STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

JEANETTE E. NORRIS, M.D. AND SANDCASTLE PEDIATRICS,

Petitioners,

vs. Case No. 02-0019MPI

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

## RECOMMENDED ORDER

Formal hearings in this case were held on April 1, 2002, in Tallahassee, Florida, and on June 3, 2002, via telephone, before the Division of Administrative Hearings by Administrative Law Judge, Stephen F. Dean.

## APPEARANCES

For Petitioners: Jeanette E. Norris, M.D., pro se
Sandcastle Pediatrics, Inc.
834 Tarpon Drive
Fort Walton Beach, Florida 32548-6069

For Respondent: Susan C. Felker-Little, Esquire
Agency for Health Care Administration
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## STATEMENT OF THE ISSUE

Whether Medicaid overpayments were made to Petitioners, Jeanette E. Norris, M.D., and Sandcastle Pediatrics, and, if so, what is the total amount of these overpayments.

## PRELIMINARY STATEMENT

The final hearing commenced in this cause on April 1, 2002, at which time the Agency for Health Care Administration (Agency/AHCA) presented the live testimony of two witnesses, agency analyst/auditor Lynne Edwards and agency registered nursing consultant Blanca Notman, and the deposition testimony of agency pediatrician peer review consultant, Larry C. Deeb, M.D., in lieu of live trial testimony (the deposition having been received into evidence as AHCA Exhibit 35). The Agency also offered documentary exhibits numbered 1 through 34, which were received into evidence. Over the objection by the Agency, Petitioner Norris was permitted to present the live testimony of statistician Ibrahim Ahmad, Ph.D., by telephone. Petitioner also presented the live testimony of Petitioner Norris.

The final hearing did not conclude on April 1, 2002, and was recessed to permit the Agency to obtain rebuttal statistical testimony.

Before the Agency obtained the testimony of Dr. Mark Johnson, the Agency's counsel left employment with the Agency and a new counsel for the Agency filed a notice of appearance. The next session of the hearing was conducted via telephone conference call on June 3, 2002. During the June 3, 2002, hearing, the Agency offered a documentary exhibit, the CV/Résumé of Dr. Johnson, which was admitted into evidence as the Agency's

Exhibit 1; and Judge's Exhibit 1, pages 116 and 117 of Thompson's statistical text, was admitted into evidence. The final hearing did not conclude on June 3, 2002, and the record was left open to permit Petitioner Norris to present surrebuttal testimony of Dr. Ahmad.

On June 10, 2002, Petitioner Norris sought an extension of time in which to present surrebuttal testimony by deposition. The Agency opposed the motion for extension of time and asserted the motion was untimely. By order dated September 6, 2002, it was determined that Petitioner Norris had good cause for its untimely motion for extension of time and Petitioner Norris further was ordered to arrange a telephone conference with the Administrative Law Judge if Petitioner Norris sought to take the deposition testimony after September 30, 2002. Petitioner Norris did not present additional surrebuttal testimony on or before September 30, 2002, and Petitioner Norris did not seek a further extension of time prior to close of business on September 30, 2002.

Pursuant to the order entered September 6, 2002, the parties were given until October 21, 2002, in which to file proposed recommended orders. On October 16, 2002, Petitioner Norris filed a Motion to Extend Time to File Proposed Recommended Order, seeking an extension to October 31, 2002. On October 17, 2002, the Agency filed a response to Petitioner Norris' motion, indicating the Agency did not oppose the

extension of time requested. The extension was verbally granted on October 21, 2002. On October 29, 2002, Petitioner Norris filed a motion to further extend the filing of proposed recommended orders to November 19, 2002. On October 29, 2002, the Agency filed a response to Petitioner Norris' motion, indicating the Agency did not oppose the extension of time requested. The extension was verbally granted. On November 6, 2002, Petitioner Norris filed a motion to further extend the filing of proposed recommended orders and an extension to December 5, 2002, was verbally granted on November 15, 2002.

The Transcript of the April 1, 2002, hearing was filed with the Division of Administrative Hearings on April 14, 2002; the Transcript of the June 3, 2002, hearing was filed with Division of Administrative Hearings on June 28, 2002. Petitioner Norris did not offer any exhibits.

On December 4, 2002, the Agency filed a Proposed Recommended Order containing findings of fact and conclusions of law. On December 6, 2002, Petitioner Norris filed a Proposed Recommended Order containing proposed findings of fact and conclusions of law. The proposed recommended order of each party was considered prior to the entry of the Recommended Order. A letter was submitted by Dr. Norris after the proposed findings were filed which the Agency moved to strike. The letter and motion were not considered because they were untimely.

## FINDINGS OF FACT

1. The Agency is the state agency charged with administration of the Medicaid program in Florida under Section 409.907, Florida Statutes.

2. Petitioner Norris is a physician who, during the period of January 1, 1997, through October 16, 1999, provided Medicaid services to Medicaid beneficiaries pursuant to a valid Medicaid provider agreement with the Agency under provider number 0543756-00. Petitioner Norris at all times relevant to this matter, provided Medicaid services in an office owned by Petitioner Norris, doing business as Sandcastle Pediatrics, but all Medicaid claims were claimed by and paid to Petitioner.

3. The Agency performed an audit of paid Medicaid claims for services claimed to have been performed by Petitioner Norris during the period January 1, 1997, through October 16, 1999.

4. On March 12, 2201, the Agency issued a Final Agency Audit Report ("Audit Report" or "FAAR"), requesting Petitioner Norris to reimburse the Agency $39,534.32, alleged for overpayments of Medicaid claims submitted by and paid to Petitioner Norris.

5. The determination of overpayment was based upon audit findings that services provided by Petitioner Norris did not meet Medicaid criteria. These criteria included: lack of documentation of services rendered; lack of documentation to support the higher level of service billed; failure to document

the required elements for early periodic screening for diagnosis; failure to document performance of treatment services; and billing for two codes when one code incorporated the elements of the other code.

6. During the Audit period, the applicable statutes, laws, rules and policy guidelines (Medicaid rules) in effect required Petitioner Norris to maintain all Medicaid-related records and information that supported any and all Medicaid invoices or claims made by Petitioner Norris during the Audit period.

7. During the Audit period, the Medicaid rules required Petitioner Norris to provide the Agency or the Agency's authorized representatives all the Medicaid-related records and other information that supported all the Medicaid-related invoices or claims for which Petitioner Norris billed Medicaid during the Audit period.

8. Petitioner Norris was required to maintain all medical and Medicaid-related records for a period of five years to satisfy all necessary inquiries by the Agency.

9. During all times relevant to this matter, Petitioner Norris had an affirmative duty to assure that each claim presented to the Agency was true and accurate, and that goods and services were provided in accord with applicable provisions of the Medicaid rules.

10. Medicaid goods and services are deemed excessive or medically unnecessary unless both the medical basis and specific

need for them are fully and properly documented in the recipient's medical record.

11. At the request of Ms. Lynne Edwards, the Agency's auditor, the Agency generated a random list of 24 Medicaid recipients (cluster sample) rendered services by Petitioner Norris during the audit period. In addition, the Agency generated work papers of: the total number of recipients to whom Petitioner Norris rendered services during the audit period; the total number of claims by Petitioner Norris with dates of service during the audit period; the total amount paid to Petitioner Norris for all claims with dates of service during the audit period; and worksheets representing each recipient's claims for the audit period.

12. Ms. Edwards obtained the work papers generated by the Agency concerning the random cluster sample, provided 24-hour advance notice to Petitioner Norris of an on-site visit, and performed an on-site visit at the office where Petitioner Norris provided medical services and maintained patient records. After the on-site visit, Ms. Edwards prepared an on-site investigative summary.

13. When Ms. Edwards performed the on-site visit, she spoke with Petitioner Norris. Ms. Edwards presented Petitioner Norris with a questionnaire and printout of the names of the 24 patients in the cluster sample, and asked Petitioner Norris to fill out the questionnaire and mail back to Ms. Edwards the

completed questionnaire along with copies of the medical records of the 24 patients in the cluster sample. Ms. Edwards also asked to see medical records of a few of the patients in the cluster sample while she was on-site. Petitioner Norris did not mail a completed questionnaire to Ms. Edwards.

14. Subsequent to the on-site visit, Petitioner Norris provided the Agency with medical records for five of the 24 recipients in the sample. The records were given to Ms. Blanca Notman, the Agency's registered nurse consultant, for policy compliance review. Thereafter, Petitioner Norris submitted medical records for an additional five recipients in the sample. Ms. Edwards forwarded the additional medical records to Ms. Notman for review. After Ms. Notman reviewed the medical records and provided her comments on the claims worksheets, Ms. Notman forwarded the records and worksheets to Dr. Larry Deeb, a pediatrician physician consultant, for a review relating to medical necessity and level of care issues. After review and comments by Dr. Deeb, the records and worksheets were returned to Ms. Notman, who calculated adjustments on the claims worksheets based on the opinions of Dr. Deeb. Ms. Notman returned the medical records and worksheets to Ms. Edwards, along with a Professional Medical Review Report signed by Ms. Notman and Dr. Deeb.

15. Ms. Edwards received the medical records, worksheets, and the Professional Medical Review Report, totaled the

overpayments per patient/cluster in the sample, and arrived at a figure of $3,298.45 as the total overpayment for all cluster sample claims. Ms. Edwards submitted the cluster sampling information and the audit review results to another Agency employee for the generation of the extrapolated overpayment calculation, using the Agency's formula. The Agency employee generated and provided to Ms. Edwards the overpayment calculation that represented the findings of the audit of the cluster sampling extrapolated to the total paid claims in the audit period, which was $39,534.32.

16. The Agency prepared its February 6, 2001, Preliminary Agency Audit Report (PAAR) based on the audit review of the medical records provided by Petitioner Norris for the paid claims in the cluster sample. Petitioner Norris provided no documentation for 14 of the 24 patients in the cluster sample, and the audit took this into account. The PAAR was mailed to Petitioner Norris. The PAAR identified all policy violations and determinations found in the audit review.

17. Petitioner Norris closed her medical practice in March 2001. Petitioner Norris joined the employees of a group that provides physicians to hospitals on contract for limited periods of time. This required Petitioner Norris to be away from home and unavailable for large periods of time, which complicated all aspects of this case.

18. The PAAR informed Petitioner Norris that the findings were preliminary and encouraged Petitioner Norris to submit any additional documentation she felt would serve to reduce the overpayment within 30 days. Petitioner Norris did not submit additional documentation to the Agency. Pursuant to Section 409.9131, Florida Statutes (2000 Supp.), the Agency prepared and mailed to Petitioner Norris its March 12, 2001, Final Agency Audit Report (FAAR), asserting a total overpayment determination of $39,534.32 and again identifying all policy violations and determinations found in the audit review.

19. After receipt of the FAAR, Petitioner Norris requested an informal hearing, which the Agency received on April 13, 2001. In her hearing request Petitioner Norris said the 30 days given between the PAAR and FAAR for the submission of additional documentation was not sufficient because she was in the process of closing her medical office and relocating her files and medical records. Petitioner Norris requested an additional 60 days for the submission of additional information, and the letter inferred there were disputed issues of material fact.

20. On April 26, 2001, the Agency's clerk submitted a request to Petitioner Norris that she clarify her hearing request, given what appeared to be disputed issues of material fact. On September 12, 2001, Petitioner Norris sent the Agency a letter that informed the Informal Hearing Officer of dates of availability and acknowledged there were disputed issues of

material fact. The matter was subsequently referred to the Division of Administrative Hearings.

21. On March 28, 2002, the Agency took the deposition of Dr. Deeb in lieu of live trial testimony. Prior to the commencement of the deposition, the determination of the Agency as to the paid claims in the cluster sample was reviewed by the parties and stipulations were entered into between the Agency and Petitioner Norris. The stipulations were restated during the deposition.

22. Based on the stipulations prior to and during the deposition of Dr. Deeb, the Agency re-calculated the total overpayment for the paid claims in the cluster sample, extrapolated the sample findings to the population, and determined the adjusted total overpayment of paid Medicaid claims.

23. Prior to the commencement of the final hearing on April 1, 2002, the parties agreed that the information set forth in AHCA Exhibit 10A represented the Agency's final determination as to the claims in the cluster sample determined to be overpayments by the Agency, with the exception of the "No Documentation" overpayment for the date of service of March 3, 1997, which the parties agreed should not be listed on the exhibit because the Agency represented that it would recalculate the extrapolated total overpayment, based upon the final determinations set forth in the Agency Exhibit 10A (subtracting

out the "No Documentation" March 3, 1997 listing), and the parties were permitted to supplement AHCA Exhibit 30 with any updated total overpayment determination.

24. The Agency recalculated the extrapolated total overpayment after April 1, 2002, which was determined to be $4,000.48, and supplemented AHCA Exhibit 30 by filing AHCA Exhibit 30A on June 7, 2002.

25. On April 1, 2002, when the final hearing commenced, the parties agreed that the only Medicaid claims overpayment determinations made by the Agency concerning the audit of the claims in the cluster sample that were in dispute were the following:

a. Blood count/fingerstick hemoglobin and hemocrit tests performed as a part of a physician office visits as follows:

| Recipient/ Patient | Date of Service | Procedure Billed | Reason for Claim Denial | Overpayment |
|---|---|---|---|---|
| 13 | 3/25/97 | Blood Count/HE | Part of OV | $ 2.00 |
| 14 | 2/24/97 | Blood Count/HE | Part of OV | $ 2.00 |
| 14 | 3/10/97 | Blood Count/HE | Part of OV | $ 2.00 |
| 16 | 4/4/98 | Blood Count/HE | Part of OV | $ 2.00 |
| 16 | 5/12/98 | Blood Count/HE | Part of OV | $ 2.00 |
| 16 | 6/18/98 | Blood Count/HE | Part of OV | $ 2.00 |

b. Office visit (OV) cannot be billed the same day that an EPSDT is billed, when patient only seen once that day:

| Recipient/ Patient | Date of Service | Procedure Billed | Reason for Claim Denial | Overpayment |
|---|---|---|---|---|
| 22 | 7/29/97 | OV-99202 | OV billed same same day as EPSDT | $31.35 |

26. On April 1, 2002, when the final hearing commenced, the parties agreed that the following claims overpayment determinations made by the Agency concerning the audit of the claims in the cluster sample were not in dispute:

a. Claims were no medical records existed to indicate services were performed:

| Recipient/ Patient | Date of Service | Procedure Billed | Reason for Claim Denial | Overpayment |
|---|---|---|---|---|
| 3 | 5/12/97 | EPSDT | No Med. Rec. | $64.98 |
| 3 | 5/12/97 | blood count | No Med. Rec. | $ 2.00 |
| 3 | 5/12/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 5/12/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 5/12/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 8/27/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 8/27/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 8/27/97 | immunization | No Med. Rec. | $10.00 |
| 3 | 8/27/97 | immunization | No Med. Rec. | $10.00 |
| 7 | 7/30/97 | OV-99213 | No Med. Rec. | $25.00 |
| 22 | 7/14/98 | EPSDT | No Med. Rec. | $65.33 |

b. Office visit (OV) claims, to include Early and Periodic Screening, Diagnosis, and Treatment Services claims (EPSDTs), that lacked all EPSDT components, adjusted to appropriate level of care OV claims.

| Recipient/ Patient | Date of Service | Adjustment Made | Reason for Adjustment | Overpayment |
|---|---|---|---|---|
| 3 | 8/27/97 | EPSDT to 99214 OV | Lacked components | $27.72 |
| 3 | 8/27/98 | 99205 OV to 99204 OV | Level of Service | $38.18 |
| 9 | 10/17/97 | 99205 OV to 99204 OV | Level of Service | $17.04 |
| 10 | 4/3/97 | 99204 OV to 99203 OV | Level of Service | $21.36 |
| 14 | 3/24/97 | 99214 OV to 99213 OV | Level of Service | $12.26 |
| 14 | 4/28/97 | 99214 OV to 99213 OV | Level of Service | $12.26 |
| 16 | 1/20/97 | 99205 OV to 99204 OV | Level of Service | $17.04 |
| 16 | 3/5/97 | 99214 OV to 99213 OV | Level of Service | $12.26 |
| 19 | 3/11/97 | 99205 OV to 99204 OV | Level of Service | $17.04 |
| 20 | 4/2/97 | 99214 OV to 99213 OV | Level of Service | $12.26 |
| 21 | 2/13/98 | 99205 OV to 99204 OV | Level of Service | $16.77 |
| 23 | 8/4/97 | 99204 OV to 99203 OV | Level of Service | $21.36 |

27. As to the disputed claims concerning the blood count/fingerstick hemoglobin and hemocrit test performed as a part of a physician office visit, Petitioner Norris testified that she did not see the test as a routine part of an office visit, she disagreed with the policy that the test could not be billed separately, and she indicated that usually her nurse would perform the test, which she agreed involved a little prick of blood run through something and took about five minutes. The preponderance of the evidence established that the Agency's determination as to these disputed claims was correct--the Medicaid Handbooks in effect during the audit prohibited Petitioner Norris from separately billing for these tests because they were done during an office visit.

28. The one disputed claim concerning an EPSDT and office visit billed on the same day when the patient was only seen once was for the treatment of the patient's oral infection (thrush). Petitioner Norris admitted that she received reimbursement for office visit procedure Code 99202, in addition to being reimbursed for an EPSDT, even though the patient was seen only once on that day.

29. It was undisputed that prior to the issuance of the Agency's audit report, a peer review was performed by Dr. Larry C. Deeb, a pediatrician in active practice pursuant to Section 409.9131, Florida Statutes (2000 Supp.)

30. Based on the documentation that Petitioner Norris provided to the Agency before the issuance of the Agency audit report, the Agency audit report and related work papers, the adjustment made because of stipulations between the parties after the Agency Audit Report was issued, a preponderance of the evidence establishes there is a Medicaid claims overpayment of $4,000.48 to Petitioner Norris for paid Medicaid claims for the audit period.

31. On April 1, 2002, at the final hearing, Petitioner Norris announced that she disputed the appropriateness of the Agency's statistical formula regarding the extrapolation of the Agency's audit findings concerning the paid claims in the cluster sample to the universe/population of all paid claims during the audit period. The Agency objected on numerous grounds, all of which were overruled. The Agency was permitted to present rebuttal testimony at the conclusion of the presentation of evidence by Petitioner Norris, which the Agency did on June 3, 2002.

32. The statistical formula utilized by the Agency when it made findings based on the cluster sample audit and applied to extrapolate those findings to the population of patient claims paid during the audit period is found on page two of the agency audit report.

33. It was undisputed that during the audit period, Petitioner Norris saw 305 Medicaid patients and had a total of 3,035 Medicaid claims paid.

34. It also was undisputed that a random sample of 24 Medicaid patients who were provided services by Petitioner Norris during the audit period was selected by the Agency for this audit, and all Medicaid paid claims during the audit period for each of the 24 randomly selected patients were reviewed in this audit.

35. Petitioner Norris presented the expert testimony of Dr. Ibrahim Ahmad, regarding the Agency's challenged formula.[1]

36. The formula used by the Agency is the one used for infinite populations. In this case, the audited cases were a sample of a finite population. This builds an error into the calculation which can only be corrected by testing the sample against the population to determine if it is reflective of the population.

37. Dr. Ahmad observed that this "proofing" had not been done and in the absence of such a proof of the sample he could not deem the results accurate.

38. The Agency presented the expert testimony of Dr. Mark Johnson on the statistics issue.[2] Dr. Johnson explained that there is an adjustment term in the challenged formula--"U" minus "N" under the square root--that adjusts the challenged formula for finite populations.[3]

39. In addition to reviewing the Agency's final audit report letter and Agency materials related to the generation of the sample in this case, Dr. Johnson conducted his own analysis of the data, using an Excel spreadsheet program and a statistical package. He was able to reproduce, independently, the same numerical results as the Agency--the estimated overpayment, variance estimates, and the lower 95 percent confidence interval limit. In this case, Dr. Johnson determined the sample was representative of the population because, looking at some of their summary values, they were consistent with the population as a whole. Dr. Johnson indicated that by using the Agency's formula, he arrived at the same calculated values as the Agency. He also investigated assumptions underlying the procedures used in the analysis of this cluster sampling design.

40. Dr. Johnson reviewed the random distribution of the 24 clusters, compared the dollar per claim values in the sample with the figures for the population, and compared the number of claims per patient in the sample with the number of claims per patient in the population. Dr. Johnson's investigation of these properties of the random sample in comparison to the properties of the whole population led him to the conclusion that the sample was representative of the population in this case.

41. The Agency's statistical formula adjusts the "best guess" estimate the total Medicaid overpayment ($7,803.10) downward based on the lower end of the 95 percent confidence

interval, causing the overpayment being sought by the Agency to be 4,000.48. The confidence interval is plus or minus the estimate--in this case, the 95 percent confidence interval is $4,000.48 to $11,605.62 (i.e., $7,803.10 plus or minus $3,802.62). Statistically, there is 95 percent confidence that the true overpayment lies within this interval, and the Agency, by seeking the overpayment at the low end of the confidence interval, is giving Petitioner Norris the entire benefit of all of the uncertainty associated with the sampling process.

42. Prior to the commencement of the final hearing in this cause, the Agency had filed its notice of intent to seek investigative costs, expert witness costs, and attorney's fees. At the final hearing, it was determined, as a matter of record, that jurisdiction would be retained for the determination of the Agency's request for such costs and fees.

43. The procedural record of the case reveals that this case was forwarded to DOAH precipitously and before the Petitioner Norris would informally present information which reduced the claim from almost $40,000 to $4,000. At the commencement of the hearing, the parties stipulated to most of the operative facts.

44. The statistical formula was a real issue, and in sum, Petitioner Norris was right; the formula reported was inappropriate. The Agency showed it did not use the reported formula, but one that adjusted for a finite population.

Further, the testimony of Petitioner Norris' expert witness was not that the amount of alleged overpayment was wrong, but that the formula was not appropriate. The Agency's expert testified that a factor not stated in the letter was used to adjust the challenged formula for a finite population. Further, the Agency's expert testified he normed the stratified sample against the sampled population, and it did represent that population. This was one of the approaches Dr. Ahmad had suggested to validate the process when using the stated formula. However, Dr. Johnson did this after the challenge, not before.

45. In sum, the burden was on the Agency to prove its case, and by failing to adopt its formula by rule, the Agency placed itself in the position of proving the formula's appropriateness at every hearing. It is so in this case.

46. The request for costs and fees is denied.

## CONCLUSIONS OF LAW

47. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. Sections 120.569 and 120.57(1), Florida Statutes.

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

49. The statutes, rules, and handbooks in effect during the audit period govern the outcome of the dispute. See Toma vs. Agency for Health Care Administration, Case No. 95-2419 (Division of Administrative Hearings 1996)[(as incorporated in Toma v. Agency for Health Care Administration, 18 FALR 4735 (Division of Administrative Hearings 1996)].

50. Section 409.913, Florida Statutes, relates to the Agency's oversight of the integrity of the Medicaid program and provides that the Agency may recover overpayments from providers.

51. "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." Section 409.913(1)(d), Florida Statutes.

52. Section 409.913(7), Florida Statutes, states as follows in relevant part:

> (7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:
>
> * * *
>
> (b) Are Medicaid-covered goods or services that are medically necessary.

*  *  *

> (e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.
>
> (f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

53. The Agency has the authority to require a provider to repay amounts received for goods and services that are inappropriate, medically unnecessary, or excessive. Section 409.913(10), Florida Statutes.

54. Regarding the audit report and Agency work papers, Section 409.913(21), Florida Statutes, states, in part, as follows: "The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." The Agency presented its audit report, supported by Agency work papers, and the Agency presented stipulated revisions to the audit report. The audit process that led to the Agency's assertion of overpayment was initiated by the Agency in accordance with Section 409.913, Florida Statutes (1999); and it was completed in accordance with Section 409.913, Florida Statutes (2000), and Section 409.9131, Florida Statutes (2000).

55. As stated in Full Health Care, Inc. vs. Agency for Health Care Administration, DOAH Case No. 00-4441 (Recommended Order, June 25, 2001), "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."

56. Although Petitioner Norris testified that she disagreed with the Agency's interpretations of Medicaid policies and handbook provisions, she cited no authority to support her contentions and presented no evidence to rebut, impeach, or otherwise undermine the Agency's evidence on these issues. When Petitioner Norris chose to become a Medicaid provider, she executed a provider agreement in accordance with Section 409.907, Florida Statutes, wherein Petitioner Norris agreed to abide by the provisions of the Florida Administrative Code, Florida Statutes, and the policies, procedures, and manuals of the Florida Medicaid Program.

57. The Agency presented its original work papers pursuant to Section 409.913, Florida Statutes, and also its revised work papers. Dr. Deeb was the physician who performed the peer review, pursuant to Section 409.9131, Florida Statutes.
Dr. Deeb is a Florida-licensed physician, whose specialty is

pediatrics. Dr. Deeb has been in active practice as a pediatrician since 1980. Dr. Deeb is an appropriate peer to review the medical records for all claims in this audit pursuant to Section 409.9131, Florida Statutes. It further presented:

a. Expert testimony from Dr. Larry Deeb regarding the medical necessity and levels of care that were appropriate for the services rendered to the 24 Medicaid patients in the cluster sample during the audit period.

b. Testimony from Ms. Lynne Edwards and Ms. Blanca Notman concerning Medicaid policy issues.

c. Testimony from Ms. Lynne Edwards and Ms. Blanca Notman, and credible expert testimony from Dr. Johnson that the Agency used a generally accepted, appropriate sampling method in selecting the cluster sample of 24 patients to be audited in this case.

d. Dr. Johnson's credible expert testimony was that the formula actually used by the Agency in this audit were appropriate and valid; however, it was not the one reported and challenged by Petitioner Norris. Further, Dr. Johnson's testimony that he "normed" the sample has been given great weight, and the alleged overage was proven. The testimony of Dr. Johnson established that the Agency used a valid sampling and statistical method.

58. Based upon the stipulations of the parties, and the policy determinations as testified to by Ms. Edwards and

Ms. Notman, Dr. Deeb's peer review, and Dr. Johnson's testimony, Petitioner Norris was overpaid a total of $4,000.48 for services rendered to all 305 Medicaid patients of Petitioner Norris during the audit period.

59. Petitioner Norris questions the appropriateness and validity of the sampling and statistical methods used by the Agency to arrive at the total amount of overpayments. Petitioner Norris' expert witness, Dr. Ahmad successfully attacked the Agency's stated formula.

60. Dr. Johnson's expert testimony was that the formula actually used by the Agency in this audit was appropriate and valid; however, it was not the one reported and challenged by Petitioner Norris. Further Dr. Johnson's testimony that he "normed" the sample has been given great weight, and the alleged overage was proven up.

61. The testimony of Dr. Johnson established that the Agency used a valid sampling and statistical method.

62. Based upon the stipulations of the parties, and the policy determinations as testified to by Ms. Edwards and Ms. Notman, Dr. Deeb's peer review, and Dr. Johnson's testimony, Petitioner Norris was overpaid a total of $4,000.48 for services rendered to all 305 Medicaid patients of Petitioner Norris during the audit period.

## RECOMMENDATION

Based on the foregoing Findings of Facts and Conclusions of Law, it is

RECOMMENDED:

That the Agency for Health Care Administration issue a final order requiring Petitioner Norris to reimburse the Agency for Medicaid overpayments in the total amount of $4,000.48, plus such interest as may statutorily accrue. For the reasons found above, the Agency's motion for investigative costs, expert witness fees, and attorney's fees is denied.

DONE AND ENTERED this 28th day of February, 2003, in Tallahassee, Leon County, Florida.

STEPHEN F. DEAN
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th day of February, 2003.

## ENDNOTES

1/ Dr. Ibrahim Ahmad was qualified by his education and experience as an expert in statistics. His testimony was credible and pertinent to the issue of the propriety of the Agency's formula.

2/ Dr. Mark Johnson was qualified by his education and experience as an expert in statistics. His testimony was credible and pertinent on the issue of the propriety of the Agency's formula.

3/ The formula set forth in the Final Agency Audit letter dated March 12, 2001.

COPIES FURNISHED:

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## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.