STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MEDICAL SERVICES CONSORTIUM, INC., d/b/a MEDICAL SERVICES CONSORTIUM Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 04-4450MPI

RECOMMENDED ORDER

Pursuant to notice a formal hearing was held in this case on October 3, 4, and 5, 2005, in Tallahassee, Florida, before Administrative Law Judge Claude B. Arrington of the Division of Administrative Hearings (DOAH).

APPEARANCES

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STATEMENT OF THE ISSUE

Whether Petitioner failed to maintain required records to support and document Medicaid prescription claims paid by the Medicaid program for the audit period (June 24, 1998, to June 1, 2000). If so, whether Petitioner received overpayments from the Medicaid program. If so, whether extrapolation was appropriately used to determine the amount of that overpayment (alleged by Respondent to be $1,053,137.49).

PRELIMINARY STATEMENT

On April 9, 2001, Respondent's Office of Medicaid Program Integrity (OMPI) issued the Final Agency Audit Report (FAAR) that underpins this proceeding. The FAAR alleged that for the audit period, Petitioner had been overpaid by the Medicaid program in the amount of $3,946,215.96. Petitioner timely challenged the allegations of the FAAR, and the matter was referred to DOAH, where it was assigned DOAH Case No. 03-2436MPI.

Respondent has not alleged, and there is no evidence to suggest, fraud on Petitioner's part.

The FAAR contained the following reference to a procedure the parties referred to as "extrapolation":

> 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.

Respondent contracted with Heritage Information Systems, Inc. (Heritage) to conduct the field work for the audit. After Heritage completed its work, Respondent prepared the subject FAAR. After the FAAR, Petitioner submitted additional documentation to Respondent. Based on that documentation, Respondent reduced the amount of the alleged overpayment to the sum at issue.

On October 21, 2003, Petitioner filed a pleading styled "Motion in Limine and Motion for Stay Pending Ruling in the First District Court of Appeal on Controlling Issues." Respondent thereafter filed notice that it did not oppose the motion to stay. The purpose of the stay was to obtain a ruling in another case [Agency for Health Care Administration v. Colonial Cut-Rate Drugs, Inc., 878 So. 2d 479 (Fla. 1st DCA 2004)] that the parties believed would impact the issues involved in DOAH Case No. 03-2436MPI. Based on the unopposed motion to stay, on October 27, 2003, the undersigned entered an order that closed DOAH Case No. 03-2436MPI.

The Colonial, supra, decision was entered at the end of July 2004. Thereafter, the parties continued to debate the implications of the appellate decision. On December 13, 2004,

Respondent filed an unopposed motion to reopen this proceeding. On December 14, 2004, the undersigned granted the motion to reopen, and this proceeding was reopened under DOAH Case No. 04-4450MPI.

On December 23, 2004, Petitioner filed a lengthy Motion in Limine seeking to exclude all evidence of an overpayment that had been calculated by the use of extrapolation. Respondent thereafter filed a lengthy response in opposition to Petitioner's Motion in Limine. Following a hearing by teleconference call the undersigned entered an Order Denying [Petitioner's] Motion in Limine on January 28, 2005. That order rejected Petitioner's contention that extrapolation cannot be used to calculate an overpayment under the circumstances of this case. That ruling was consistent with the ruling made by Administrative Law Judge J. D. Parrish involving nearly identical circumstances in DOAH Case 03-3238MPI (Compscript, Inc., d/b/a Compscript v. Agency for Health Care Administration).[1]

The Pre-Hearing Stipulation filed by the parties on September 29, 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 six-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.

At the final hearing, Respondent presented the testimony of Dana Kenneth Yon (the OMPI program administrator for pharmacies); Mark Tripodi (vice-president of Heritage); Mark Snapp (an auditor employed by Heritage); John Dennis Taylor (a pharmacist and former executive director of the Board of Pharmacy); Ramona Stewart (a pharmacist employed by Respondent); JoAnn Jackson (a pharmacist employed by Respondent); Robert D. Pierce (a statistics expert employed by MPI); and Mark E. Johnson, Ph.D. (an expert in sampling and analysis). Respondent offered 45 sequentially-numbered exhibits, each of which was admitted into evidence.

Petitioner offered the testimony of Jerry Kelly (a pharmacist employed by Petitioner's parent corporation); Lynn D'Avico (a consulting pharmacist); and Michael Intriligator, Ph.D. (an expert in sampling and analysis). Petitioner offered 35 sequentially-numbered exhibits, each of which was admitted into evidence. Petitioner's exhibits included depositions of Ramona Stewart and Douglas Y. Rowland, Ph.D. (a consultant for Heritage in the area of statistics).

Both parties timely submitted Proposed Recommended Orders, which 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.

Unless otherwise noted, all references to statutes or rules are to the version of the statute or rule in effect at the time of the subject audit.

FINDINGS OF FACT

PETITIONER

1. At all times relevant to the allegations of this case, the Petitioner was licensed pursuant to Chapter 465, Florida Statutes, to provide pharmacy services in Florida with pharmacy license number PH0012223.

2. At all times relevant to this proceeding, Petitioner was an authorized Medicaid provider with provider number 102126500.

3. At all times relevant to this proceeding, Petitioner had a valid Medicaid Provider Agreement with Respondent.

4. During the audit period, Petitioner provided pharmacy services to Medicaid recipients and billed those services to the Medicaid program under its Medicaid provider number. Specifically Petitioner sold or dispensed drugs to Medicaid recipients who resided in nursing homes. Petitioner operated solely to serve nursing home populations.

5. Petitioner usually received pharmacy orders by telephone or facsimile transmission from a nursing home.

Typically, the staff at Petitioner's facility would take the call or receive the facsimile transmission, write down the pertinent information, enter the data into the pharmacy's computer system, dispense the item, and route the drugs to the nursing home via courier. All drugs are dispensed in sealed containers and are delivered with a manifest listing all the medications by name and patient.

6. Jerry Kelly, a pharmacist employed by Petitioner's parent corporation, described how nursing home orders or prescriptions were obtained and taken, beginning on line 11, page 716, of Volume VI of the hearing transcript:

> A. The vast majority, probably 90, 95 percent, are faxed over from the nursing home by nurses. A few may be called in with the nurse acting under the regulatory authority to act as the agent of the physician. These orders are then reviewed by the pharmacist. An order issue technician will enter that information into the computer, creating the original prescription.[2] The pharmacist then checks that data that was entered into the prescription to make sure all elements are there and the order entry is correct. Labels are then printed, which go to the floor to be filled by technicians. The pharmacist then checks the final product. That product is sent to a staging area where delivery manifests are printed. Those orders are then checked off the delivery manifest to make sure that no orders have been missed. The tote is sealed and then delivered to a nursing home by courier service.
>
> At the nursing home, the nurse and the driver check these orders off together, both

> sign that delivery manifest, and a copy of that delivery manifest comes back to the pharmacy.
>
> Q. Can you explain to the Court the typical process at [Petitioner's parent corporation] by which refills, so to speak, are received and handled.
> A. Back then refills were handled by pulling a label off of the prescription container, apply it to a refill order sheet or a piece of paper of any kind that would fax . . . those are faxed to the pharmacy, those labels are pulled and faxed to the pharmacy by a nurse acting again under the regulatory authority of a -- to act as the agent of the physician. That's also verifying to us that those orders are continued for another month. The prescription number is put in by an order entry tech. Those labels are printed and filled.
> From there on, the process is exactly the same.

7. Prior to the audit period, Petitioner was purchased by another corporation. Subsequent to the audit, Petitioner ceased to operate as a pharmacy.

RESPONDENT

8. Respondent is the state agency charged with the responsibility and authority to administer the Medicaid program in Florida. Respondent's OMPI is responsible for overseeing the integrity of the Medicaid program in Florida. Pursuant to this authority Respondent's OMPI oversees 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, Respondent paid Medicaid claims submitted by Medicaid providers and then, after-the-fact, OMPI audited such providers for accuracy and quality control. These integrity audits are to assure that the provider maintains records to support the paid claims.

HERITAGE

10. In 1999 OMPI contracted with Heritage through Consultec, L.L.C. (Medicaid's fiscal agent), to perform and report pharmacy audits of pharmacy providers within the state. Auditors from Heritage were assigned Petitioner's audit. The Heritage employees in charge of the subject audit were experienced and appropriately trained.

THE AUDIT

11. Respondent's audit no 01-1017-00-3/H/JDJ reviewed Petitioner's Medicaid claims paid by Respondent for the period June 24, 1998, through June 1, 2000.

12. Ken Yon is the OMPI administrator who was responsible for managing the instant case and who worked with the Heritage auditors to assure the policies and practices of Respondent were met. In this case, the Heritage auditors presented at

Petitioner's facility unannounced on July 31, 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 139,036 claims (the total number of claims that the Petitioner submitted during the audit period).

13. For the universe of 139,036 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 extrapolating a sample of 250 claims to the universe of 139,036 claims would be statistically valid if the sampled claims were randomly chosen. The 250 sample claims selected for the subject audit were randomly chosen.

14. Heritage asked the Petitioner to present prescription records it was required to retain to support the claims for the audit period. Petitioner offered the auditors its computerized records for many of the 250 samples in lieu of the hard copies the auditors requested. The auditors refused to accept the computerized records and, as reflected by the Audit Report, Petitioner was unable to produce acceptable evidence of prescriptions for a great many of the 250 samples.[3]

15. The auditors found that 171 of the 250 claims sampled were discrepant, in that they did not meet standards for

payment. The auditors analyzed the number of discrepant claims and determined that the average overcharge per sampled claim was $36.3434 (sic). Multiplying the number of claims in the universe by that average yielded an initial estimate of the overcharge in the amount of $5,053,040.96. The 95% one-sided, lower-confidence limit[4] for the initial estimate was determined to be $3,946.215.96, which is the amount of the overpayment alleged in the FAAR.

THE FAAR AND SUBSEQUENT COMPUTATIONS

16. After the auditors completed their review of the records at Petitioner's facility, JoAnn Jackson, a licensed pharmacist with extensive experience in auditing pharmacies, was assigned by Respondent to review Heritage's audit report and to prepare the Respondent's FAAR. The vast majority of the discrepant claims (165 of the 171) were categorized as CF, which meant that the auditors could not find required documentation of the subject prescription or could not find required documentation for the refill of a prescription.

17. These findings were reported to the Petitioner, who was given additional time to locate and produce documents to support the claims. Respondent was willing to accept documentation for claims up through the time of hearing.[5] Based on additional documentation submitted by Petitioner after the auditors had completed their field work, Respondent's staff

recalculated the amount of the overpayment by the use of extrapolation (including the reduction of the initial estimate to the 95% one-sided, lower confidence limit) to be the amount of $1,053,137.49, which is the amount of the overpayment at issue at the formal hearing. Respondent established that each alleged discrepant claim that it used to recalculate the amount of the overpayment was, in fact, discrepant and did not meet Medicaid record-keeping standards.

RECORD RETENTION REQUIREMENTS

18. Although Petitioner's manner of doing business was different from the conventional pharmacy (the so-called corner drugstore), it was subject to the same Medicaid records retention requirements as a conventional pharmacy that serves as a Medicaid provider.

19. Pursuant to the applicable Medicaid Provider Agreement between Petitioner and Respondent, Petitioner was to comply with all Medicaid handbooks in effect during the audit period. Petitioner was also required to comply with all applicable state and federal Medicaid Program rules and laws in effect during the audit period.

20. For each claim submitted during the audit period by Petitioner to Respondent for payment under the Medicaid Program, Petitioner was required to "keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-

related records as Respondent requires for a period of at least five (5) years." Petitioner was also required to make these supporting records available to Respondent upon Respondent's request.

21. A Medicaid provider must retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient. In addition to the foregoing, a Medicaid provider must maintain a patient record for each recipient for whom new or refill prescriptions are dispensed. Specific to the issues of this case, a Medicaid provider must retain prescription records for five years from the date the prescription was last filled or refilled. For the audit period in this case, the prescription that authorized the dispensing of each drug for which Petitioner claimed payment under the Medicaid program should have been maintained and made available for the auditors since each prescription would have been within the five-year period.

22. 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.

23. Applicable records that must be kept for quality control so that an after-the-fact audit can verify the integrity of the Medicaid claims that were paid by Respondent.

24. 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.

25. 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.

26. At the times relevant to this proceeding, Florida Administrative Code Rule 64B16-28.140(1)(d) and (e), provided, in part, as follows:

> (d) Original prescriptions . . . shall be reduced to writing if not received in written form. All original prescriptions shall be retained for a period of not less than two years from date of last filling. To the extent authorized by 21 C.F.R. Section 1304.04, a pharmacy may, in lieu of retaining the actual original prescriptions, use an electronic imagining record keeping system, provided such system is capable of capturing, storing, and reproducing the exact image of the prescription, including the reverse side of the prescription if

> necessary, and that such image be retained for a period of no less than two years from the date of the last filling.
>
> (e) Original prescriptions shall be maintained in a two or three file system as specified in 21 C.F.R. 1304.04(h).

PETITIONER'S COMPUTERIZED RECORDS

27. There was a dispute between the parties as to whether Petitioner's computer records should have been accepted as evidence that valid prescriptions underlie each dispensed drug within the sample. That dispute is resolved by finding that the computer records maintained by the Petitioner did not retain 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.

28. An electronic system must be able to produce a contemporaneous hard-copy printout of all original prescriptions dispensed and refilled. The original prescriptions must be maintained in a two or three file system as specified in 21 C.F.R. 1304.04(h). If the Petitioner's system could do that, it did not.

29. Fundamentally, a Medicaid claim for a drug that has been dispensed by a Medicaid provider must have as its basis a valid prescription. While Petitioner's computer records

established what drugs had been dispensed, those records did not meet the requirements for establishing that the drugs were dispensed pursuant to valid prescriptions.

OVERPAYMENT

30. Any Medicaid providers not in compliance with the Medicaid documentation and record retention policies may be subject to the recoupment of Medicaid payments. As set forth in the Conclusions of Law section of this Recommended Order, the term "overpayment" is defined by Section 409.913(1)(d), Florida Statutes (2000).

EXTRAPOLATION

31. At hearing, 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. Extensive testimony was taken as to the extrapolation process used in this proceeding. Respondent 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. All testimony, including the testimony of Dr. Intriligator, has been fully considered in the findings reached in this case.

32. 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 case. The only way to determine the amount of the actual overpayment is to examine each of the 139,036 claims that were made during the audit period. Dr. Johnson's testimony established that the probability is overwhelming that the amount of the alleged overpayment is substantially less than the actual overpayment.

33. Respondent established that Petitioner received an overpayment during the audit period as alleged in the FAAR and it established that the amount of the overpayment is at least $1,053,137.49.

CONCLUSIONS OF LAW

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

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

36. 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).

37. Petitioner does not dispute Respondent's authority to perform audits such as the one at issue. Petitioner maintains its records are sufficient to support the paid claims and that Respondent has unreasonably imposed its interpretation of the requirements. An agency's interpretation of statutes and rules it is required to enforce is entitled to deference unless the interpretation contradicts the plain meaning of the statute or is clearly erroneous or contrary to law. See Level 3 Communications, LLC v. Jacobs, 841 So. 2d 447 (Fla. 2003) and Osorio v. Board of Professional Surveyors and Mappers, 898 So. 2d 188, (Fla. 5th DCA 2005). No such conflict exists here. The undersigned is constrained to give deference to Respondent's position that Petitioner's computer records do not constitute prescriptions.

38. 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:

* * *

(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. . . .

* * *

(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. . . .

39. 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 . . .
>
> * * *
>
> (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.

40. 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).

41. During the audit period Respondent paid the Petitioner for all Medicaid claims at issue in this proceeding. Respondent honored the claims submitted by Petitioner. Through the audit

process, the Agency attempted to verify that those claims were supported by the documentation required by law.

42. 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.

43. 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. 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, Respondent is attempting to collect monies paid to a provider who cannot produce the documentation to support the paid claim because it did not comply with its agreement to maintain appropriate records. In complying with its mandate from the federal government, Respondent is held to a high standard and must assure that overpayments are recouped. See 42 C.F.R. § 433.312(a)(2).

44. 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.

45. Respondent has met its burden of proof in this case and has established by a preponderance of the evidence that the Petitioner received overpayments in an amount greater than $1,053,137.49. Moreover, it is further concluded that 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 Respondent 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 finds that Petitioner has received an overpayment from the Medicaid program in the amount of $1,053,137.49. It is further recommended that the final order require Petitioner to repay that overpayment.

DONE AND ENTERED this 28th day of February, 2006, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
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Filed with the Clerk of the
Division of Administrative Hearings
this 28th of February, 2006.

ENDNOTES

[1/] The are no material differences between the issues and facts of this proceeding and those of DOAH Case No. 03-3238MPI. On December 9, 2005, Respondent entered a Final Order in DOAH Case No. 03-3238MPI based on Judge Parrish's Recommended Order dated October 6, 2005. From DOAH's docket sheet for DOAH Case No. 03-3238MPI, it appears that the Final Order in that proceeding has been appealed to the First District Court of Appeal. Prior to the entry of a Final Order in this proceeding, Respondent should determine the status of that appeal and whether the opinion, if issued, would impact the issues in this proceeding. The undersigned adopts the rationale expressed by Judge Parrish in her Order entered October 22, 2004, in concluding that extrapolation is not prohibited by the provisions of Section 465.188, Florida Statutes (2004) because the claims were submitted for payment prior to the date more stringent audit standards set forth in that statute are to apply (July 11, 2003), and because Respondent seeks an overpayment in this proceeding, not the imposition of penalties. The undersigned has also followed the general format of Judge Parrish's Recommended Order in DOAH Case No. 03-3238MPI and has adopted many of her conclusions of law.

[2/] In a pharmacy setting where a practitioner faxes or calls in a prescription, only a pharmacist or a pharmacist intern working under the supervision of a pharmacist can create a prescription. See Fla. Admin. Code R. 64B16-27.103.

[3/] Many of the records that were subsequently accepted by Respondent to reduce the amount of the alleged overpayment were nursing home records that Petitioner obtained and delivered to Respondent after the auditors had completed their field work. These records included physician order sheets and medication administration records.

[4/] This is an accepted statistical process that is used in extrapolation to reduce the initial estimate of an overpayment to a figure that has a high degree of probability of being less than the amount of the actual overpayment had that overpayment been calculated by examining each of the 139,036 claims made. Such a reduction works to the advantage of the provider.

[5/] As of May 25, 2005, Petitioner had either provided Respondent (or Respondent's authorized representative) with all the Medicaid-related records and information supporting each claim submitted by Petitioner to Respondent during the audit period or had concluded that it would be unable to obtain those records.

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.