STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION, Petitioner, vs. JAMAREL ENTERPRISES, INC., d/b/a CAMAGUEY PHARMACY, Respondent.	)	Case No. 07-1511MPI

RECOMMENDED ORDER

Pursuant to notice a formal hearing was held in this case on October 25, 2007, in Tallahassee, Florida, before J. D. Parrish, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: L. William Porter, II, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3, Mail Stop 3
Tallahassee, Florida 32308-5403

For Respondent: No Appearance

STATEMENT OF THE ISSUE

Whether the Petitioner, Agency for Health Care Administration (AHCA or Petitioner) is entitled to a recoupment for a Medicaid overpayment to the Respondent, Jamarel Enterprises, Inc., d/b/a Camaguey Pharmacy (Respondent or Jamarel) in the amount of $29,366.12. The Petitioner also seeks the imposition of a fine and costs in this matter in the amounts

of $6,500.00 and $4,568.00. The Respondent denied it was overpaid any amount.

PRELIMINARY STATEMENT

On or about February 6, 2007, the Petitioner issued a Final Audit Report that advised the Respondent an audit of Jamarel's Medicaid claims for the period May 1, 2005 through April 30, 2006, was complete. According to the Petitioner's claim, the Respondent was overpaid for drugs dispensed for which the Respondent could not establish an invoice or other proof of purchase. In accordance with Florida Administrative Code Rule 59G-9.070, the Petitioner sought the amount of the overpayment together with a fine and the cost of the audit and recoupment proceeding.

Thereafter, the Respondent timely filed a Petition for Formal Hearing to dispute the factual allegations of the audit and to request a formal hearing to address the allegations of the audit. The case was then forwarded to the Division of Administrative Hearings for formal proceedings on April 2, 2007. The case was initially scheduled for final hearing for June 11 and 12, 2007. The case was continued on two occasions and ultimately rescheduled to October 25 and 26, 2007. A third Motion for Continuance filed by the Respondent on October 24, 2007, was denied.

At the hearing, the Petitioner presented the testimony of Ramona Stewart and Arlene Elliott. The Petitioner's Exhibits numbered 1-19 and 10-A were admitted into evidence. The Respondent did not appear for the hearing and no evidence was presented on its behalf.

The transcript of the proceeding was filed on November 8, 2007. The parties were afforded 30 days within which to file Proposed Recommended Orders. The Petitioner timely filed a proposal that has been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material to the allegations of this case, the Petitioner is the state agency charged with the responsibility of administering the Medicaid program in Florida. See § 409.907, Fla. Stat. (2007).

2. As part of its duties, the Petitioner attempts to recover Medicaid overpayments to Medicaid providers. See § 409.913, Fla. Stat. (2007).

3. At all times material to this case, the Respondent was a licensed pharmacy under contract to AHCA as a Medicaid provider, provider number 026840200.

4. As a Medicaid provider, the Respondent was subject to audit. This case arose as result of a routine audit that was conducted by the Petitioner for the audit period May 1, 2005 through April 30, 2006.

5. This audit sought information regarding a selected and limited number of drugs that had been dispensed to Medicaid recipients during the audit period. Essentially, the Petitioner's audit team asked the Respondent to produce documents to establish that it had lawfully acquired the subject drugs so that they would be "on hand" during the audit period.

6. If a certain drug was dispensed, the pharmacy should have been able to show it lawfully purchased that drug prior to the dispensing of same.

7. The Petitioner's auditor reviewed the purchases made by the Respondent to verify that each drug was purchased by Jamarel before it was billed to Medicaid as dispensed.

8. To verify the purchase, the Respondent was asked to produce invoices or other proof of purchase for the drugs being audited.

9. The total of "overpayment" in this case is the total for all drugs for which the Respondent could not produce an invoice or other documentation establishing proof of purchase.

10. The Petitioner claims a total overpayment of $29,366.12.

11. The $29,366.12 is the total paid by the Petitioner to Respondent for drugs it allegedly dispensed to Medicaid recipients for which it could not establish a prior invoice of acquisition.

12. In addition to the overpayment amount claimed, the Petitioner also seeks a fine in the amount of $6,500.00 and costs of the case in the amount of $4,568.00. The Petitioner's presentation regarding its costs incurred has been credited. The fine is a calculated amount as authorized by rule.

13. The Respondent presented no evidence to refute the amounts claimed by the Petitioner. If records were available to refute the Petitioner's claim, the Medicaid provider agreement required that Respondent retain such records and make them available to the agency for review.

14. Pharmacy records are to be retained for a period of at least five years.

15. The Petitioner gave the Respondent credit for any record it produced to reduce the amount of the overpayment. The overpayment cannot be reduced further without credible records.

CONCLUSIONS OF LAW

16. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of these proceedings. § 120.57(1), Fla. Stat. (2007).

17. As the party asserting the overpayment, AHCA 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).

18. Section 409.913, Florida Statutes (2007), provides, in pertinent part:

> The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate.
>
> (1) For the purposes of this section, the term:
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> * * *
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> (d) "Overpayment" includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.
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> (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:
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> * * *
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> (e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.
>
> (8) A Medicaid provider shall retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years

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

* * *

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

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

(21) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony, either on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business.

19. Section 409.907, Florida Statutes (2007), provides, in part:

The agency may make payments for medical assistance and related services rendered to Medicaid recipients only to an individual or entity who has a provider agreement in effect with the agency, who is performing services or supplying goods in accordance with federal, state, and local law, and who agrees that no person shall, on the grounds of handicap, race, color, or national origin, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from the agency.

* * *

(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.

20. In this case the Petitioner seeks the overpayment based upon an inadequate records keeping system that could not document purchases of the drugs dispensed and billed to Medicaid. The plain language of the statute directing a provider to maintain in a "systematic and orderly manner" all Medicaid records dictates that AHCA may demand repayment regardless of the circumstances that produced the payment. Participation in the Medicaid program is voluntary. The Respondent 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 Respondent is not entitled to payment for its claims. See Colonnade Medical Center, Inc. v. Agency for Health Care Administration, 847 So. 2d 540 (Fla. 4th DCA 2003).

21. Section 409.906(20), Florida Statutes (2007), authorized the Agency to pay for medications that were prescribed for a recipient by a physician or other licensed practitioner and that were dispensed to the recipient by a licensed pharmacist in accordance with applicable state and federal law. During the audit period the Agency paid Jamarel for all Medicaid claims at issue in this proceeding. In effect, the Agency honored the claims submitted. Now, after-the-fact, and through the audit process, the Agency attempted to verify that those claims were

supported by the documentation required by law. The Respondent could not produce records to support the overpayment amount.

22. The "overpayment" in this cause results from an unacceptable practice. The unacceptable practice was the Respondent's lack of documentation to support the claims filed. All of the record-keeping requirements were known or should have been known to Respondent, inasmuch as the Agency has always requested an audit trail for Medicaid claims.

23. In this case, the audit report supports and constitutes evidence of the overpayment claimed. See § 409.913(22), Fla Stat. (2007). The Respondent has failed to present substantial, credible evidence to rebut the overpayment claimed.

24. The Petitioner has met its burden of proof in this case and has established by a preponderance of the evidence that the Respondent received an overpayment the amount of $29,366.12.

25. Florida Administrative Code Rule 59G-9.070 authorizes the imposition of fines and the assessment of costs for Medicaid violations. In this case it is established the Petitioner incurred costs in the amount of $4,568.00 in the audit and administrative action to seek recoupment of the overpayment. Additionally, the fine in the amount of $6,500.00 is within the guidelines of the rule.

RECOMMENDATION

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

Administration enter a Final Order that accepts an amended audit report to support an overpayment and recoupment against the Respondent in the amount of $40,434.12.

DONE AND ENTERED this 3rd day of January, 2008, in Tallahassee, Leon County, Florida.

S

J. D. PARRISH
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 3rd day of January, 2008.

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.