STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

COMPSCRIPT, INC., d/b/a COMPSCRIPT,	)	
Petitioner,	)	
vs.	)	Case No. 03-3238MPI
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice a formal hearing was held in this case on March 28, 29, and 30, 2005, in Tallahassee, Florida, before J. D. Parrish, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

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For Respondent: L. William Porter, II, Esquire
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Agency for Health Care Administration
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STATEMENT OF THE ISSUE

Whether the Petitioner was overpaid for Medicaid prescriptions. The Agency for Health Care Administration (AHCA, Agency or Respondent) asserts the Petitioner, Compscript, Inc., d/b/a Compscript (Petitioner or Compscript) failed to maintain proper records to support and document the Medicaid prescription claims paid by the Agency for the audit period. According to the Agency, the audit findings must be extrapolated to the universe of all claims for the audit period. If so, the Agency maintains the Petitioner should reimburse AHCA for a Medicaid overpayment in the amount of $216,974.07 (this is the “recoupment” amount). The Petitioner denies it was overpaid any amount, asserts it kept records in accordance with applicable laws and regulations governing pharmacy records, and maintains that the Agency may not apply the extrapolation accounting procedure in this case.

PRELIMINARY STATEMENT

This case began in 2001. The Petitioner is a Medicaid provider and in the regular course of doing business was audited by the Agency regarding its Medicaid claims. The audit period pertinent to the case is May 28, 1999 through July 18, 2000. The audit was unannounced and was begun on October 23, 2000. When the results of the audit were provided to the Petitioner, Compscript timely challenged the alleged

Medicaid overpayment. That challenge was referred to the Division of Administrative Hearings for formal proceedings on May 21, 2001, and was assigned DOAH Case No. 01-1970. On July 16, 2001, the parties filed an Agreed Motion for Remand and Notice of Limited Withdrawal. By Order entered July 17, 2001, DOAH Case No. 01-1970 was closed and jurisdiction in the matter was relinquished to the Agency.

On September 10, 2003, the Agency filed an Agreed Motion to Re-Open that represented the parties had worked toward but failed to reach a settlement of the case, that records were unavailable for review that were necessary to resolve issues in the cause, and that the parties wanted to be placed on a litigation schedule so that the unresolved issues could be addressed through formal hearing. Accordingly, the matter was re-opened as DOAH Case No. 03-3238MPI and was scheduled for hearing for January 12 through 14, 2004.

In November 2003 the parties represented that the appeal of another case [Agency for Health Care Administration v. Colonial Cut-Rate Drugs, Inc., 878 So. 2d 479 (Fla. 1st DCA 2004)] would impact the parties in the instant dispute such that both sides were desirous of abating the matter until the district court could enter its decision. Based upon the representations of counsel at that time, the case was placed in abeyance. The Colonial, supra, decision was entered at the

end of July 2004. Thereafter, the parties continued to debate the implications of the appellate decision. In substance, the Petitioner continued to maintain that calculations based upon an extrapolation from the audit findings were inappropriate whereas the Agency argued that the court's ruling did not change the unambiguous language of the statute as to the use of extrapolation in this case. On October 22, 2004, an Order was entered to resolve outstanding procedural issues. By virtue of that Order the parties were put on notice of the law to be applied in the instant case. The October 22, 2004 Order provided, in pertinent part:

> 5. . . .[T]he subject matter of these cases (whether identified as DOAH Case No. 01-1970 or DOAH Case No. 03-3238MPI) has been the alleged overpayment of Medicaid claims paid by the Respondent to the Petitioner.
> 6. The Final Agency Audit Report dated April 6, 2001, covering the audit period May 28, 1999 through July 18, 2000, claimed that the Petitioner received a Medicaid overpayment in the amount of $1,341,466.27.
> 7. The Petitioner disputed the overpayment and has contested the audit results.
> 8. In computing the alleged overpayment amount the Respondent represented in its audit report that:
>
> > The audit included a statistical analysis of a random sampling, with the results applied to the random sample universe of claims submitted during the audit period. ... The actual overpayment was calculated using a procedure that has been proven valid and is deemed admissible in

administrative and law courts as evidence of the overpayment.

9. The parties have referred to the above-described accounting practice as "extrapolation."
10. The Petitioner opposes the use of "extrapolation" to compute any alleged Medicaid overpayment. The question of whether the Respondent may use "extrapolation" was the subject matter of the Petitioner's Motion in Limine.
11. The Petitioner filed a Motion in Limine on November 4, 2003, and alleged that the Respondent could not use the accounting practice because the Florida Legislature had passed Section 465.188(e), Florida Statutes (2003), that provided:
(e) A finding of an overpayment or underpayment must be based on the actual overpayment or underpayment and may not be a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs.
12. The parties disputed whether or not the law cited was applicable to audits and administrative cases pending before the effective date of the statute. The legislation was signed into law and became effective July 11, 2003.

* * *

14. . . .In AHCA v. Colonial Cut-Rate Drug, Case No. 1D03-4024, the court found that Section 465.188, Florida Statutes (2003) is procedural and remedial. Accordingly, its provisions would be applicable to the issues of this matter.
15. Based upon the foregoing, the Petitioner renewed its Motion in Limine and filed a Motion to Lift the Abeyance. Both motions were granted in error.
16. At the time such motions were reviewed, the undersigned was unaware of the provisions of Section 465.188, Florida Statutes (2004). The statute as amended

during the 2004 session changed significant provisions of the law.
17. Pertinent to this matter is subsection (k) of the law that provides:

> The audit criteria set forth in this section applied only to audits of claims submitted for payment subsequent to July 11, 2003. Notwithstanding any other provision in this section, the agency conducting the audit shall not use the accounting practice of extrapolation in calculating penalties for Medicaid audits.

18. The Respondent does not seek a "penalty" in this case.
19. The words "penalty" and "overpayment" are not synonymous.

* * *

ORDERED:
1. That the court has found the provisions of the law to be procedural and remedial. The unambiguous language of the statute provides that it applies only to audits of claims submitted for payment subsequent to July 11, 2003. Accordingly the more stringent audit standards set forth in Section 465.188, Florida Statutes (2004) do not apply to this cause.
2. The prohibition regarding the use of extrapolation does not apply to the calculation of an overpayment.

Thereafter, the parties proceeded with discovery and the case advanced to hearing. The Pre-Hearing Stipulation filed by the parties on March 22, 2005, outlined the issues to be tried, the facts not disputed, the law not disputed, and the witnesses and exhibits each side intended to offer at hearing. The hearing in this matter was conducted over the course of

three days: March 28 through 30, 2005. The five-volume transcript of the proceedings correctly chronicles the witnesses' testimony, the exhibits admitted into evidence, as well as objections preserved for the record. The Petitioner was granted a continuing objection to the use of extrapolation to compute the alleged overpayment. All parties acknowledged that whether or not extrapolation could be utilized remained an issue of law.

At the conclusion of the hearing, the parties were granted additional time to file their Proposed Recommended Orders. That time was subsequently extended four times. The parties were directed to file the Proposed Recommended Orders no later than 5:00 p.m., August 22, 2005. Both proposed orders have been considered in the preparation of this Recommended Order. Also, pertinent stipulated facts set forth in the parties' Pre-hearing Stipulation are incorporated below.

FINDINGS OF FACT

1. At all times material to the allegations of this case, the Petitioner was a licensed pharmacy authorized to do business in the State of Florida; its pharmacy license number is PH0016271.

2. At all times material to the allegations of this case, the Petitioner was authorized to provide Medicaid

prescriptions pursuant to a provider agreement with the Respondent. The Petitioner's Medicaid provider number is 106629300. The terms of the provider agreement govern the contractual relationship between this provider and the Agency. The parties do not dispute that the provider agreement together with the pertinent laws or regulations controls the relationship between the provider and the Agency.

3. The provider agreement pertinent to this case is a voluntary agreement between AHCA and the Petitioner. Pursuant to the provider agreement, the Petitioner was to "keep, maintain, and make available in a systematic and orderly manner all medical
and Medicaid-related records as AHCA requires for a period of at least five (5) years."

4. In addition to the foregoing, a Medicaid provider must maintain a patient record for each recipient for whom new or refill prescriptions are dispensed.

5. Any Medicaid providers not in compliance with the Medicaid documentation and record retention policies may be subject to the recoupment of Medicaid payments.

6. A Medicaid provider must retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient. The records may be kept on paper, magnetic material, film, or other media. However, in order to

qualify for reimbursement, the records must be signed and dated at the time of service, or otherwise attested to as appropriate to the media. Rubber stamp signatures must be initialed. The records must be accessible, legible and comprehensive.

7. Specific to the issues of this case, a Medicaid provider must also retain prescription records for five years.

8. The Respondent is the state agency charged with the responsibility and authority to administer the Medicaid program in Florida. Pursuant to this authority AHCA conducts audits to assure compliance with the Medicaid provisions and provider agreements. These “integrity” audits are routinely performed and Medicaid providers are aware that they may be audited.

9. At all times material to the allegations of this case, the Medicaid program in Florida was governed by a “pay and chase” procedure. Under this procedure, the Agency paid Medicaid claims submitted by Medicaid providers and then, after-the-fact, audited such providers for accuracy and quality control. These “integrity” audits are to assure that the provider maintains records to support the paid claims. In this case, the audit period is May 28, 1999 through July 18, 2000. The pertinent audit has been designated AHCA audit no. 01-0514-000-3/H/KNH and was initiated on October 23, 2000.

The Petitioner does not dispute the Agency's authority to perform audits such as the one at issue. The Petitioner maintains its records are sufficient to support the paid claims and that the Agency has unreasonably imposed its interpretation of the requirements.

10. The Medicaid provider agreement that governs this case required that the Petitioner comply with all Medicaid handbooks in effect during the audit period. Essentially, this standard dictates the records that must be kept for quality control so that the after-the-fact audit can verify the integrity of the Medicaid claims that were paid by the Agency.

11. During the audit period the Petitioner sold or dispensed drugs to Medicaid recipients. Equally undisputed is the fact that Medicaid claims were paid by the Agency during the audit period. Each claim reviewed and at issue in this cause was a paid Medicaid claim subject to the Petitioner's provider agreement and the pertinent regulations.

12. The Agency required that each and every claim submitted by the Petitioner during the audit period under the Medicaid program be filed electronically. Each claim submitted was filed electronically.

13. Nevertheless, the Agency also required the Petitioner to retain records supporting the claim.

Additionally, the Petitioner was to make such supporting records available to the Agency upon request.

14. The Agency asked the Petitioner to present its records to support the claims for the audit period. The disclosure of the records proved difficult for this Medicaid provider because it does not operate in a conventional pharmacy setting. More specifically, it operates solely to serve a nursing home population. All of the patients whose prescriptions were filled were nursing home residents.

15. Compscript maintains its manner of doing business is slightly different from the conventional pharmacy. Rather than the walk-in patient who presents a written prescription to be filled, this Petitioner receives its pharmacy orders by telephone or facsimile transmission from nursing homes. Typically, the staff at Compscript takes the call, writes down the pertinent information, enters the data into the pharmacy's computer system, and the item is dispensed and routed to the nursing home via the delivery driver. All drugs are dispensed in sealed containers and are delivered with a manifest listing all the medications by name and patient. Given the volume of prescriptions being prepared and delivered, for the audit period at issue in this case, the Petitioner made 2-3 trips to the nursing home per day.

16. Once the information for the prescription was

entered into the Petitioner's computer system, Compscript had little interest in maintaining the written telephone message or the facsimile sheet that generated the request. In some instances the Compscript employee did not make a written record of the prescription request. In those instances the employee entered the request directly into the Petitioner's computer system and bypassed the written step altogether. The Compscript computer system tracks the initials of the pharmacist who entered the prescription information and cannot be altered without such alteration being tracked and noted. Since the pharmacy fills "over the counter" items, as well as controlled and non-controlled pharmacy products, the computer record denotes that information along with the patient information.

17. When the Respondent's audit agents went into the Compscript facility to audit the Medicaid claims, the Petitioner could not readily produce the written documentation to support the dispensed drugs. In fact, many of the records that verified the prescriptions dispensed were found on the nursing home records. The nursing home patient's physician order sheet specified the item or items requested for the patient. This "physician order sheet" (POS) should theoretically always support the dispensing of the product

from the Petitioner. In this case there were instances when the POS did not corroborate the claim.

18. When the auditors from the Agency presented at Compscript, the Petitioner did not have the POS records to produce. Obviously, those records were maintained within the nursing home. Additionally, Compscript did not have the telephone notes or the facsimile transmission sheets to support items dispensed during the audit period. When the hearing in this cause proceeded it was also discovered that records that were generated daily by the Petitioner's computer system that would have corroborated the claims (and which were allegedly maintained in storage) were not produced or available to support Medicaid claims submitted during the audit period.

19. During the audit the Agency's auditors requested records from a random sample of the claims submitted during the audit period. The results from that sample where then applied to the universe of claims for the audit period. When this mathematical calculation was performed the audit produced a Medicaid overpayment in the amount of $1,341,466.27. Afterwards, when the Petitioner was able to locate additional records to correspond to and support the prescriptions dispensed, the amount of overpayment was reduced to

$217,715.28 (the amount set forth in the parties' Pre-hearing Stipulation).

20. At hearing, the Agency maintained that the amount of overpayment was $216,974.07 for which the Petitioner could produce no adequate documentation.

21. At hearing, the Petitioner continued to dispute the procedure of applying the audit sample overpayment to the population of claims to mathematically compute the overpayment for the audit period. This "extrapolation" process was admitted into evidence and has been fully considered in the findings reached in this case.

22. The Petitioner was required to maintain Medicaid-related records for a period of 5 years. Thus, for the audit period in this case, any record supporting the claims should have been maintained and made available for the Agency. Such records would have been within the five-year period.

23. The Agency designates Medicaid compliance to its office of Medicaid Program Integrity. In turn, that office contracted with Heritage Information Systems, Inc. (Heritage) to perform and report pharmacy audits of the numerous pharmacy providers within the state. Auditors from Heritage were assigned the Compscript audit. At the time of the audit the Heritage auditors were not privy to any of the POS documents later produced in the case.

24. Ken Yon is the Agency's administrator who was responsible for managing the instant case and who worked with the Heritage auditors to assure the policies and practices of the Agency were met. In this case, the Heritage auditors presented at Compscript unannounced on October 23, 2000, and sought 250 randomly selected claims for review. By limiting the number of claims, the auditors were not required to sift through the records of 46,000+ claims (the approximate number of claims that the Petitioner submitted during the audit period).

25. For the universe of 46,000+ claims, 250 randomly selected claims is a reasonable sample to audit. The adequacy of the sample number as well as the manner in which it was generated is supported by the weight of credible evidence presented in this matter. Also, the results of a sample of 250 from the universe of 46,000+ would be statistically valid if randomly chosen as they were in this case. In this regard the testimony of Dr. Mark Johnson, an expert in statistical sampling and analysis, has been deemed credible and persuasive as to the issues of the appropriateness of the sample (as to size and how it was generated), the use of the sample overpayment to calculate an overall payment, and the statistical trustworthiness of the amounts claimed in this cause. If anything, as Dr. Johnson asserted, the actual

overpayment would be greater than the recoupment amount sought by the Agency.

26. The Agency has used a statistical extrapolation method to compute overpayments for years. The statistical concept and process of applying a sample to a universe to mathematically compute an overpayment is not novel to this case.

27. After the auditors completed their review of the records at the Compscript pharmacy, Kathryn Holland, a licensed pharmacist (who is also a consulting pharmacist) prepared the Respondent's Final Agency Audit Report. Prior to completing the report, Ms. Holland received and reviewed the information provided by the Petitioner through the auditors. As a result of the review, a number of "can't find" conclusions were reached. By "can't find" the auditors and Ms. Holland meant that the original prescription or refill documentation could not be located for the paid Medicaid claim. These "can't find" claims were reported to the Petitioner, who was given additional time to locate and produce documents to support the claims. In fact, the Agency continued to accept documentation for claims up through the time of hearing. Consequently, the amount sought for overpayment has been substantially reduced. Whether the Agency had the authority to accept documents outside the

prescription records maintained by the pharmacy is not an issue. In fact, the Agency did reduce the overpayment amount when subsequent supporting documents were located.

28. A second error in the documentation for the Petitioner's prescriptions was noted as "no doctor's address on the prescription." That expression meant that pursuant to state and federal law the physician's address is required for a controlled substance and when it was not provided the auditor deemed the documentation incomplete. Although the Petitioner maintained doctor addresses in its computer system, the records did not correspond to the specific prescriptions that were filled for the audited claims.

29. In order to stand as a sufficient prescription form, a writing must be created contemporaneous to the order (phone requests that are transcribed are acceptable), must contain specific information (type of drug, strength, dose, patient, doctor, DEA number, refill, etc.), and it must be kept for the requisite time. It would be acceptable for the prescription to be computer generated so long as it was written contemporaneous to the order and preserved as required by law.

30. In this case, at the conclusion of the audit, the Agency identified 194 discrepant claims within the random sample of 250. The vast majority of those discrepancies were noted as "can't find." Had the Agency not accepted other

documentation to support the dispensing of the drugs, the calculated overpayment would have been $1,575,707.44. Applying a lower confidence limit of 95 percent to that amount generated the calculated overpayment of $1,341,466.27. The audit findings set forth in the Agency's Final Agency Audit Report (dated April 6, 2001) is supported by the weight of credible evidence in this case.

31. Nevertheless, the Agency did allow the provider here to supplement the documentation disclosed during the audit. And, to that end, the calculated overpayment was reduced to $216,974.07 (this amount is 95% of the calculated overpayment). In reality, the amount owed by this Petitioner for failure to maintain proper documentation for this audit would be greater than the recoupment amount sought by the Agency. Had the Agency held the Petitioner to a standard of "no prescription, no payment" standard arguably 194 of the 250 audited claims could have been disallowed. That is not the standard applied by the Agency.

32. A "patient record" may include information regarding the patient's prescription history. The terms "patient record" and "prescription" are not synonymous. For example, while a prescription would contain information such as patient's name, doctor, DEA number, doctor's address, dosage, drug, and whether it may be refilled, it would be expected

that the “patient record” would contain additional information not typically found on a prescription. For instance, a “patient record” might contain a historical track of past medications or known patient allergies.

33. In this case, the computer records or “patient records” maintained by the Petitioner did not retain the prescriptions in the format dictated by rule. An electronic imaging recording system may be used when the system captures, stores, and can reproduce the exact image of the prescription, including the reverse side of the prescription if necessary. The Petitioner’s system did not do that.

34. An electronic system must be able to produce a daily hard-copy printout of all original prescriptions dispensed and refilled. If the Petitioner’s system could do that, it did not.

35. An acceptable electronic system must generate the prescription contemporaneous to the dispensing order. The Petitioner’s system did not do that.

36. The Agency has not alleged, and there is no evidence to suggest, fraud in the Petitioner’s failure to maintain its records.

37. The Agency’s interpretation of the requirement that a prescription be reduced to writing is consistent with the rules and regulations in effect at the time of this audit.

38. The last category of discrepant items was “UR” which stood for “unauthorized refills.” These were claims for refills on drugs for which the original prescription could not be located or documentation from the nursing home could not be found. Again, the Petitioner the maintained that within the nursing home setting a physician’s reorder for medications for the patient could be found on the POS. These refill requests were handled orally among the physician, the nursing home staff, and the pharmacy. Nevertheless, because they were not documented in writing the Agency disallowed this claims and included them among the discrepant list.

39. If the Petitioner was able to produce a physician order to support the UR claims, it was removed from the recoupment list. In most instances, the Petitioner did not have the requisite paperwork to support the refill. Instead, the Petitioner relied on its computer records (again not kept in accordance with the applicable standards) to support the UR claims. The Agency has not claimed that the refills were not dispensed, merely that the paperwork to support the claim cannot be produced.

CONCLUSIONS OF LAW

40. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of these proceedings. § 120.57(1), Fla. Stat. (2005).

41. Pursuant to Section 409.902, Florida Statutes (2000), the Respondent is responsible for administering the Medicaid Program in Florida.

42. As the party asserting the overpayment, the Respondent bears the burden of proof to establish the alleged overpayment by a preponderance of the evidence. See Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992).

43. Section 409.913, Florida Statutes (2000), provides, in pertinent part:

> The agency shall operate 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.
>
> (1) For the purposes of this section, the term:
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> * * *
>
> (d) "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.
>
> * * *

(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:

* * *

(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.

(8) A Medicaid provider shall 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 the date of furnishing such services or goods. The agency may investigate, review, or analyze such records, which must be made available during normal business hours. However, 24-hour notice must be provided if patient treatment would be disrupted. The provider is responsible for furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records. The authority of the agency to obtain Medicaid-related records from a provider is neither curtailed nor limited during a period of litigation between the agency and the provider.

* * *

(19) In making a determination of overpayment to a provider, the agency must use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods, or combinations

thereof. Appropriate statistical methods may include, but are not limited to, sampling and extension to the population, parametric and nonparametric statistics, tests of hypotheses, and other generally accepted statistical methods. Appropriate analytical methods may include, but are not limited to, reviews to determine variances between the quantities of products that a provider had on hand and available to be purveyed to Medicaid recipients during the review period and the quantities of the same products paid for by the Medicaid program for the same period, taking into appropriate consideration sales of the same products to non-Medicaid customers during the same period. In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods as evidence of overpayment.

(20) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.

(21) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, 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.

44. Section 409.907, Florida Statutes (2000), provides, in part:

> The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.
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> * * *
>
> (3) The provider agreement developed by the agency, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:
>
> * * *
>
> (b) Maintain in a systematic and orderly manner all medical and Medicaid-related records that the agency requires and determines are relevant to the services or goods being provided.
>
> (c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the agency.

45. In this case the Agency seeks the overpayment based upon an inadequate records keeping system utilized by the Petitioner. The plain language of the statute directing a

provider to maintain in a "systematic and orderly manner" all Medicaid records dictates that the Respondent may demand repayment regardless of the circumstances that produced the payment. The Petitioner voluntarily participated in a program that dictated the manner in which all records would be maintained. Apart from the strict compliance with those dictates, the Petitioner is not entitled to payment for its claim. See Colonnade Medical Center, Inc. v. Agency for Health Care Administration, 847 So. 2d 540 (Fla. 4th DCA 2003).

46. Section 409.906(20), Florida Statutes (2000), authorized the Agency to pay for medications that were prescribed for a recipient by a physician or other licensed practitioner and that were dispensed to the recipient by a licensed pharmacist in accordance with applicable state and federal law. During the audit period the Agency paid the Petitioner for all Medicaid claims at issue in this proceeding. In effect, the Agency honored the claims submitted. Now, after-the-fact, and through the audit process, the Agency attempted to verify that those claims were supported by the documentation required by law.

47. Section 465.015(2)(c), Florida Statutes (2000), states that it is illegal to sell or dispense drugs without first being furnished with a prescription. The term

“prescription” is defined in Section 465.03(14), Florida Statutes (2000). That section provides:

> "Prescription" includes any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist. The term also includes an orally transmitted order by the lawfully designated agent of such practitioner. The term also includes an order written or transmitted by a practitioner licensed to practice in a jurisdiction other than this state, but only if the pharmacist called upon to dispense such order determines, in the exercise of her or his professional judgment, that the order is valid and necessary for the treatment of a chronic or recurrent illness. The term "prescription" also includes a pharmacist's order for a product selected from the formulary created pursuant to s. 465.186. Prescriptions may be retained in written form or the pharmacist may cause them to be recorded in a data processing system, provided that such order can be produced in printed form upon lawful request.

48. From the foregoing it is apparent that a prescription maintained in a data processing system must be produced in printed form upon lawful request. In this case, the Petitioner’s computer system did not maintain the prescriptions in that format. Nor were they printed upon lawful request.

49. As to the discrepant claims in this cause (“can’t find,” “UR,” or no doctor’s address), it is concluded the

Petitioner did not maintain the requisite data processing system to electronically retain the pertinent prescriptions. The Petitioner's system did not retain a prescription that had been reduced to writing contemporaneous to the order.

50. The "overpayment" in this cause results from an unacceptable practice not fraud, abuse, or mistake. The unacceptable practice was Petitioner's lack of documentation to support the claims filed. All of the record-keeping requirements were known or should have been known to Petitioner, inasmuch as the Agency has always requested an audit trail for Medicaid claims.

51. This audit and recoupment claim occurred prior to July 11, 2003. Consequently, the auditing mandates set forth in Section 465.188, Florida Statutes (2004) are not applicable. See Colonial, supra. Additionally, since the Agency is not seeking a "penalty" in this matter, the current law does not prohibit the use of the accounting practice of extrapolation. It is concluded that the calculation of an overpayment using extrapolation is not a penalty. See Bennett v. Kentucky Department of Education, 470 U.S. 656, 662-63, 105 S. Ct. 1544, 1548-1549 (1985). In this case, the Agency is merely attempting to collect monies paid to a provider who cannot produce the documentation to support the paid claim. In a technical sense, it is the recoupment of funds paid to a

provider who did not comply with the strict letter of its agreement to maintain appropriate records. In complying with its mandate from the federal government, AHCA is held to a high standard and must assure that overpayments are recouped. See 42 C.F.R. § 433.312(a)(2).

52. In this case, the audit report supports and constitutes evidence of the overpayment claimed. See § 409.913(22), Fla Stat. (2004). The Petitioner has failed to present substantial, credible evidence to rebut the overpayment claimed. The Petitioner has not presented a credible challenge to the use of extrapolation (as applied in this case), nor its failure to provide documentation for the discrepant claims.

53. The Agency has met its burden of proof in this case and has established by a preponderance of the evidence that the Petitioner received overpayments in amount greater than $216,974.07. Moreover, it is further concluded that the Petitioner failed to comply with record-keeping requirements, failed to produce adequate documentation to support the paid discrepant claims, and failed to discredit the accounting practices utilized by the Agency in this cause.

RECOMMENDATION

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

Administration enter a Final Order that accepts an amended Final Agency Action Report to support an overpayment and recoupment against the Petitioner in the amount of $216,974.07.

DONE AND ENTERED this 6th day of October, 2005, in Tallahassee, Leon County, Florida.

J. D. PARRISH
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 6th day of October, 2005.

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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.