STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

HENRY LEPELY, M.D.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 04-3025MPI
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

A formal hearing was conducted in this case on October 25, 2004, and November 4, 2004, in Tallahassee, Florida, before Suzanne F. Hood, Administrative Law Judge with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: John D. Buchanan, Jr., Esquire
Henry, Buchanan, Hudson,
Suber & Carter, P.A.
117 South Gadsden Street
Tallahassee, Florida 32302

For Respondent: Debora E. Fridie, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station 3
2727 Mahan Drive, Suite 3431
Tallahassee, Florida 32308

STATEMENT OF THE ISSUES

The issues are whether Petitioner received a Medicaid overpayment for claims paid during the audit period, August 1, 1997, through August 25, 1999, and if so, what is the amount that Petitioner is obligated to reimburse to Respondent.

PRELIMINARY STATEMENT

In a Final Agency Audit Report (FAAR) dated October 1, 2003, Respondent Agency for Health Care Administration (Respondent) advised Petitioner Henry Lepely, M.D. (Petitioner) that he had received overpayment for Medicaid claims in the amount of $39,055.34 during the audit period, August 1, 1997, through August 25, 1999. On November 25, 2003, Petitioner requested an administrative hearing to challenge Respondent's findings in the FAAR. On January 5, 2004, Respondent referred Petitioner's request to the Division of Administrative Hearings.

A Notice of Hearing scheduled the case for hearing on April 27-28, 2004. However, on March 30, 2004, the parties filed a Joint Motion to Relinquish Jurisdiction and Remand Back to the Agency. In an Order Closing File dated April 2, 2004, the undersigned granted the motion with leave for either party to request that the file be reopened if further administrative proceeding became necessary.

On August 24, 2004, Respondent filed a Motion to Reopen Proceeding.

On August 27, 2004, the Division of Administrative Hearings issued the Initial Order in this case. On September 3, 2004, the parties filed a Joint Response to the Initial Order.

In a Notice of Hearing dated September 8, 2004, the undersigned rescheduled the hearing for October 25-26, 2004.

On September 30, 2003, Respondent filed a Motion to Allow Expert Testimony by Deposition in lieu of trial testimony. The undersigned granted the motion in an Order dated October 8, 2004.

On September 30, 2004, Respondent filed a Motion for Official Recognition of the following: (a) Chapters 409 and 414, Florida Statutes (1999)(1998) and (1997); (b) Rules 59G-1, 59G-4, and 59G-5, Florida Administrative Code; and (c) excerpts from the Florida Medicaid Physician Coverage and Limitations Handbook, January 1999, January 1998, November 1997, and January 1996 (Limitations Handbook), and the Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-Up 221, November 1996 (Reimbursement Handbook). The motion was granted on the record during the hearing.

On October 1, 2004, Respondent filed a Motion for Costs. Respondent cites Section 409.913(23), Florida Statutes, as grounds for the motion. The motion is hereby granted as set forth below in the Conclusions of Law.

On October 1, 2004, Petitioner filed a Motion for Costs and Attorney's Fees without citing specific authority as grounds for the motion. Petitioner's motion is hereby denied.

On October 20, 2004, Respondent filed a Motion to Restrict Use and Disclosure of Information concerning Medicaid applicants and beneficiaries. The motion was granted on the record during the hearing.

When the hearing commenced, Respondent presented the testimony of two witnesses. Respondent offered Respondent's Exhibit Nos. R1-R11, R26-R27, and RR1, which were accepted as evidence.

Petitioner testified on his own behalf and presented the testimony of one additional witness. Petitioner offered Petitioner's Exhibit Nos. P1-P4, which were accepted into evidence.

The Transcript of the hearing was filed on November 30, 2004.

On December 10, 2004, the parties filed a Joint Motion for Enlargement of Time to File Proposed Recommended Orders. The motion was granted in an Order dated December 14, 2004.

On January 21, 2005, Petitioner filed the deposition testimony of Ephraim Asher, Ph.D. Pursuant to the agreement of the parties, Dr. Asher's deposition testimony is hereby accepted as evidence in lieu of testimony at hearing.

On January 21, 2005, both parties filed Proposed Recommended Orders.

There has been no substantive change to the relevant provisions of Chapter 409, Florida Statutes, since 1997. Therefore, all references hereinafter shall be to Florida Statutes (2004) unless otherwise specified.

FINDINGS OF FACT

1. Respondent is the agency responsible for administering the Florida Medicaid Program. One of its duties is to recover Medicaid overpayments from physicians providing care to Medicaid recipients.

2. Petitioner is a licensed psychiatrist and an authorized Medicaid provider. His Medicaid provider number is No. 048191200.

3. Chapter Three of the Limitations Handbook describes the procedure codes for reimbursable Medicaid services that physicians may use in billing for services to eligible recipients. The procedure codes are Health Care Financing Administration Common Procedure Coding System (HCPCS), Levels 1-3. The procedure codes are based on the Physician's Current Procedural Terminology (CPT) book, published by the American Medical Association. The CPT book, includes HCPCS descriptive terms, numeric identifying codes, and modifiers for reporting services and procedures.

4. The Limitations Handbook further provides that Medicaid reimburses physicians using specific CPT codes. The CPT codes are listed on Medicaid's physician fee schedule.

5. The CPT book includes a section entitled Evaluation and Management (E/M) Services Guidelines. The E/M section classifies medical services into broad categories such as office visits, hospital visits, and consultations. The categories may have subcategories such as two types of office visits (new patient and established patient) and two types of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific CPT codes. The classification is important because the nature of a physician's work varies by type of service, place of service, and the patient's status.

6. According to the CPT book, the descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. They are history, examination, medical decision making, counseling, coordination of care, nature of presenting problem, and time. The most important components in selecting the appropriate level of E/M services are history, examination, and medical decision making. However, since 1992, the CPT book has included time as an explicit factor in selecting the most appropriate level of E/M services.

7. At all times relevant here, Petitioner provided services to Medicaid patients pursuant to a valid Medicaid provider agreement. Therefore, Petitioner was subject to all statutes, rules and policy guidelines that govern Medicaid providers. The Medicaid provider agreement clearly gives a Medicaid provider the responsibility to maintain medical records sufficient to justify and disclose the extent of the goods and services rendered and billings made pursuant to Medicaid policy.

8. This case involves Respondent's Medicaid audit of claims paid to Petitioner for Medicaid psychiatric services during the audit period August 1, 1997, through August 25, 1999 (the audit period). Petitioner provided these services to his Medicaid patients, which constituted approximately 85 to 90 percent of his practice, at his office and at hospitals in the Jacksonville, Florida, area.

9. During the audit period, Petitioner billed Medicaid for services furnished under the following CPT codes and E/M levels of service: (a) 99215, office or other outpatient visit for the evaluation and management of an established patient; (b) 99223, initial hospital care per day for the evaluation and management of a patient; (c) 99232, subsequent hospital care per day for the evaluation and management of a patient; (d) 99233, subsequent hospital care per day for the evaluation and management of a patient; (e) 99238, hospital discharge day

management; (f) 99254, initial inpatient consultation for a new or established patient; and (g) 90862, other psychiatric service or procedures, pharmacologic management.

10. Except for CPT code 90862, the E/M levels of services billed by Petitioner require either two or all three of the key components as to history, examination, and medical decision-making. The CPT book assigns a typical amount of time that physicians spend with patients for each level of E/M service.

11. The CPT book contains specific psychiatric CPT codes. CPT codes 90804-90815 relate to services provided in the office or other outpatient facility and involve one of two types of psychotherapy. CPT codes 90816-90829 relate to inpatient hospital, partial hospital, or residential care facility involving different types of psychotherapy. CPT codes 90862-90899 relate to other psychiatric services or procedures.

12. CPT code 90862 specifically includes pharmacologic or medication management; including prescription, use, and review of medication with no more than minimal medical psychotherapy. CPT code 90862 is the only psychiatric procedure code that Petitioner used in billing for the psychiatric services he provided. CPT code 90862 does not have specific requirements as to history, examination, and medical decision-making or a specified amount of time.

13. Most of Petitioner's hospital patients were admitted to the hospital for psychiatric services through the emergency room. As part of the admission process, Petitioner performed psychiatric and physical examinations. However, testimony at hearing that Petitioner generally performed the psychiatric evaluations and the physical examinations on separate days is not persuasive. The greater weight of the evidence indicates that the hospital physical examinations were conducted as part of the routine admission process and appropriately included in claims for the patients' initial hospital care.

14. Some of Petitioner's hospital patients had complicated conditions. Some patients required crisis intervention and/or lacked the ability to perform activities of daily living. The initial hospital care of new hospital patients required Petitioner to take an extensive medical and psychiatric history.

15. Petitioner attended his hospital patients on a daily basis. However, there is no persuasive evidence that Petitioner routinely spent 20-25 minutes with his hospital patients for each subsequent daily visit until the day of discharge.

16. Petitioner used a team approach when attending his hospital patients. On weekdays, the team consisted of Petitioner, a social worker, a music therapist, and the floor nurses. On weekends, Petitioner generally made his rounds with the floor nurses. Petitioner's use of the team approach to

treat hospital patients did not change the level of service he provided in managing their medication.

17. Petitioner did not document the time he spent with patients during hospital visits. However, his notations as to each of these visits indicate that, excluding admissions and discharges, the hospital visits routinely involved medication management. Petitioner's testimony that his treatment during subsequent hospital visits involved more than mere medication management is not persuasive.

18. Petitioner also failed to document the time he spent with patients that he treated at his office. He did not present his appointment books as evidence to show the beginning and ending time of the appointments.

19. Petitioner's notes regarding each office visit reflect a good bit of thought. However, without any notation as to time, the office progress notes are insufficient to determine whether Petitioner provided a level of service higher than medication management for established patients.

20. Petitioner and his office manager agreed in advance that, unless Petitioner specified otherwise, every office visit for an established patient would be billed as if it required two of the following: a comprehensive history; a comprehensive examination; and a medical decision making of high complexity. With no documented time for each appointment, Petitioner's

records do not reflect that he provided a level of service higher than medication management for the office visits of established patients. Petitioner's testimony to the contrary is not persuasive.

21. Petitioner treated some patients at their place of residence in an adult congregate living facility (ACLF). Respondent does not pay for psychiatric services in such facilities. Instead of entirely denying the claims for ACLF patients, Respondent gave Petitioner credit for providing a lower level of service in a custodial care facility.

22. Sometime in 1999, Respondent made a decision to audit Petitioner's paid claims for the period of time at issue here. After making that decision, Respondent randomly selected the names of 30 Medicaid patients that Petitioner had treated. The 30 patients had 282 paid claims that were included in the "cluster sample."

23. Thereafter, Respondent's staff visited Petitioner's office, leaving a Medicaid provider questionnaire and the list of the 30 randomly selected patients. Respondent's staff requested copies of all medical records for the 30 patients for the audit period.

24. Petitioner completed the Medicaid questionnaire and sent it to Respondent, together with all available medical records for the 30 patients. The medical records included

Petitioner's progress notes for office visits. Petitioner did not send Respondent all of the relevant hospital records for inpatient visits.

25. The original hospital records belonged to the hospitals where Petitioner provided inpatient services. Petitioner had not maintained copies of all of the hospital records even though Medicaid policy required him to keep records of all services for which he made Medicaid claims.

26. When Respondent received Petitioner's records, one of Respondent's registered nurses, Claire Balbo, reviewed the records to determine whether Petitioner had provided documentation to support each paid claim. Ms. Balbo made handwritten notes on the records of claims that were not supported by documentation. Ms. Balbo reviewed the documentation in the records between February 10, 2000, and March 7, 2000.

27. Next, one of Respondent's investigators, Art Williams, reviewed the records. Mr. Williams made his review on or about January 23, 2001.

28. In some instances, Mr. Williams changed some of Petitioner's CPT codes from an inappropriate hospital inpatient or office visit procedure code to a psychiatric procedure code with a lower reimbursement rate. Additionally, Mr. Williams noted Petitioner's visits in ACLF's that, according to Medicaid

policy, were not reimbursable. Finally, Mr. Williams noted that Petitioner occasionally made several claims on one line of the claim form contrary to Medicaid policy.

29. Mr. Williams made these changes to the CPT codes based on applicable Medicaid policy. His review of the audit documents and patient records did not involve a determination as medical necessity or the appropriate level of service. A peer reviewer makes determinations as to medical necessity and the appropriate level of service for each paid claim in the random sample of 30 patients.

30. Respondent then sent the records to Dr. Melody Agbunag, a psychiatrist who conducted a peer review of Petitioner's records. Dr. Agbunag's primary function was to determine whether the services that Petitioner provided were medically necessary and, if so, what the appropriate level of service was for each paid claim.

31. Dr. Agbunag conducted the peer review between June 8, 2001, and August 29, 2001. She agreed with Respondent's staff regarding the adjustments to the procedure codes that corresponded with the level of service reflected in the medical records.

32. When Dr. Agbunag returned the records to Respondent, Ms. Balbo calculated the monetary difference between the amount that Medicaid paid Petitioner for each claim and the amount that

Medicaid should have paid based on Dr. Agbunag's review. The difference indicated that Respondent had overpaid Petitioner for claims that in whole or in part were not covered by Medicaid.

33. Respondent sent Petitioner a Preliminary Agency Audit Report (PAAR) dated December 27, 2001. The PAAR stated that Petitioner had been overpaid $54,595.14. The PAAR stated that Petitioner could furnish additional information or documentation that might serve to reduce the overpayment.

34. Petitioner responded to the PAAR in a letter dated February 28, 2001. According to the letter, Petitioner challenged the preliminary determinations in the PAAR and advised that he was waiting on additional patient records from a certain hospital.

35. In a letter dated June 30, 2002, Petitioner advised Respondent that he generally spends 15-20 minutes with his hospital inpatients. The letter does not refer to any additional hospital records.

36. Petitioner's office manager sent Respondent a letter dated August 1, 2002. The letter discusses every service that Petitioner provided to the 30 patients during the audit period. Some of these services were not included in the random "cluster sample" because Medicaid had not paid for them during the audit period.

37. According to the August 1, 2002, letter, Petitioner's office manager attached some of the patient records that Petitioner had not previously provided to Respondent. The additional documentation related to multiple claims involving several of Petitioner's hospital and office patients.

38. Sometime after receiving the additional documentation, Dr. Agbunag conducted another peer review. She did not change her prior determination regarding the level of service as to any paid claim.

39. In 2003, Vicki Remick, Respondent's investigator, reviewed the audit, the patient records, and all correspondence. Her review included, but was not limited to, the determination of the appropriate CPT code and amount of reimbursement, taking into consideration Medicaid policy and Dr. Agbunag's findings regarding medical necessity and the level of care for each paid claim.

40. On or about October 1, 2003, Respondent issued the Final Agency Audit Report (FAAR). The FAAR informed Petitioner that he had been overpaid $39,055.34 for Medicaid claims that, in whole or in part, were not covered by Medicaid. The FAAR included a request for Petitioner to pay that amount for the overpayment.

41. The FAAR concluded, as to some patients, that Petitioner's documentation did not support the CPT codes that

Petitioner used to bill and that Respondent used to pay for services. Thus, Respondent "down graded" the billing code to a lesser amount. As a result, the difference between the amount paid and the amount that should have been paid was an overpayment.

42. The FAAR also stated that Petitioner billed and received payment for some undocumented services. In each such instance, Respondent considered the entire amount paid as an overpayment.

43. The FAAR indicated that Petitioner billed Medicaid for some services at acute care hospital psychiatric units without documenting the medical records as to the appropriate CPT codes and medical illness diagnosis codes. Respondent adjusted the payments for these services to the appropriate psychiatric CPT codes.

44. According to the FAAR, Petitioner billed and received payment for services which only allowed one unit of service per claim line. For this audit, Respondent allowed charges for the additional units of service where Petitioner's documentation for the additional dates of service supported the services allowed by the peer reviewer.

45. The FAAR stated that Petitioner billed for psychiatric services at an ACLF or an assisted living facility. Medicaid normally does not pay for such services. However, in this case,

Respondent adjusted the claims to a domiciliary or custodial care visit.

46. Sometime after Petitioner received the FAAR, Petitioner sent Respondent some additional patients' medical records. Some of the records were duplicates of documents that Petitioner previously had furnished to Respondent. Other records were for services that may have been provided during the audit period but which were not a part of the random sample because Medicaid did not pay for them during relevant time frame.

47. Respondent requested Dr. James R. Edgar to conduct a second peer review of Petitioner's correspondence and patient records to determine the appropriate level of service. Respondent provided Dr. Edgar with a copy of the patients' medical records, a copy of Respondent's worksheets, including Dr. Agbunag's notes, and the appropriate policy handbooks. Respondent requested Dr. Edgar to make changes in the level of service as he deemed appropriate.

48. Dr. Edgar performed his review between July 25, 2004, and July 29, 2004, making an independent determination regarding issues of medical necessity and level of care. Initially, as to every disputed paid claim, Dr. Edgar agreed with Dr. Agbunag that Petitioner's patient records were insufficient to justify the procedure code and higher level of service claimed by

Petitioner. Specifically, Dr. Edgar presented persuasive evidence that a number of paid claims, which Petitioner billed under CPT codes 99215, 99223, 99232, 99233, and 99238, were properly adjusted to CPT code 90862. Petitioner was not entitled to bill at a higher level of reimbursement because he failed to adequately document as to history, examination, medical decision-making, and time.

49. Dr. Edgar agreed that, upon reconsideration, Petitioner's claim for Recipient 14, date of service September 7, 1998, billed under CPT code 99238, was appropriate.

50. As to Recipient 1, date of service March 9, 1999, Petitioner was not entitled to bill for services using CPT code 99255, initial inpatient consultation for a new or established patient. CPT code 99222, initial hospital care, per day, for the E/M of a new or established patient, was more appropriate because Petitioner provided the consultation for one of his established patients. His services included a comprehensive history, a comprehensive examination, and medical decision making of moderate complexity.

51. An independent analysis of the selection of the random sample, the statistical formula used by Respondent, and the statistical calculation used to determine the overpayment, confirms the conclusions in the FAAR. The greater weight of the

evidence indicates that Respondent properly extrapolated the results from the sample to the total population.

52. Out of a population of 222 recipients and a population of 2,123 claims, 30 recipients selected at random with 282 paid claims capture most of the characteristics of the total population. In this case, the statistical evidence indicates that 29 of the 30 recipients had overpayments. The odds that 29 out of 30 randomly selected recipients would have overpayments, if no overpayments existed, are greater than the odds of winning the Florida Lotto Quick Pick three weeks in a row. In fact, within a statistical certainly, the amount claimed in this cause based on the records of 30 recipients is lower than the reimbursement amount that Petitioner would owe if all records were reviewed.

53. Respondent incurred costs during the investigation of this matter. The amount of those costs was not known at the time of the formal hearing.

CONCLUSIONS OF LAW

54. The Division of Administrative Hearing has jurisdiction over the parties and the subject matter of this proceeding. See §§ 120.569 and 120.57(1), Fla. Stat.

55. Respondent has the burden of proving by a preponderance of the evidence that Petitioner has been overpaid for Medicaid services delivered to Medicaid recipients. South

Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440 (Fla. 3rd DCA 1995).

56. Section 409.907, Florida Statutes, governs Medicaid provider agreements, which require the provider to comply with all state and federal laws that relate to the Medicaid program. See § 409.907(1), Fla. Stat.

57. Section 409.907(2), Florida Statutes, states as follows in pertinent part:

> (2) The provider agreements are voluntary contracts between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program . . . and the agency agrees to pay a sum, as determined by fee schedule, payment methodology, or other manner, for the service or goods provided to the Medicaid recipient.

58. The agreements require providers to "retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the agency." See § 409.907(3)(c), Fla. Stat. The agreements also require providers to "[p]ermit the agency . . . access to all Medicaid-related information . . . and other information pertaining to services or goods billed to the Medicaid program. . . ." See § 409.907(3)(e), Fla. Stat.

59. Section 409.913, Florida Statutes, which relates to Respondent's oversight of the integrity of the Medicaid program, states that:

> 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.

60. Section 409.913(1)(d), Florida Statutes, states as follows in pertinent part:

> . . . For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

61. "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." See § 409.913(1)(e), Fla. Stat.

62. Section 409.913(2), Florida Statutes, states as follows:

> (2) The agency shall conduct, or cause to be conducted by contract or otherwise, review, investigation, 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.

63. 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:
>
> * * *
>
> (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.

64. Section 409.913(9), Florida Statutes, states as follows in relevant part:

> (9) 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. . . The provider is responsible for

> furnishing to the agency, and keeping the agency informed of the location of, the provider's Medicaid-related records.

65. Respondent has authority to require a provider to repay amounts received for goods and services that are inappropriate, medically unnecessary, or excessive. See § 409.913(11), Fla. Stat.

66. Section 409.913(15), Florida Statutes, states as follows in relevant part:

> (15) The agency may seek any remedy provided by law . . . if:
>
> * * *
>
> (d) The provider has failed to maintain medical records made at the time of service, or prior to service if prior authorization is required, demonstrating the necessity and appropriateness of the goods or services rendered;
>
> (e) The provider is not in compliance with provision of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; . . . with provisions of the provider agreement between the agency and the provider . . . .;
>
> * * *
>
> (h) The provider or an authorized representative of the provider, or a person who ordered or prescribed the goods or services, has submitted or caused to be submitted false or a pattern of erroneous Medicaid claims.
>
> * * *

> (n) The provider fails to demonstrate that it had available during a specific audit or review period sufficient quantities of goods, or sufficient time in the case of services, to support the provider's billings to the Medicaid program.

67. In the instant case, Respondent made its determination of overpayment to Petitioner using accepted and valid auditing, accounting, and analytical review methods as required by Section 409.913(20), Florida Statutes. Regarding the audit report and agency work papers, Section 409.913(22), Florida Statutes, states as follows:

> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, 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 notices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

68. "Recoupment" means "the process by which the department recovers an overpayment or inappropriate overpayment from a Medicaid provider." See Fla. Admin. Code Rule, 59G-1.010.

69. As stated in Full Health Care, Inc. v. 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. (Emphasis included)

70. In this case, Respondent met its prima facie burden of proving that Petitioner received an overpayment in the amount of $39,055.34 less an adjustment for the claim for Recipient 14, date of service September 7, 1998. Petitioner, on the other hand, presented no persuasive evidence to the contrary. In fact, he presented no documentation to support his position regarding the time he spent providing treatment to established patients in his office or in a hospital.

71. Petitioner presented no persuasive evidence that Respondent's statistical formula, data, or calculations are invalid. To the contrary, Respondent made its determination of overpayment to Petitioner using accepted and valid auditing, accounting, and analytical review methods as required by Section 409.913(20), Florida Statutes.

72. The Limitations Handbook includes the following: (a) a definition of "consultative services" and a description of the minimum documentation required to be included in the recipient's record; (b) a policy requiring psychiatric services provided to hospital patients to be billed using psychiatric procedure and diagnosis codes; (c) a policy requiring that only one unit of service may be billed on one line of the claim form; and (d) a policy prohibiting reimbursement for psychiatric services rendered in a custodial care facility, including assisted living facilities or ACLFs. There is no persuasive evidence that Respondent improperly applied these or any other Medicaid policy provisions to the disputed claims in the instant case.

73. Respondent cites Section 409.913(23), Florida Statutes, in support of its Motion for Costs. That statutes provides as follows:

> (23)(a) In an audit or investigation of a violation committed by a provider which is conducted pursuant to the section, the agency is entitled to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.
>
> (b) The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. The amount of costs that may be recovered must be reasonable in relations to the seriousness of the violation and must be set taking into consideration the financial resources, earning ability and needs of the provider,

> who has the burden of demonstrating such factors.
>
> (c) The provider may pay the costs over a period to be determined by the agency if the agency determines that an extreme hardship would result to the provider from immediate full payment. Any default in the payment of costs may be collected by any means authorized by law.

See § 409.913(23), Fla. Stat.

74. Respondent did not renew its request for costs in its Proposed Recommended Order. There is no authority in Section 409.913(23), Florida Statutes, for the an Administrative Law Judge to retain jurisdiction on the issue of Respondent's costs. See Meji, Inc., d.b.a. 7th Avenue Pharmacy, DOAH Case No. 03-1195MPI (Recommended Order, July 15, 2003). Rather, Respondent, once it has "ultimately prevailed" in this case, may then determine the amount of its costs and assess them against Petitioner. Should Petitioner dispute Respondent's determination and raise disputed issues of material fact, the matter may then be referred by Respondent to the Division of Administrative Hearings.

RECOMMENDATION

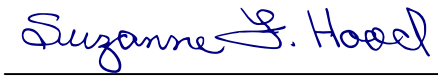
Based on the forgoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED:

That Respondent enter a final order finding that Petitioner owes Respondent for an overpayment in the amount of $39,055.34,

less an adjustment for the September 7, 1998 claim for Recipient 14, plus interest.

DONE AND ENTERED this 25th day of March, 2005, in Tallahassee, Leon County, Florida.



SUZANNE F. HOOD
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 25th day of March, 2005.

COPIES FURNISHED:

Alan Levine, Secretary
Agency for Health Care Administration
Fort Knox Building III
2727 Mahan Drive, Suite 3116
Tallahassee, Florida 32308

Valda Clark Christian, General Counsel
Agency for Health Care Administration
Fort Know Building III
2727 Mahan Drive, Suite 3431
Tallahassee, Florida 32308

Debora E. Fridie, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station 3
2727 Mahan Drive, Suite 3431
Tallahassee, Florida 32308

John D. Buchanan, Jr., Esquire
Henry, Buchanan, Hudson,
  Suber & Carter, P.A.
117 South Gadsden Street
Post Office Box 1049
Tallahassee, Florida 32302

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.