STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 06-4290MPI

RICARDO L. LLORENTE,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a hearing was held in this case pursuant to Sections 120.569 and 120.57(1), Florida Statutes,[1] on January 29, 2007, in Tallahassee, Florida, before Stuart M. Lerner, a duly-designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Tracie L. Wilks, Esquire
Jeffries H. Duvall, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

For Respondent: Patrick A. Scott, Esquire
2800 Miami Center
201 South Biscayne Boulevard
Miami, Florida 33131-4330

STATEMENT OF THE ISSUES

1. Whether Medicaid overpayments were made to Respondent and, if so, what is the total amount of those overpayments.

2. Whether, as a "sanction," Respondent should be directed to submit to a "comprehensive follow-up review in six months."

PRELIMINARY STATEMENT

By letter dated June 29, 2004 (Final Agency Audit Report), the Agency for Health Care Administration (AHCA) advised Respondent, a physician participating in the Medicaid program, that, following a "review of [Respondent's] Medicaid claims for the procedures specified [in the letter] for dates of service during the period January 1, 2000, through December 31, 2001" (Audit Period), AHCA had determined that Respondent had been "overpaid $80,788.23 for services that in whole or in part [were] not covered by Medicaid." The letter further provided, in pertinent part, as follows:

> Be advised that pursuant to Section 409.913(22)(a), F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs. Additionally, pursuant to Section 409.913, Florida Statutes (F.S.), this letter shall serve as notice of the following sanction(s): The provider is subject to a comprehensive follow-up review in six months.
>
> * * *
>
> You have the right to request a formal or informal hearing pursuant to section 120.569, F.S. . . . .

AHCA first referred the matter to the Division of Administrative Hearings (DOAH) on December 20, 2004, requesting the assignment of a DOAH Administrative Law Judge to conduct a

"formal administrative hearing." The case was docketed by DOAH's Clerk as DOAH Case No. 05-0012MPI and assigned to the undersigned.

The final hearing in DOAH Case No. 05-0012MPI was twice continued. On June 1, 2005, in response to Respondent's unopposed request that the final hearing be continued a third time (to give the parties "extra time . . . for meaningful discovery"), the undersigned issued an order closing the file in DOAH Case No. 05-0012MPI and relinquishing jurisdiction to AHCA, "without prejudice to the matter being returned to the Division of Administrative Hearings, upon the request of either party."

On or about October 30, 2006, after receiving from Respondent an "amended petition for a hearing involving disputed issues of material fact," AHCA referred the matter back to DOAH. A new case number, DOAH Case No. 06-4290MPI, was assigned by DOAH's Clerk.

On November 17, 2006, the undersigned issued a Notice of Hearing, setting the hearing in the instant case for January 29 through 31, 2007, and February 1, 2007. On December 28, 2006, Respondent filed a motion requesting that the hearing be continued to give his counsel of record (who had been representing him since April 29, 2005) more time to "identify and locate a witness" and otherwise "properly prepare" for hearing. On December 29, 2006, AHCA filed a response to the

motion, opposing the requested continuance. On December 31, 2006, it filed an "addendum" to its response. On January 4, 2007, Respondent filed a motion to strike this "addendum." A hearing on Respondent's motion to strike and motion for a continuance was held by telephone conference call on January 5, 2007. On January 8, 2007, the undersigned issued an order on these motions, which provided as follows:

> Upon consideration, it is hereby ORDERED:
>
> 1. Respondent's motion to strike the "addendum" to Petitioner's response is denied. See Wal-Mart Stores, Inc. v. Ballasso, 789 So. 2d 519 (Fla. 1st DCA 2001)(Section 90.408, Florida Statutes, "exclude[s] statements made in settlement negotiations only where offered to prove liability.").
>
> 2. Regardless of whether the contents of the "addendum" are considered, Respondent has failed to make the requisite showing of good cause in support of his motion for a continuance. Accordingly, the motion is denied. § 409.913(31), Fla. Stat. ("If a provider requests an administrative hearing pursuant to chapter 120, such hearing must be conducted within 90 days following assignment of an administrative law judge, absent exceptionally good cause shown as determined by the administrative law judge or hearing officer."); and United States v. Robbins, 197 F.3d 829, 847 (7th Cir. 1999)("The possibility that an investigator would find information to destroy the credibility of Osborne, a key government witness, is speculative and is an insufficient basis on which to demand a continuance.").

On January 22, 2007, the parties filed a Joint Prehearing Stipulation, which provided, in pertinent part, as follows:

> A. STATEMENT OF THE NATURE OF THE CASE
>
> The Respondent, at all times material hereto, was a health care provider in the State of Florida, and was enrolled as a Medicaid provider.
>
> 1. The Respondent was notified by the Agency by a Provisional Agency Audit Report dated July 7, 2003, of a determination of an overpayment to the Respondent for services provided to Medicaid recipients covering the period January 1, 2000 through December 31, 2001 (the "Audit Period"). This letter indicated that the Respondent had submitted claims and had been overpaid in the amount of $80,788.23 for services that, in whole or in part, were not covered by Medicaid. Following receipt of the Provisional Agency Audit Report, the Respondent was given the opportunity to submit additional information which could result in a reduction in the provisional determination of overpayment.
>
> 2. Respondent submitted additional documentation in response to the Provisional Agency Audit Report. However, the Agency did not accept this second set of documents provided, as the Agency determined that the records were not made contemporaneously with the services provided as required by § 409.913(7), Florida Statutes.
>
> 3. On June 29, 2004, the Respondent was notified by a Final Agency Audit Report ("FAAR") of a determination of overpayment to Respondent for services provided to Medicaid recipients covering the Audit Period. This letter indicated that the Respondent had submitted claims and had been overpaid in the amount of $80,788.23 for services that, in whole or in part, were not covered by Medicaid.

4. The Respondent has appealed the agency action of June 29, 2004, and sought an administrative hearing pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes.

B. BRIEF STATEMENT OF EACH PARTY'S POSITION

Petitioner's Position

The Agency's position is that the FAAR of June 29, 2004, reflects a proper application of the provisions of section 409.913; the amount of $80,788.23 is a correct computation of the overpayment to the Respondent; and the Agency is entitled to recoup the overpayment plus all investigative, legal, and expert witness costs.

Respondent's Position

The Respondent denies being overpaid in the amount of $80,788.23. Dr. Llorente submitted two sets of photocopies in response to the Agency's request for supporting documentation for the dates of service included in the cluster sample. The first set of copies was submitted in or about March 2003. The second set of photocopies was submitted in or about September 2003. The appearance of virtually every photocopy in the second set is inconsistent with the corresponding photocopy in the first set. Specifically, more notations appear on the front of the photocopies in the second set than in their respective photocopy records in the first set. Further, while there is no writing on the back sides of the pages in the first set of photocopies, writing appear[s] on the back sides of many corresponding photocopies in the second set. Dr. Llorente contends that the second set of photocopies more accurately reflects his original records. The Agency contends that the inconsistency

between the two sets of photocopies results from non-contemporaneous documentation added to the second set of photocopies. Dr. Llorente contends that the inconsistencies were the result of bad photocopying.

* * *

D. STATEMENT OF ADMITTED FACTS.

1. Respondent has operated as an authorized Medicaid provider, and has been issued the Medicaid provider number 370947700.

2. During the Audit Period, the Respondent had a valid Medicaid provider agreement with the Agency.

3. For services provided during the Audit Period, the Respondent received in excess of $80,788.23 in payments for services to Medicaid recipients.

4. The Respondent agrees that valid mathematical and statistical computations were utilized in the audit. However, it is not agreed that the empirical data utilized were correct.

F. STATEMENT OF AGREED ISSUES OF LAW.

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

2. Venue for this proceeding is in Leon County, Florida, or such other place as designated by the Administrative Law Judge.

3. The Agency for Health Care Administration is an executive agency created by Sections 20.42 and 23.21, Florida Statutes.

4. The Agency for Health Care Administration has the responsibility for

overseeing and administering the Medicaid Program for the State of Florida.

5. The Agency has the burden of proof in this proceeding and must show by a preponderance of the evidence that there exists an overpayment to the [Respondent].

6. All pleadings were timely and appropriately filed in this matter.

G. STATEMENT OF FACTS REMAINING TO BE LITIGATED

1. Whether the Respondent was overpaid $80,788.23 for certain claims for services during the audit period of January 1, 2000, through December 31, 2001, that in whole or in part are not covered by Medicaid.

2. Whether the Agency has incurred investigative, legal, and expert witness costs, including, but not limited to, employee salaries, employee benefits and out-of-pocket expenses, which the Agency is entitled to recover pursuant to § 409.913, Florida Statutes.

3. Whether Dr. Llorente has incurred attorney's fees which he is entitled to recover.

H. ISSUES OF LAW REMAINING TO BE DETERMINED.

1. Whether applicable Florida Statutes, rules of the Florida Administrative Code, and the applicable Medicaid handbooks permit the Agency to recoup the alleged Medicaid overpayment.

2. Whether any records not made at the time goods and services were provided are admissible in evidence.

*   *   *

After receiving the parties' Joint Prehearing Stipulation the undersigned, on January 23, 2007, issued an Order Directing Filing of Supplement to Joint Prehearing Stipulation, which provided as follows:

> The undersigned['s] having issued a Notice of Hearing (scheduling the instant matter for hearing for January 29, 2007, through February 1, 2007) and an Order of Pre-Hearing Instructions, and having received the parties' Joint Prehearing Stipulation, it is hereby ORDERED, pursuant to Florida Administrative Code Rule[] 28-106.211:
>
> The Joint Prehearing Stipulation submitted by the parties makes reference to a first set and a second set of supporting documentation that Respondent provided Petitioner. The parties shall file, no later than the commencement of the final hearing in this case, a supplement to their Prehearing Stipulation, in which they identify, by patient and date of service, those instances, if any, where these first and second sets of supporting documentation, with respect to a particular disputed cluster sample claim, are identical. (In other words, if that portion of the second set of supporting documentation pertaining to a particular claim in dispute merely duplicates, and does not add to, what is in the first set of supporting documentation, that claim should be listed by the parties in their supplement.)

On January 26, 2007, the parties filed a pleading containing the following additional stipulation:

> The parties stipulate that the only instances where the first and second sets of supporting documentation, with respect to the disputed sample claims, are identical are the progress notes for recipient 21's

January 8, 2001 and March 5, 2001 dates of service.

As noted above, the final hearing commenced and concluded on January 29, 2007. The live testimony of two witnesses, AHCA Program Analyst Theresa Mock (testifying on behalf of AHCA) and Respondent (testifying on his own behalf), was presented at the hearing. In addition to this live testimony, 29 exhibits (Petitioner's Exhibits 1 through 27,[2] and 31, and Respondent's Exhibit 1) were offered and received into evidence.

At the close of the evidentiary portion of the hearing on January 29, 2007, the undersigned set the deadline for the filing of proposed recommended orders at 60 days from the date of the filing of the hearing transcript with DOAH, as requested by the parties.[3]

The hearing Transcript (consisting of one volume) was filed with DOAH on February 14, 2007. Accordingly, proposed recommended orders were due on Monday, April 16, 2007, in accordance with Florida Administrative Code Rule 28-106.103. AHCA and Respondent timely filed their Proposed Recommended Orders on April 13, 2007, and April 16, 2007, respectively.

FINDINGS OF FACT

Based upon the evidence adduced at hearing, and the record as a whole, the following findings s of fact are made to supplement and clarify the factual stipulations set forth in the

parties' Joint Prehearing Stipulation and their January 26, 2007, pleading:[4]

Respondent and his Practice

1. Respondent is a pediatric physician whose office is located in a poor neighborhood in Hialeah, Florida.

2. He has a very busy practice, seeing approximately 50 to 60 patients each day the office is open.

3. Respondent documents patient visits by making handwritten notations on printed "progress note" forms.

4. Because of the fast-paced nature of his practice, he does not always "have time to write everything as [he] would like, because [there] is too much" for him to do.

Respondent's Participation in the Medicaid Program

5. During the Audit Period, Respondent was authorized to provide physician services to eligible Medicaid patients.

6. Respondent provided such services pursuant to a valid Provider Agreement (Provider Agreement) with AHCA, which contained the following provisions, among others:

> The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:
>
> * * *
>
> (2) Quality of Services. The provider agrees to provide medically necessary services or goods of not less than the scope and quality it provides to the general public. The provider agrees that services

or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with the Agency. The services or goods must have been actually provided to eligible Medicaid recipients by the provider prior to submitting the claim.

(3) Compliance. The provider agrees to comply with all local, state and federal laws, rules, regulations, licensure laws, Medicaid bulletins, manuals, handbooks and Statements of Policy as they may be amended from time to time.

(4) Term and signatures. The parties agree that this is a voluntary agreement between the Agency and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. . . .

(5) Provider Responsibilities. The Medicaid provider shall:

* * *

(b) Keep and maintain in a systematic and orderly manner all medical and Medicaid related records as the Agency may require and as it determines necessary; make available for state and federal audits for five years, complete and accurate medical, business, and fiscal records that fully justify and disclose the extent of the goods and services rendered and billings made under the Medicaid. The provider agrees that only records made at the time the goods and services were provided will be admissible in evidence in any proceeding relating to the Medicaid program.

*   *   *

> (d) Except as otherwise provided by law, the provider agrees to provide immediate access to authorized persons (including but not limited to state and federal employees, auditors and investigators) to all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and all other information pertaining to services or goods billed to the Medicaid program. This shall include access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records.

*   *   *

> (f) Within 90 days of receipt, refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program.

*   *   *

> (i) . . . . The provider shall be liable for all overpayments for any reason and pay to the Agency any fine or overpayment imposed by the Agency or a court of competent jurisdiction. Provider agrees to pay interest at 12% per annum on any fine or repayment amount that remains unpaid 30 days from the date of any final order requiring payment to the Agency.

*   *   *

7. Respondent's Medicaid provider number (under which he billed the Medicaid program for providing these services) was (and remains) 370947700.

Handbook Provisions

8. The handbooks with which Petitioner was required to comply in order to receive Medicaid payment for services rendered during the Audit Period included the Medicaid Provider Reimbursement Handbook, HCFA-1500 (MPR Handbook); Physician Coverage and Limitations Handbook (PCL Handbook); the Early and Periodic Screening, Diagnosis and Treatment Coverage and Limitations Handbook (EPSDTCL Handbook); and the Child Health Check-up Coverage and Limitations Handbook (CHCUCL Handbook).

Medical Necessity

9. The PCL Handbook provided that the Medicaid program would reimburse physician providers for services "determined [to be] medically necessary" and not duplicative of another provider's service, and it went on to state as follows:

> In addition, the services must meet the following criteria:
>
> - the services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
>
> - the services cannot be experimental or investigational;
>
> - the services must reflect the level of services that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available statewide; and

> - the services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered services.
>
> Note See Appendix D, Glossary, in the Medicaid Provider Reimbursement Handbook, HCFA-1500 and EPSDT 224, for the definition of medically necessary.[[5]]

The EPSDTCL and CHCUCL Handbooks had similar provisions.

Documentation Requirements

10. The MPR Handbook required the provider to keep "accessible, legible and comprehensible" medical records that "state[d] the necessity for and the extent of services" billed the Medicaid program and that were "signed and dated at the time of service." The handbook further required, among other things, that the provider retain such records for "at least five years from the date of service" and "send, at his or her expense, legible copies of all Medicaid-related information to the authorized state and federal agencies and their authorized representatives."

11. The MPR Handbook warned that providers "not in compliance with the Medicaid documentation and record retention policies [described therein] may be subject to administrative sanctions and recoupment of Medicaid payments" and that

"Medicaid payments for services that lack required documentation or appropriate signatures will be recouped."

EPSDT Screening/Child Health Check-Up

12. The EPSDTCL Handbook provided:

> To be reimbursed by Medicaid, the provider must address and document in the recipient's medical record all the required components of an EPSDT screening. The following required components are listed in the order that they appear on the optional EPSDT screening form:
>
> - Health and developmental history
> - Nutritional assessment
> - Developmental assessment
> - Physical examination
> - Dental screening
> - Vision screening
> - Hearing screening
> - Laboratory tests
> - Immunization
> - Health education
> - Diagnosis and treatment

13. The CHCUCL Handbook, which replaced the EPSDTCL Handbook in or around May 2000, similarly provided as follows:

> To be reimbursed by Medicaid, the provider must assess and document in the child's medical record all the required components of a Child Health Check-Up. The required components are as follows:
>
> - Comprehensive Health and Developmental History, including assessment of past medical history, developmental history and behavioral health status;
> - Nutritional assessment;
> - Developmental assessment;
> - Comprehensive Unclothed Physical Examination

- Dental screening including dental referral, where required;
- Vision screening including objective testing, where required;
- Hearing screening including objective testing, where required;
- Laboratory tests including blood lead testing, where required;
- Appropriate immunizations;
- Health education, anticipatory guidance;
- Diagnosis and treatment; and
- Referral and follow-up, as appropriate.

Coding

14. Chapter 3 of the PCL Handbook "describe[d] the procedure codes for the services reimbursable by Medicaid that [had to be] used by physicians providing services to eligible recipients."

15. As explained on the first page of this chapter of the handbook:

> The procedure codes listed in this chapter [were] Health Care Financing Administration Common Procedure Coding System (HCPCS) Levels 1, 2 and 3. These [were] based on the Physician[]s['] Current Procedural Terminology (CPT) book.

16. The Current Procedural Terminology (CPT) book referred to in Chapter 3 of the PCL Handbook was a publication of the American Medical Association.

17. It contained a listing of procedures and services performed by physicians in different settings, each identified by a "procedure code" consisting of five digits or a letter followed by four digits.

18. For instance, there were various "procedure codes" for office visits.

19. These "procedure codes" included the following, among others:

> New Patient
>
> * * *
>
> 99204 Office or other outpatient visit for the evaluation and management of a new patient which requires these three key components:
>
> - a comprehensive history;
> - a comprehensive examination; and
> - medical decision making of moderate complexity.
>
> Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
>
> Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.
>
> * * *
>
> Established Patient
>
> * * *
>
> 99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
>
> - an expanded problem focused history;
> - an expanded problem focused examination;
> - medical decision making of low complexity.

Counseling and coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a detailed history;
- a detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

* * *

<u>Fee Schedules</u>

20. In Appendix J of the PCL Handbook, there was a "fee schedule," which established the amount physicians would be paid by the Medicaid program for each reimbursable procedure and service (identified by "procedure code"). For both "new patient" office visits (99201-99205 "procedure code" series) and "established patient" office visits (99211-99215 "procedure

code" series), the higher numbered the "procedure code" in the series, the more a physician would be reimbursed under the "fee schedule."

The Audit and Aftermath

21. Commencing in or around August 2002, AHCA conducted an audit of Respondent's Medicaid claims for services rendered during the Audit Period (Audit Period Claims).[6]

22. Respondent had submitted 18,102 such Audit Period Claims, for which he had received payments totaling $596,623.15.

23. These Audit Period Claims involved 1,372 different Medicaid patients. From this group, AHCA randomly selected a "cluster sample" of 40 patients.

24. Of the 18,102 Audit Period Claims, 713 had been for services that, according to the claims, had been provided to the 40 patients in the "cluster sample" (Sample Claims). Respondent had received a total of $23,263.18 for these 713 Sample Claims.

25. During an August 28, 2002, visit to Respondent's office, AHCA personnel "explain[ed] to [Respondent] what the audit was about [and] why [AHCA] was doing it" and requested Respondent to provide AHCA with copies of the medical records Respondent had on file for the 40 patients in the "cluster sample" documenting the services provided to them during the Audit Period.

26. The originals of these records were not inspected by AHCA personnel or agents during, or any time after, this August 28, 2002, site visit.

27. Sometime within approximately 30 to 45 days of the August 28, 2002, site visit, Respondent, through his office staff, made the requested copies (First Set of Copies) and provided them to AHCA. There is nothing on the face of these documents to suggest that they were not true, accurate, and complete copies of the originals in Respondent's possession, as they existed at the time of copying (Copied Originals). They do not appear, upon visual examination, to be the product of "bad photocopying." While the handwritten entries and writing are oftentimes difficult (at least for the undersigned) to decipher, this is because of the poor legibility of the handwriting, not because the copies are faint or otherwise of poor quality.

28. Each of the Sample Claims was reviewed to determine whether it was supported by information contained in the First Set of Copies.

29. An initial review was conducted by AHCA Program Analyst Theresa Mock and AHCA Registered Nurse Consultant Blanca Notman.

30. AHCA then contracted with Larry Deeb, M.D., to conduct an independent "peer review" in accordance with the provisions of Section 409.9131, Florida Statutes. Since 1980, Dr. Deeb has

been a Florida-licensed pediatric physician, certified by the American Board of Pediatrics, in active practice in Tallahassee.

31. AHCA provided Dr. Deeb with the First Set of Copies, along with worksheets containing a "[l]isting of [a]ll claims in [the] sample" on which Ms. Notman had made handwritten notations indicating her preliminary determination as to each of the Sample Claims (Claims Worksheets).

32. In conducting his "peer review," Dr. Deeb did not interview any of the 40 patients in the "cluster sample," nor did he take any other steps to supplement the information contained in the documents that he was provided.

33. Dr. Deeb examined the First Set of Copies. He conveyed to AHCA his findings regarding the sufficiency of these documents to support the Sample Claims by making appropriate handwritten notations on the Claims Worksheets before returning them to AHCA.

34. Based on Dr. Deeb's sufficiency findings, as well as Ms. Notman's "no documentation" determinations, AHCA "provisional[ly]" determined that Respondent had been overpaid a total $80,788.23 for the Audit Period Claims. By letter dated July 7, 2003 (Provisional Agency Audit Report), AHCA advised Petitioner of this "provisional" determination and invited Respondent to "submit further documentation in support of the claims identified as overpayment," adding that "[d]ocumentation

that appear[ed] to be altered, or in any other way appear[ed] not to be authentic, [would] not serve to reduce the overpayment." Appended to the letter were "[t]he audit work papers [containing a] listing [of] the claims that [were] affected by this determination."

35. In the Provisional Agency Audit Report, AHCA gave the following explanation as to how it arrived at its overpayment determination:

> REVIEW DETERMINATION(S)
>
> Medicaid policy defines the varying levels of care and expertise required for the evaluation and management procedure codes for office visits. The documentation you provided supports a lower level of office visit than the one for which you billed and received payment. The difference between the amount you were paid and the correct payment for the appropriate level of service is considered an overpayment.
>
> Medicaid policy specifies how medical records must be maintained. A review of your medical records revealed that some services for which you billed and received payment were not documented. Medicaid requires documentation of the services and considers payment made for services not appropriately documented an overpayment.
>
> Medicaid policy addresses specific billing requirements and procedures. You billed Medicaid for Child Health Check Up (CHCUP) services and office visits for the same child on the same day. Child Health Check-Up Providers may only bill for one visit, a Child Health Check-Up or a sick visit. The difference between the amount you were paid

> and the appropriate fee is considered an overpayment.
>
> The overpayment was calculated as follows:
>
> A random sample of 40 recipients respecting whom you submitted 713 claims was reviewed. For those claims in the sample which have dates of service from January 01, 2000 through December 31, 2001 an overpayment of $4,168.00 or $5.84667601 per claim was found, as indicated on the accompanying schedule. Since you were paid for a total (population) of 18,102 claims for that period, the point estimate of the total overpayment is 18,102 x $5.84667601= $105,836.33. There is a 50 percent probability that the overpayment to you is that amount or more.

There was then an explanation of the "statistical formula for cluster sampling" that AHCA used and how it "calculated that the overpayment to [Respondent was] $80,788.23 with a ninety-five percent (95%) probability that it [was] that amount or more."

36. After receiving the Provisional Agency Audit Report, Respondent requested to meet with Dr. Deeb to discuss Dr. Deeb's sufficiency findings.

37. The meeting was held on September 25, 2003, approximately six months after Dr. Deeb had reviewed the First Set of Copies and a year after AHCA had received the First Set of Copies from Respondent. At the meeting, Respondent presented to Dr. Deeb what Respondent represented was a better set of copies of the Copied Originals than the First Set of Copies (on which Dr. Deeb had based the sufficiency findings AHCA relied on

in making its "provisional" overpayment determination). According to Respondent, the First Set of Copies "had not been properly Xeroxed." He stated that his office staff "had not copied the back section of the documentation and that was one of the major factors in the documentation not supporting the [claimed] level of service."

38. The copies that Respondent produced at this meeting (Second Set of Copies) had additional handwritten entries and writing (both on the backs <u>and</u> fronts of pages) not found in the First Set of Copies: the backs of "progress note" pages that were completely blank in the First Set of Copies contained handwritten narratives, and there were handwritten entries and writing in numerous places on the fronts of these pages where, on the fronts of the corresponding pages in the First Set of Copies, just blank, printed lines appeared (with no other discernible markings).

39. The Second Set of Copies was not appreciably clearer than the First Set of Copies.

40. In the two hours that he had set aside to meet with Respondent, Dr. Deeb only had time to conduct a "quick[]," partial review of the Second Set of Copies. Based on this review (which involved looking at documents concerning approximately half of the 40 patients in the "cluster sample"), Dr. Deeb preliminarily determined to "allow" many of the Sample

Claims relating to these patients that he had previously determined (based on his review of the First Set of Copies) were not supported by sufficient documentation.

41. Following this September 25, 2003, meeting, after comparing the Second Set of Copies with the First Set of Copies and noting the differences between the two, AHCA "made the decision that [it] would not accept the [S]econd [S]et [of Copies]" because these documents contained entries and writing that appeared to have been made, not contemporaneously with the provision of the goods or services they purported to document (as required), but rather after the post-Audit Period preparation of the First Set of Copies. Instead, AHCA, reasonably, based its finalized overpayment determination on the First Set of Copies.

42. Thereafter, AHCA prepared and sent to Respondent a Final Agency Audit Report, which was in the form of a letter dated June 29, 2004, advising Respondent that AHCA had finalized the "provisional" determination announced in the Provisional Agency Audit that he had been overpaid $80,788.23 for the Audit Period Claims (a determination that the preponderance of the record evidence in this case establishes is a correct one).

CONCLUSIONS OF LAW

43. AHCA is statutorily charged with the responsibility of "operat[ing] 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[7] and impose sanctions as appropriate." § 409.913(1), Fla. Stat.

44. "Overpayment," as that term is used in Section 409.913, Florida Statutes, "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." § 409.913(1)(e), Fla. Stat. "[T]he plain meaning of the statute dictates that it is within the AHCA's power to demand repayment" of such monies, regardless of the circumstances that produced the unauthorized payment, provided the overpayment is not "attributable to error of [AHCA] in the determination of eligibility of a recipient." Colonnade Medical Center, Inc. v. State, Agency for Health Care Administration, 847 So. 2d 540, 541-42 (Fla. 4th DCA 2003); § 409.907(5)(b), Fla. Stat.; and § 409.913(11), Fla. Stat.

45. Payments are "not authorized" to be made by the Medicaid program where the provider has not complied with the provisions of Section 409.913(7), Florida Statutes, which, at all times material to the instant case, has provided as follows:

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:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(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.[[8]]

The agency may deny payment or require repayment for goods or services that are not presented as required in this subsection.

46. To enable AHCA to ascertain whether paid-for goods and services have been appropriately documented and otherwise meet the requirements of Section 409.913(7), Florida Statutes, the Legislature has, pursuant to Section 409.907(3), Florida Statutes, at all times material to the instant case, required providers to, among other things, "[m]aintain 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"; "[r]etain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the agency"; and permit AHCA "access to all Medicaid-related information, which may be in the form of records, logs, documents, or computer files, and other information pertaining to services or goods billed to the Medicaid program, including access to all patient records and other provider information if the provider cannot easily separate records for Medicaid patients from other records."

47. In the instant case, AHCA is seeking to recover $80,788.23 in Medicaid overpayments allegedly made to Respondent for physician services Respondent claimed he rendered during the Audit Period.

48. Section 409.913(21), Florida Statutes, requires that AHCA, "[w]hen making a determination that an overpayment has occurred, prepare and issue an audit report to the provider

showing the calculation of overpayments." Before "formal proceedings are initiated" on any such overpayment determination involving "physician service claims," AHCA must, pursuant to Section 409.9131(5)(b), Florida Statutes, "[r]efer all [such] claims for peer review when [its] preliminary analysis indicates that an evaluation of the medical necessity, appropriateness, and quality of care needs to be undertaken to determine a potential overpayment."

49. "Peer review," as that term is used in Section 409.9131(5), Florida Statutes, is defined in Subsection (2)(d) of the statute as "an evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health care standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate."

50. "Peer," as that term is used in Section 409.9131(5), Florida Statutes, is defined in Subsection (2)(c) of the statute as "a Florida licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice."

51. "Active practice," as that term is used in Section 409.9131(5), Florida Statutes, is defined in Subsection (2)(a) of the statute to mean that "a physician must have regularly provided medical care and treatment to patients within the past 2 years."

52. Dr. Deeb is Respondent's "peer," as that term is used in Section 409.9131(5), Florida Statutes.

53. A Medicaid provider who is the subject of an audit report that reveals an overpayment is entitled to an administrative hearing pursuant to Chapter 120, Florida Statutes, before AHCA takes final agency action ordering repayment.

54. At any such hearing, AHCA has the burden of establishing, by a preponderance of the evidence, that Medicaid overpayments in the amount it is seeking to recoup were made to the provider. See South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992); Florida Department of Transportation v. J. W. C. Co., Inc., 396 So. 2d 778, 788 (Fla. 1st DCA 1981); Florida Department of Health and Rehabilitative Services, Division of Health v. Career Service Commission, 289 So. 2d 412, 415 (Fla. 4th DCA 1974); and Full Health Care, Inc. v. Agency for Health

Care Administration, No. 00-4441, slip op. at 18 (Fla. DOAH June 25, 2001)(Recommended Order), adopted in toto, (AHCA September 28, 2001).

55. At all material times to the instant case, Section 409.913, Florida Statutes, has provided that "[t]he audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." It has been said that this language enables AHCA to "make a prima facie case without doing any heavy lifting: it need only proffer a properly-supported audit report, which must be received in evidence." Full Health Care, slip op. at 19; see also Agency for Health Care Administration v Orietta Medical Equipment, Inc., No. 05-0873MPI, 2006 Fla. Div. Adm. Hear. LEXIS 555 *11 (Fla. DOAH December 1, 2006)(Recommended Order), adopted in toto, (AHCA December 22, 2006)("It is concluded that the Legislature has determined that the audit reports in these matters may be considered evidence of the overpayment. As such, the Agency met its prima facie burden to establish the overpayment and the amount claimed to be due."); The Children's Office, Inc. v. Agency for Health Care Administration, No. 05-0807MPI, 2006 Fla. Div. Adm. Hear. LEXIS 43 *32 (Fla. DOAH February 3, 2006)(Recommended Order), adopted in toto, (AHCA December 22, 2006)("[T]he Agency can make a prima facie case merely by proffering a properly supported audit report, which

must be received in evidence."); Lee v. Agency for Health Care Administration, No. 03-2251MPI, 2004 Fla. Div. Adm. Hear. LEXIS 2444 *77 (Fla. DOAH December 9, 2004)(Recommended Order)("[A]lthough it has the ultimate burden of persuasion by the greater weight of the evidence, AHCA can make a prima facie case of overpayment through the introduction into evidence of the audit report; the provider is then required to respond by producing evidence to support its Medicaid claims."); Choices in Support and Services, Inc. v. Agency for Health Care Administration, No. 01-1977MPI, 2003 Fla. Div. Adm. Hear. LEXIS 207 *19 (Fla. DOAH March 13, 2003)(Recommended Order), adopted in toto, (AHCA August 1, 2003)("The evidence submitted by the agency, with the benefit of the provisions of Section 409.913(21), Florida Statutes,[[9]] is sufficient to present a prima facie case."); Lifeline Pharmacy, Inc. v. Agency For Health Care Administration, No. 01-2153MPI , 2002 Fla. Div. Adm. Hear. LEXIS 156 *16 (Fla. DOAH March 8, 2002)(Recommended Order), adopted in toto, (AHCA April 11, 2002)("[T]he Agency can make a prima facie case by merely proffering a properly supported audit report, which must be received in evidence."); and Maz Pharmaceuticals, Inc., d/b/a Maz Pharmacy v. Agency For Health Care Administration, No. 97-3791, 1998 Fla. Div. Adm. Hear. LEXIS 6245 *6-7 (Fla. DOAH March 20, 1998)(Recommended Order), adopted in toto, (AHCA June 26, 1998)("Section

409.913(21), Florida Statutes, provides, in part, that: 'The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment.' Petitioner argues that this provision means the documents relied on for all of the agency's testimony may be admitted in evidence but then must be ignored. Such a construction would render meaningless the language contained in Section 409.913(21) and would be contrary to the normal rules of statutory construction. Since the Legislature determined that the audit report and work papers constitute evidence which must be considered, the Agency presented a prima facie case, which Petitioner chose not to rebut.").[10] Consistent with the provisions of Section 409.913, Florida Statutes, Section 409.9131(5)(a), Florida Statutes, at all material times to the instant case, has provided that, "[i]n meeting its burden of proof in any administrative or court proceeding [involving physician service claims], [AHCA] may introduce the results of [the] statistical methods [described in the statute] and its other audit findings as evidence of overpayment.").

56. "[O]nce [AHCA] 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 [AHCA's] statutorily-authorized evidence;

it cannot simply present witnesses to say that [AHCA] lacks evidence or is mistaken."[11] Full Health Care, slip op. at 19-20.

57. In the instant case, at the administrative hearing that Respondent requested and was granted, AHCA met its burden of proving, by a preponderance of the evidence, that Respondent received $80,788.23 in Medicaid overpayments.

58. While it presented other evidence (most notably, the unrebutted, credible deposition testimony of Dr. Deeb, the "peer reviewer," concerning the sufficiency of the First Set of Copies to support the Sample Claims), the Final Agency Audit Report and supporting audit work papers[12] alone, pursuant to Section 409.913, Florida Statutes, established a prima facie case of overpayment in the amount of $80,788.23,[13] which Respondent, through the presentation of his evidence, failed to overcome.

59. In his evidentiary presentation, Respondent made no effort to establish that the First Set of Copies supported the Sample Claims AHCA found not to have been appropriately documented. Rather, he attempted to show that the First Set of Copies (which his office had copied and sent AHCA) was a product of "bad photocopying" and that AHCA should have based its audit findings, not on the First Set of Copies, but instead on the Second Set of Copies, which, according to Respondent, unlike the First Set of Copies, contained true, accurate, and complete copies of the Copied Originals.

60. In his attempt to make such a showing, Respondent offered only his own testimony, plus a single exhibit, a receipt from Professional Office Systems, Inc., reflecting that he had a photocopier serviced on September 15, 2003.[14]

61. Respondent's testimony was at times equivocal, unclear, and confusing, even seemingly self-contradictory. Overall, it was unpersuasive.

62. In his testimony (as the undersigned understands it), Respondent told the following story about the copying of the Copied Originals: AHCA personnel visited his office and told him about the audit; the First Set of Copies was subsequently made, while he was on a two-week vacation, by his office manager, using a seven-year old photocopier (Old Photocopier) which, at the time, as he was aware, was producing "poor copies"; because a "bad photocopier" was used, the First Set of Copies did not "contain everything that was on the [front pages of the Copied Originals]"; and to remedy the situation, after having the Old Photocopier serviced three or four times and ultimately purchasing a new photocopier, he had the Second Set of Copies made.[15] Why Respondent would allow his office manager to use a "bad photocopier" that he knew produced "poor copies" to copy the Copied Originals and why he would wait as long as he did to let AHCA know of the "flaws" in the First Set of Copies

and to provide AHCA with the Second Set of Copies[16] are questions that Respondent's testimony leaves unanswered.

63. To corroborate his testimony, Respondent did not produce his office manager, the person or persons who serviced the Old Photocopier, a photocopying expert, or any other witness; nor did he offer the originals of any of his medical records. His lone effort at corroboration was offering the aforementioned Professional Office Systems receipt. This receipt, however, was for a service visit on September 15, 2003, which was approximately a year after the First Set of Copies was made. It is also worthy of note that the receipt indicates that the "customer['s]" complaint was, "copies are bad and unreadable," and it makes no mention of any copies "missing parts" of the original, which, according to Respondent's testimony, was the problem plaguing the First Set of Copies.

64. In short, Respondent has failed to convince the undersigned that the First Set of Copies is anything other than what Respondent's office initially represented it to be: a true, accurate, and complete set of copies of the Copied Originals. The Second Set of Copies does contain handwritten entries and writing not found in the First Set of Copies (Additional Documentation). However, based on the undersigned's consideration and evaluation of the record evidence, including, most significantly, his observations upon making a visual

comparison between those portions of the Second Set of Copies where the Additional Documentation appears and those corresponding portions of the First Set of Copies, he finds it more likely than not that the Additional Documentation was not included in the Copied Originals, but rather was created sometime after the First Set of Copies was made. Because this Additional Documentation has not been shown to have been "made at the time the goods or services [to which it refers] were provided," it cannot be relied on to support any of the Sample Claims. To hold otherwise would render meaningless the clear and unambiguous statutory language imposing this contemporaneous documentation requirement upon reimbursement-seeking Medicaid providers like Respondent. See State v. Goode, 830 So. 2d 817, 824 (Fla. 2002)("[A] basic rule of statutory construction provides that the Legislature does not intend to enact useless provisions, and courts should avoid readings that would render part of a statute meaningless."); and Florida Department of Education v. Cooper, 858 So. 2d 394, 396 (Fla. 1st DCA 2003)("[C]ourts should not construe a statute so as to render any term meaningless.").

65. Respondent's not having overcome AHCA's prima facie showing of overpayment, AHCA should enter a final order finding that Respondent was overpaid a total of $80,788.23 for the Audit Period Claims.[17] Were AHCA to do otherwise it would be acting in

derogation of its statutory responsibility, under Section 409.913, Florida Statutes, to exercise oversight of the integrity of Florida's Medicaid program.

66. Upon entering such a final order, AHCA will be entitled to recover "investigative, legal, and expert witness costs" pursuant to Section 409.913(23), Florida Statutes.[18] Should there arise a dispute of a factual nature regarding the amount of costs that can be recovered, Respondent may timely request an administrative hearing on the matter. Should AHCA determine that the petition requesting the hearing is sufficient and raises disputed issues of material fact, AHCA may then refer the matter to DOAH for the assignment of an administrative law judge to conduct the requested hearing and issue a recommended order. See Agency for Health Care Administration v. Brown Pharmacy, No. 05-3366MPI, 2006 Fla. Div. Adm. Hear. LEXIS 515 *59 (Fla. DOAH November 3, 2006)(Recommended Order), adopted in pertinent part, (AHCA December 22, 2006)("[A]ny claim for costs may be raised once it is determined that the Petitioner has prevailed in this case, whereupon, if it should attempt to assess them against the Respondent, the Respondent would have the opportunity, by separate proceeding, to contest the matter before the Division of Administrative Hearings."); Lepley v. Agency for Health Care Administration, No. 04-3025MPI, 2004 Fla. Div. Adm. Hear. LEXIS 2528 *30 (Fla. DOAH December 14,

2004)(Recommended Order), adopted in toto, (AHCA June 10, 2005)("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."); and Meji, Inc. v. Agency for Health Care Administration, No. 03-1195MPI, slip op. at 10 (Fla. DOAH July 15, 2003)(Recommended Order), adopted in toto, (AHCA October 21, 2003)("[T]he Agency, once it has 'ultimately prevailed' in this case, may then determine the amount of its costs associated with this matter and assess those costs against Meji. Should Meji dispute the Agency's determination and raise disputed issues of material fact, the matter may then be referred by the Agency to the Division for hearing.").

67. Not only is AHCA seeking to recover the $80,788.23 in overpayments Respondent received, as well as the "investigative, legal, and expert witness costs" it has incurred, it also seeks (according to the Final Agency Audit Report) to impose a "sanction" on Respondent: subjecting Respondent to "a comprehensive follow-up review in six months."

68. Although AHCA now has the authority, pursuant to Section 409.913(16)(h), Florida Statutes, to "sanction" providers by ordering "[c]omprehensive followup reviews . . .

every 6 months to ensure that they are billing Medicaid correctly," it was not authorized to impose this "sanction" until June 7, 2002, the effective date of Chapter 2002-400, Laws of Florida, the legislative enactment which added to Section 409.913 the language now found in Subsection (16)(h) of the statute.

69. Since the wrongdoing alleged in the instant case occurred prior to June 7, 2002, AHCA may not "sanction" Respondent for engaging in such wrongdoing by ordering a "comprehensive follow-up review in six months." See Willner v. Department of Professional Regulation, Board of Medicine, 563 So. 2d 805, 806 (Fla. 1st DCA 1990)("[A]ppellant argues that the fines imposed against him are in violation of the ex post facto provisions of the state and federal constitutions. We agree. In 1986, Section 458.331(2)(d), Florida Statutes, was amended to increase the amount of the maximum administrative fine which could be assessed by appellee for violations of Section 458.331(1), Florida Statutes. The 1986 amendment increased the maximum fine from $1,000 per violation to $5,000 per violation. Since all the violations for which appellant was found guilty occurred prior to the effective date of the 1986 amendment, the maximum fine which could lawfully be imposed by appellee was $1,000 per violation.")(citation omitted); and Baker v. State, 499 So. 2d 15, 16 (Fla. 2d DCA 1986)("Appellant argues that the

order requiring him to pay costs violated the constitutional prohibition against ex post facto laws (U.S. Const. art. I, § 9; Fla. Consti. Art. I, § 10), since it imposed a penalty that was not in effect at the time that appellant committed the offense. . . . Appellant's crime occurred on June 25, 1985, and the section under which appellant was ordered to pay costs (section 27.3455, Florida Statutes (1985)) became effective on July 1, 1985. We agree . . . that the imposition of costs here pursuant to section 27.3455 violated the constitutional prohibition against ex post facto laws and is, as such, invalid.")(citation omitted).

RECOMMENDATION

Based upon the foregoing Findings of Fact and Conclusions of Law, it is hereby

RECOMMENDED that AHCA enter a final order finding that Respondent received $80,788.23 in Medicaid overpayments for the Audit Period Claims, and requiring Respondent to repay this amount to AHCA.

DONE AND ENTERED this 30th day of April, 2007, in Tallahassee, Leon County, Florida.

S

STUART M. LERNER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of April, 2007.

ENDNOTES

[1] Unless otherwise noted, all references in this Recommended Order to Florida Statutes are to Florida Statutes (2006).

[2] Petitioner's Exhibit 27 is the deposition of Larry Deeb, M.D., taken March 16, 2005, and October 25, 2006. It was offered and received into evidence, over objection, in lieu of Dr. Deeb's live testimony at hearing. In urging its admissibility, AHCA's counsel stated that Dr. Deeb's deposition was being offered only for the purpose of showing the inadequacy of the "first set of records [Respondent provided AHCA]" to support Respondent's Audit Period Medicaid billings and that it was not being offered to demonstrate when the additional entries on the "second set of records" were made. The deposition was received into evidence for the purpose offered.

[3] The amount of time that the parties requested for the filing of proposed recommended orders was, in the view of the undersigned, not unreasonably excessive, given the voluminous nature of the exhibits received into evidence.

[4] The undersigned has accepted these factual stipulations. See Columbia Bank for Cooperatives v. Okeelanta Sugar Cooperative,

52 So. 2d 670, 673 (Fla. 1951)("When a case is tried upon stipulated facts the stipulation is conclusive upon both the trial and appellate courts in respect to matters which may validly be made the subject of stipulation."); Schrimsher v. School Board of Palm Beach County, 694 So. 2d 856, 863 (Fla. 4th DCA 1997)("The hearing officer is bound by the parties' stipulations."); and Palm Beach Community College v. Department of Administration, Division of Retirement, 579 So. 2d 300, 302 (Fla. 4th DCA 1991)("When the parties agree that a case is to be tried upon stipulated facts, the stipulation is binding not only upon the parties but also upon the trial and reviewing courts. In addition, no other or different facts will be presumed to exist.").

[5] The term "medically necessary" was defined in Appendix D of the MPR Handbook, in pertinent part, as follows:

> Medically Necessary or Medical Necessity
>
> Means that the medical or allied care, goods, or services furnished or ordered must:
>
> (a) Meet the following conditions:
>
> 1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
>
> 2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
>
> 3. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
>
> 4. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

> 5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
>
> * * *
>
> (c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.

[6] In taking such action, AHCA was exercising its statutory authority under Section 409.913(2), Florida Statutes, to "conduct . . . audits . . . to determine possible . . . overpayment . . . in the Medicaid program."

[7] "The Medicaid program provides reimbursement to service providers on a 'pay-and-chase' basis. In other words, claims are paid initially subject to preliminary review. [AHCA] or its agent may later subject these claims to closer scrutiny during periodic audits. If overpayments are found, [AHCA] obtains reimbursement from the service provider." Agency for Health Care Administration v. Cabrera, No. 92-1898, 1994 Fla. Div. Adm. Hear. LEXIS 5127 *3 (Fla. DOAH January 24, 1994)(Recommended Order).

[8] To meet this requirement, the provider's records must be legible and comprehensible. Cf. Tsoutsouris v. Shalala, 977 F. Supp. 899, 905 (N.D. Ind. 1997)("Dr. Freeman stated that although Dr. Tsoutsouris' medical records alone would not enable a third party to make a determination that medical necessity existed in the cases of Hazel Kershaw and Emma MacIntosh, Dr. Tsoutsouris' testimony deciphering his illegible handwriting and explaining his abbreviations and 'as above' references would permit a determination of medical necessity. . . . However, as in the cases of Mr. Walker and Mrs Potts, this conclusion does not compel a finding of medical necessity because the issue that the ALJ was reviewing was whether Dr. Tsoutsouris provided sufficient documentation for a third party to find that the appropriate medical necessity existed to enable payment of Dr. Tsoutsouris' claims.").

[9] Effective July 1, 2004, Section 409.913(21), Florida Statutes, was renumbered Section 409.013(22), Florida Statutes (but not otherwise changed). See Ch. 2004-344, §§ 6 and 34, Laws of Fla.

[10] That the Legislature has amended Section 409.913, Florida Statutes, but has left unchanged the language therein that AHCA, since prior to these amendments, has interpreted as enabling it to make a prima facie showing of overpayment by merely offering its audit report and supporting audit work papers, suggests that the Legislature approves of this interpretation. See State ex rel. Szabo Food Services, Inc. v. Dickinson, 286 So. 2d 529, 531 (Fla. 1973)("When the Legislature reenacts a statute, it is presumed to know and adopt the construction placed thereon by the State tax administrators."); Cole Vision Corp. v. Department of Business and Professional Regulation, Board of Optometry, 688 So. 2d 404, 408 (Fla. 1st DCA 1997)("When the legislature reenacts a statute, it is presumed to know and adopt the construction of the statute by the agency responsible for its administration except to the extent that the new statute differs from prior constructions."); and Lanoue v. Department of Law Enforcement, No. 98-4571RX, 2000 Fla. Div. Adm. Hear. LEXIS 4899 *56 (Fla. DOAH May 23, 2000)(Final Order)(citations omitted)("FDLE adopted Rule 11D-8.002(1), Florida Administrative Code, in 1997 prior to the most recent amendment of the statutes in 1998. Therefore, the Legislature is presumed to have adopted the Department's interpretation of Sections 316.1932(1)(b)2. and 316.1932(1)(f)1., Florida Statutes.").

[11] "[O]bligat[ing] [a provider] to come forward with written proof to rebut, impeach, or otherwise undermine [AHCA's] statutorily-authorized evidence" of overpayment is not an unreasonable burden to place on the provider. See Illinois Physicians Union v. Miller, 675 F.2d 151, 158 (7th Cir. 1982)("We see nothing arbitrary or capricious about requiring physicians who are benefiting from the [Medicaid] program to bear this burden, particularly when the state has already borne the cost of the initial audit and the evidence to rebut that initial determination is uniquely within the physician's control.").

[12] These supporting audit work papers are found in Petitioner's Exhibit 31, under the "Original Submission" cover sheets.

[13] Although, in his Proposed Recommended Order, Respondent decries AHCA's failure to "call Ms. Notman as a witness" and to elicit more specific and detailed testimony from Dr. Deeb

concerning his findings, AHCA did not need to present this additional evidence to make a _prima_ _facie_ case.

[14] The Second Set of Copies is part of the evidentiary record, but it was offered into evidence by AHCA, not Respondent.

[15] Respondent initially suggested in his testimony (on page 66 of the Transcript) that the Second Set of Copies was made with the Old Photocopier after "they [had] added the ink to it." He later testified, however (on pages 93, 94, and 95 of the Transcript), that the new copier was used to make the Second Set of Copies.

[16] The timing is certainly suspicious: Respondent took these steps only after having received the July 7, 2003, Provisional Agency Audit Report advising him of the deficiencies found by AHCA in the documentation contained in the First Set of Copies.

[17] Section 409.913(25)(c), Florida Statutes, contains the following provisions regarding the repayment of overpayments AHCA has determined to have been made to a provider:

> Overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings. A provider who does not enter into or adhere to an agreed-upon repayment schedule may be terminated by the agency for nonpayment or partial payment.

[18] The version of the statute in effect during the Audit Period capped the amount of "investigative, legal, and expert witness costs" AHCA could recover upon establishing the correctness of its audit findings at $15,000.00. The current version of the statute, which has been in effect since January 1, 2002, allows AHCA to recover "all" of its "investigative, legal, and expert witness costs." _See_ Ch. 2001-377, §§ 12 and 21, Laws of Fla.

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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.