), as
allowing the Final Agency Audit Report and the attached supporting worksheets to come in as
evidence of the overpayment. See, Rubenstein v. Agency for Health Care Administration, Case
105. In Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, Case No. 97-3791, 1998 WL 870139 (Fla. DOAH. March 20, 1998), the Division of Administrative Hearings interpreting Section 409.913(21), ruled as follows:

"13. Petitioner argues that the Agency has primarily relied upon hearsay evidence and that the Agency, therefore, has failed to meet its burden of proof by presenting sufficient evidence upon which findings of fact can be made. Section 120.57(1)(c), Florida Statutes. Petitioner is correct in that the Agency's evidence is replete with hearsay and was based primarily on other hearsay. Indeed, the Agency did not attempt to qualify any of its exhibits as an exception to the hearsay rule.

"14. However, Section 409.913(21), Florida Statutes, provides, in part, that: "The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Petitioner argues that this provision means the documents relied on for all of the agency's testimony may be admitted in evidence but then must be ignored. Such a construction would render meaningless the language contained in Section 409.913(21) and would be contrary to the normal rules of statutory construction. Since the Legislature determined that the audit report and work papers constitute evidence which must be considered, the Agency presented a prima facie case, which Petitioner chose not to rebut. The agency has, accordingly, proven the overpayment.

(Emphasis added).

106. AHCA can meet its prima facia burden by the introduction of its properly supported Audit Report and worksheets. Petitioner must then offer evidence or testimony to rebut AHCA’s prima facia case. Then, and only then, does AHCA need to tip the scales by a preponderance of
the evidence.

107. In this case, AHCA has met that burden in this case. The Petitioners have failed to rebut this and has done so at their own peril. See Full Health Care, Inc. v. Agency for Health Care Administration, Case No. 00-4441, 2001 WL 729127 (Fla. DOAH June 25, 2001).

108. As more fully stated in Full Health Care, Inc. v. Agency for Health Care Administration, Case No. 00-4441, 2001 WL 729127 (Fla. DOAH June 25, 2001):

"35. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on the Agency. South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

36. Although the Agency bears the ultimate burden of persuasion and thus must present a prima facie case (i.e. create a genuine issue of fact as to each essential element of the dispute) through the introduction of competent substantial evidence before the provider is required to respond, the legislature has lightened the Agency’s load considerably. Section 409.913(21), Florida Statutes, provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, the Agency can make a prima facie case without doing any heavy lifting: it need only proffer a properly-supported audit report, which must be received in evidence. See Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, DOAH Case No. 97-3791, 1998 WL 870139, (Recommended Order issued Mar. 20, 1998).

37. The same statute also heightens the provider’s duty of producing evidence to meet the Agency’s prima facie case. It states:

A provider may not present or elicit testimony, either 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.

Section 409.913(21), Florida Statutes. In other words, once the Agency has put on a prima facie case of overpayment——which may involve no
more than moving a properly-supported audit report into evidence----the provider is obligated to come forward with written proof to rebut, impeach, or otherwise undermine the Agency's statutorily-authorized evidence; it cannot simply present witnesses to say that the Agency lacks evidence or is mistaken. [FN9]

38. Thus, because the ultimate burden of persuasion rests lightly on the Agency, the provider in a typical Medicaid overpayment case refrains at its peril from proffering documentary evidence in support of its position."

109. Furthermore, petitioners' failure to provide any documentary evidence or written proof, as required in Full Health Care, Inc., mandates that he has failed to sufficiently rebut the Agency’s prima facia case proving the stated overpayment.

110. However, this Tribunal notes that despite this purely legal finding, the Tribunal also finds that the Agency has proved that the greater weight of the evidence proves that petitioners violated the Medicaid policy, and therefore was overpaid in the amount of $81,682.06, for Medicaid services during the Audit Period.

111. The petitioners offered the testimony of Jeffrey L. Howard. Mr. Howard's testimony, however, lacked credibility. The Court should find that Mr. Howard lacked credibility for a number of reasons. First, Mr. Howard does not have a health care degree, license or patient-caregiver experience, and therefore, he does not have the expertise or experience (p.87 lines 3-11) necessary to opine on “complexity of medical decision making”, “counseling”, nor "nature of the presenting problem”. Mr. Howard testified that these were all pertinent factors in coding (p.175 line 2 to p.185 line 11). When asked how he as a non-medical person could determine “medical complexity”, Mr. Howard could only respond that he could review the records (p.185 lines 4 to p.187 line 8). This is supported by the fact that the majority of Mr. Howard’s answers to questions regarding specific patient records were merely his reading to the court parts of the record. This highlights Mr. Howard’s inability to give a proper expert
opinion. Second, Mr. Howard was unfamiliar with medical terminology (p.226 lines 23 to p.227
line 2; 229 lines 12-16; p.229 lines 22 to p. 230 line 4;). Finally, Mr. Howard was never able to
logically or adequately support his conclusions.

112. Medicaid providers are required by law to document the need for a particular level
of service, thereby showing the medical necessity of that level of service. The petitioners clearly
were unable to support the level of their billings.

113. Additionally, petitioners inappropriately billed for x-ray services that were not
allowable under the Medicaid handbooks. For instance, petitioners billed for radiology
procedure interpretation when said procedure had been previously billed.

114. The petitioners’ medical records often did not comply with the “Medicaid Provider
Reimbursement Handbook” “requirements for Medical records” (pages 2-19 to 2-20 July 1999;
pages 2-45 to 2-46 May 2001).

115. Petitioners have not supported their argument by any law, rule or policy.
Petitioners as a Medicaid provider is obligated to follow the applicable laws, rules and policies
set forth in the Medicaid program.

V. RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is
RECOMMENDED that the Agency enter a final order finding that petitioners were overpaid in
the amount of $81,682.06, and ordering petitioners to immediately repay the principal amount of
$81,682.06 plus interest.
AGENCY FOR HEALTH CARE ADMINISTRATION

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was furnished by U.S.

Mail and/or facsimile to: William Furlow, Esquire, Akerman Senterfitt, 106 East College Avenue, Tallahassee, FL 32301 this 24th day of October 2005.

GRANT P. DEARBORN, ESQUIRE