STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 08-5524MPI
GRACE VALENTE, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

This cause came on for final hearing before Harry L. Hooper, Administrative Law Judge with the Division of Administrative Hearings, on December 17, 2008, in Tallahassee, Florida.

APPEARANCES

For Petitioner: William Blocker, II, Esquire
Agency for Health Care Administration
Fort Knox Building 3, Mail Stop 3
2727 Mahan Drive, Suite 3431
Tallahassee, Florida 32308

For Respondent: Grace Valente, M.D., pro se
3474 Paddle Point
Spring Hill, Florida 34609

STATEMENT OF THE ISSUE

The issue is whether Respondent violated federal and state laws addressing Medicaid payments, and, if so, what is an appropriate remedy.

PRELIMINARY STATEMENT

Grace Valente (Dr. Valente) is a medical doctor, practicing obstetrics, and is licensed to practice medicine in the State of Florida. She was practicing medicine during the period January 1, 2003, until sometime in 2005. Dr. Valente, prior to this period, had signed a Medicaid Provider Agreement and had been informed of the policies affecting payment for services under Medicaid.

Petitioner Agency for Health Care Administration (AHCA) conducted an audit of Dr. Valente's billing for Medicaid patients covering the period January 1, 2003, until December 31, 2005. An analyst with the Office of Medicaid Program Integrity determined that Dr. Valente had been overpaid on 38 occasions for more than the allowed visits during a pregnancy, for providing more than one Healthy Start Prenatal Screening per pregnancy on nine occasions, and for conducting Healthy Start Prenatal Screenings in the first trimester when the screenings had taken place after the first trimester on 61 occasions. Completing the audit was made difficult because Dr. Valente refused to respond to the analyst's requests for her medical records.

The foregoing was reported in a final audit report dated March 21, 2008. This report asserted that overpayments to Dr. Valente totaled $6,618.68 and suggested that a fine in the

amount of $500.00 should be imposed. The final audit report was sent via certified mail to Dr. Valente. The report advised Dr. Valente of her right to a hearing. A demand for a formal hearing was contained in a letter received by AHCA on April 16, 2008.

Nevertheless, AHCA provided Dr. Valente with an informal hearing. That hearing was terminated by Hearing Officer Brevin Brown, on October 28, 2008, when Dr. Valente again disputed the facts contained in the final audit report. Thereafter, a request for a formal hearing was forwarded to the Division of Administrative Hearings, where it was filed November 4, 2008. The case was set for December 17, 2008, and tried as scheduled.

On December 15, 2008, AHCA filed Petitioner's Motion to Restrict Use and Disclosure of Information Concerning Medicaid Program Applicants and Beneficiaries. Dr. Valente did not respond to the Motion. The Motion was granted, and the Clerk was instructed by separate memorandum to ensure the confidentiality of information concerning Medicaid Program Applicants and Beneficiaries.

At the hearing, Petitioner presented the testimony of Terri Dean, an analyst with the Office of Medicaid Program Integrity; Dr. Valente; Sharon Dewey, R.N.; and Dr. Karl Franz, a medical consultant for the Office of Medicaid Program Integrity. Dr. Franz was accepted as an expert in the determination of

medical necessity. AHCA offered seven exhibits into evidence and all seven were accepted. Dr. Valente offered one exhibit, consisting of a volume of medical records, and it was accepted. She also testified on her own behalf.

At the hearing, the parties were advised that they would be allowed ten days subsequent to the filing of the transcript to submit proposed recommended orders. The Transcript was filed on January 6, 2009. After the hearing, Petitioner timely filed its Closing Argument and Proposed Recommended Order on January 12, 2009. Subsequently, in a letter dated January 22, 2009, Dr. Valente asserted that she would submit a response by "January 24/25." Dr. Valente late-filed a response on February 6, 2009, with the permission of Petitioner. Dr. Valente's letter is considered in the preparation of this Recommended Order.

References to statutes are to Florida Statutes (2003) unless otherwise noted.

FINDINGS OF FACT

1. AHCA is the single state agency charged with the administration of the Medicaid program in Florida pursuant to Chapter 409, Florida Statutes, and federal law. One of AHCA's duties is to recover overpayments. Overpayments are any amounts paid to providers that were not authorized.

2. Dr. Valente, during all times pertinent, was a licensed medical doctor in the State of Florida. She was an authorized Medicaid Provider and held provider number 253493200. As such, she was on notice of Medicaid billing policy and rules.

3. AHCA conducted a generalized analysis of obstetricians in Florida who submitted Medicaid claims during the period January 1, 2003, through December 31, 2005. AHCA investigated over-billing in three different categories: (1) excessive prenatal visits, (2) billing for Healthy Start Prenatal Risk Screening (Screening) more than once during a pregnancy, and (3) billing for the W1992 Screening during the second and third trimesters. The W1992 Screening was and is only applicable to the first trimester of pregnancy.

4. Dr. Valente was one of the obstetricians AHCA found to have over-billed in the three categories.

5. With regard to Category 1, excessive prenatal visits, the Physician Coverage and Limitations Handbook provides, at page 2-53, that "Antepartum visits are limited to a maximum of 10 for low-medical risk recipients and 14 for high-medical risk recipients. Payment for antepartum care is based on a total amount for complete care. Antepartum care is prorated, based on an average standard of 10 visits for a low-medical risk recipient or 14 for a high-risk recipient. Reimbursement for the 10 or 14 visits is the maximum reimbursement for the full

course of antepartum care. If additional visits are provided, payment is considered to have already been made, and the provider may not bill the additional visits to Medicaid or the recipient."

6. For Category 1, the audit searched for instances when Dr. Valente billed for excessive prenatal visits 38 times, as follows:

Patient 1: This was a high-risk patient. Dr. Valente billed for 16 visits, which was two more than the 14 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $102.00 more than allowed.

Patient 2: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Therefore, according to AHCA, Dr. Valente billed Medicaid $52.00 more than allowed. However, Dr. Valente stated, and medical records indicated, that Patient 2 was a high-risk patient even though her claimed Physician Coverage and Limitations Handbook diagnosis code, 642.43, a code for high risk, did not appear on the billing submission. Upon consideration of all of the evidence, this charge was permissible.

Patient 3: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente asserted that the patient was a high-risk patient because of high blood pressure. However, in the billing submission there is no code indicating high risk. Dr. Valente claimed at the hearing that it should have been coded 645.13. That is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 4: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente claimed the patient had an iron deficiency and should have been coded 281.2. That is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 5: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed for patients who are not high risk. The medical record revealed that Patient 5 was obese with poor sugar control, and Dr. Valente asserted she should have been coded 642.43, which is high risk. She did not use this code in the bill.

However, upon consideration of all of the evidence, this charge was permissible.

Patient 6: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed for patients who are not high risk. Dr. Valente stated that this was a high-risk patient because she was suffering from oligohydramnious. Dr. Valente did not code this on the bill. The code she claimed, 656.93, is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 7: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed for patients who are not high risk. This patient had lung problems. Dr. Valente asserted she should have been coded 496.0 and 491.2 instead of the V22.0 presented on the bill. Codes 496.0 and 491.2 are not high-risk codes. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 8: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed for a patient that was not high risk. Dr. Valente suspected a possible birth

defect and coded the patient 759.9 and 655.23. Code 655.23 is a high-risk code. Dr. Valente did not use this code in the bill. However, upon consideration of all of the evidence, this charge was permissible.

Patient 9: AHCA asserted this was a low-risk patient. Dr. Valente billed for only five visits, thus never reaching the ten visit threshold. The assertion that Dr. Valente over-billed with regard to Patient 9 was not proven.

Patient 10: AHCA asserted this was a low-risk patient. Dr. Valente stated that the records revealed decreased fetal movement, codes 655.73 and V28.4. Code 655.73 is a high-risk code. Dr. Valente did not put this code on the bill. However, upon consideration of all of the evidence, this charge was permissible.

Patient 11: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 12: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute

AHCA's finding. Therefore, Dr. Valente billed Medicaid $50.00 more than allowed.

Patient 13: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 14: This was a low-risk patient. Dr. Valente billed for 12 visits, which was two more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $100.00 more than allowed.

Patient 15: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 16: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 17: This was a low-risk patient. Dr. Valente billed for 12 visits, which was two more

than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $104.00 more than allowed.

Patient 18: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 19: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 20: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not dispute AHCA's finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 21: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente said this patient was at risk for cervical cancer and entered diagnosis codes 795.0 and 795.09. These are not high-

risk codes. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 22: AHCA asserted this was a low-risk patient. AHCA asserted Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente stated, and the records revealed, that the patient had a psychiatric disorder and, therefore, should have had a diagnosis code of 648.43, which is high risk. Dr. Valente did not assert this code on the bill. However, upon consideration of all of the evidence, the amount billed was permissible.

Patient 23: AHCA asserted this was a low-risk patient. AHCA asserted that Dr. Valente billed for 11 visits, which was one more than the 10 allowed. This patient's baby had dilated kidneys. The patient was coded 655.0, which is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 24: AHCA asserted this was a low-risk patient. AHCA asserted that Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente's records indicated that this patient had impending pre-eclampsia, which she coded 642.03, as hypertension. This is a high-risk code. Dr. Valente

failed to assert that code on the Medicaid bill. However, upon consideration of all of the evidence, Dr. Valente did not bill more than was permissible.

Patient 25: This was a high-risk patient. Dr. Valente billed for 15 visits, which was one more than the 14 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $50.00 more than allowed.

Patient 26: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 27: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed for a low-risk patient. Dr. Valente stated that the patient had a heart murmur and was asthmatic requiring medicine, which is code 493.0. She billed for 493.0, a high-risk code, and, therefore, was entitled to see the patient 14 times. Dr. Valente only saw the patient 11 times. Therefore, Dr. Valente did not bill more than allowed.

Patient 28: AHCA asserted this was a low-risk patient. Dr. Valente billed for 11 visits that she

coded V22.0. She said the patient had a childhood seizure disorder and should have been coded 345.0, which is high risk. Therefore, Dr. Valente did not bill more than allowed.

Patient 29: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente found this patient to have high-risk viral cells and assigned diagnosis code 622.1. According to the Physician Coverage and Limitations Handbook, this is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 30: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 31: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 32: AHCA asserted that this was a low-risk patient. Dr. Valente billed for 11 visits, which

is one more than permitted. Dr. Valente stated that this patient had a mild pregnancy-induced hypertension and should have been assigned diagnosis code 642.43, which is high risk. However, no such code was assigned. The only code assigned on the Medicaid bill was V22.0. This is not a high-risk code. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 33: AHCA asserted this was a low-risk patient. Dr. Valente stated that the patient was an alcohol abuser and that the patient developed decreased fetal movement late in the pregnancy. Dr. Valente assigned the code 655.43, which is a high-risk code. The patient was entitled to 14 visits. Dr. Valente billed for 11, which was within the allowed limits.

Patient 34: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 35: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this

finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 36: AHCA asserted this was a low-risk patient and that Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente decided that the patient's baby was not reactive to a stress test, and the patient had to be induced. Dr. Valente coded this 658.03, which is not high risk. AHCA's witness, Dr. Franz, agreed with this. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 37: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

Patient 38: This was a low-risk patient. Dr. Valente billed for 11 visits, which was one more than the 10 allowed. Dr. Valente did not contest this finding. Therefore, Dr. Valente billed Medicaid $52.00 more than allowed.

7. The total amount over-billed in Category 1 was $1,602.00.

8. Category 2 addressed billing for the Screening more than once during a pregnancy. The Physician Coverage and Limitation Handbook provides for Florida's Healthy Start Prenatal Risk Screening. It states, "The Healthy Start Prenatal Risk Screening should be offered at the first antepartum visit. The antepartum visit that includes completion of the Healthy Start Prenatal Risk Screening is reimbursed once per pregnancy by billing code W1991 antepartum visit plus Healthy Start Prenatal Risk Screening, or W1992 antepartum visit plus Healthy Start Prenatal Risk Screening performed during the first trimester of pregnancy."

9. Therefore, for Category 2, the audit searched for situations where there was more than one Healthy Start prenatal visit per pregnancy. In other words, a W1991 might be billed or a W1992 might be billed, but both could not be billed during a single pregnancy. The audit asserts this occurred nine times as follows:

> Patient 1: Dr. Valente billed for the W1991, which is an antepartum visit with the Screening after the first trimester, and then billed for a W1992, which is the Screening during the first trimester, for the same recipient. This overpayment was in the amount of $148.

Patient 2: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $98.

Patient 3: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $100.

Patient 4: Dr. Valente billed for the W1991, which is an antepartum visit with the Screening after the first trimester, and then billed for a H1001, which is the Screening during the first trimester for the same recipient. This overpayment was in the amount of $104.

Patient 5: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $100.

Patient 6: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $100.

Patient 7: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $100.

Patient 8: Dr. Valente billed for the W1992, which is the Screening during the first trimester, and then billed for a W1991, which is an antepartum visit with the Screening after the first trimester, for the same recipient. This overpayment was in the amount of $100.

Patient 9: Dr. Valente billed for the W1991, which is an antepartum visit with the Screening after the first trimester, and then billed for a W1992, which is the Screening during the first trimester for the same recipient. This overpayment was in the amount of $150.

10. The total amount overpaid in Category 2 was $1,000. Dr. Valente pointed out that even though she over-billed in this category, she should have received $50 on each occurrence for an office visit. Although this may be true, it is beyond the jurisdiction of this forum to make recommendations with regard to that.

11. Category 3 included a search for billings for W1992, which is the Screening during the first trimester, that were made subsequent to the end of the first trimester. AHCA defines the first trimester as the first 13 weeks of a pregnancy. The Screening form says the first trimester is determined to be 13 weeks (or 91 days) from the date of the last menstrual cycle. The audit asserted 61 instances of billing for the Screening, subsequent to the first trimester.

12. In determining whether the Screening was accomplished later than the first trimester, 181 days were subtracted from the delivery date. This meant that a Screening provided less than 181 days before delivery was, perforce, beyond the first trimester. The auditors found 61 instances where this occurred.

13. Dr. Valente agreed that she screened subsequent to the first trimester for patients number 2-8, 11-14, 16-18, 20-22, 25-31, 33-36, 38, 40, 43-46, 48-49, 51-54, and 56-61. This amounted to 44 over-bills at $50 and two at $49.34, for a total of $2,298.68.

14. When evaluating the audit at this point, it is helpful to recall that the medical records of the patients were not available when the final audit was issued, but they were available at the time of the hearing.

15. The Medicaid bills for the Healthy Start Prenatal Risk Screening Instruments are typically submitted before the baby is born. Thus, the physician at the time of submission cannot know the actual delivery date with mathematical precision. Accordingly, the physician has to estimate the due date using the date of the last menstrual period (LMP); by ultrasounds; and by following the progress of the pregnancy. Moreover, babies arrive before their predicted due date as well as after.

16. The disputed cases in Category 3 are discussed below.

Patient 1: The estimated delivery date (EDD) was July 9, 2003. The actual delivery date was May 15, 2003. The EDD on December 3, 2002, was determined by ultrasound to be nine weeks and by LMP to be ten weeks. The Screening date was December 3, 2002. This was well within the 13-week window for the Screening. Dr. Valente did not improperly bill for this patient.

Patient 9: This patient did not agree to the screening. If the patient does not agree to the Screening, AHCA is not permitted to pay for the

Screening. Accordingly, Dr. Valente over-billed $50.00.

Patient 10: This patient did not agree to the screening. If the patient does not agree to the Screening, AHCA is not permitted to pay for the Screening. Accordingly, Dr. Valente over-billed $50.00.

Patient 15: An ultrasound on this patient on June 18, 2003, indicated the patient was nine weeks pregnant. The Screening was accomplished on the same day. Accordingly, Dr. Valente did not improperly bill for this patient.

Patient 19: This patient did not agree to the screening. If the patient does not agree to the Screening, AHCA is not permitted to pay for the Screening. Accordingly, Dr. Valente over-billed $50.00.

Patient 23: The Screening for this patient is dated February 26, 2003, according to the Screening form signed by the patient. The delivery date provided to AHCA is incorrect because due to an absence of fetal heartbeat the patient experienced a "Suction D&E followed by sharp D&C of the uterine cavity." This occurred about the 13th week, on

March 28, 2003. In other words, there was no delivery. However, the Screening was not signed at the bottom and that is a reason for rejecting payment. Accordingly, Dr. Valente over-billed $50.00 for this patient.

Patient 24: The Screening form is completely absent for this patient. Accordingly, Dr. Valente over-billed $50.00 for this patient.

Patient 32: This patient declined screening, so Dr. Valente over-billed $49.34.

Patient 37: The Screening form is completely absent for this patient. Accordingly, Dr. Valente over-billed $50.00 for this patient.

Patient 39: This patient declined screening, so Dr. Valente over-billed $50.00.

Patient 41: The Screening date for this patient was October 30, 2002. The first ultrasound on this patient was provided on the same day and indicated the baby was at 12.7 weeks with an EDD of May 9, 2003. The baby was delivered April 19, 2003, which means it came earlier than anticipated and that the Screening was accomplished during the first trimester. Accordingly, Dr. Valente did not improperly bill for this patient.

Patient 42: The screening form is completely absent for this patient. Accordingly, Dr. Valente over-billed $50.00 for this patient.

Patient 47: The Screening for this patient listed on the AHCA spreadsheet was May 8, 2003. However, the form indicates it was signed by the patient on March 27, 2003. The patient's LMP was February 13, 2003, and the first ultrasound indicated the patient was eight and one-half weeks pregnant on April 10, 2003. Even if the Screening was accomplished May 8, 2003, as alleged, it was accomplished in the first trimester. Accordingly, Dr. Valente did not improperly bill for this patient.

Patient 55: The alleged Screening was accomplished August 7, 2003. The Screening date is unreadable as to month, but the day is 31. Dr. Valente's testimony is that it was in March and that the patient was at 11 weeks and three days. This appears more correct than AHCA's allegation. Accordingly, Dr. Valente did not improperly bill for this patient.

17. The over-payment alleged was a total of $3,048.68. The evidence indicates that on five occasions Dr. Valente was correct in her assertion that the Screening for five of the

patients, at $50.00 per patient, was actually within the first trimester. Accordingly, it is found that Dr. Valente only owes $2,748.02 for Category 3.

18. A request for records was sent to Dr. Valente via certified mail to the address she maintained on file with AHCA, on or about October 29, 2007. This provided Dr. Valente with the preliminary audit findings and invited her to illuminate or explain the findings so they could be adjusted if appropriate. The letter was returned. AHCA found a more current address and sent the same letter, and it was delivered to that address in Jacksonville on December 6, 2007. The receipt was signed by Dr. Valente's father.

19. Eventually, Dr. Valente received the materials and called AHCA Investigator Terri Dean, who was listed as the contact point in the letter sent to Dr. Valente. Dr. Valente informed Investigator Dean that she could not get the records. Accordingly, the audit became final as written on March 21, 2008, and was provided to Dr. Valente. The report stated that Dr. Valente owed $6,118.68 for overpayments and should pay a $500.00 fine for failure to provide records.

20. Dr. Valente provided the records about six months later, in late September or early October of 2008. AHCA reviewed the records and determined that there were overpayments in the amount of $7,344.00. Because litigation was already

underway, AHCA did not attempt to extract the additional amount from Dr. Valente.

CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2008).

22. AHCA may recover overpayments from a Medicaid provider through a process called "recoupment," as provided in Florida Administrative Code Rule 59G-1.010(245).

23. Florida Administrative Code Rule 59G-5.020 provides, in part, that: "(1) All Medicaid providers enrolled in the Medicaid program and billing agents who submit claims to Medicaid on behalf of an enrolled Medicaid provider must comply with the provisions of the Florida Medicaid Provider General Handbook, July 2008, which is incorporated by reference and available from the fiscal agent's Web Portal at http://mymedicaid-florida.com."

24. As provided by Florida Administrative Code Rule 59G-4.230, a payment is authorized only when the Medicaid provider has complied with the terms and conditions set forth in the Physician Services Coverage and Limitations Handbook.

25. A provider participating in the Medicaid program has an affirmative duty to supervise and be responsible for the preparation and submission of accurate claims for payment from

the program. It is the provider's duty to ensure that all claims "Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law."
§ 409.913(7)(e), Fla. Stat.

26. The Florida Medicaid Provider General Handbook requires that the provider retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient.

27. The Florida Medicaid Provider General Handbook requires that the aforementioned records must be retained by the provider for a period of five years. It provides that the provider must send, at his or her expense, legible copies of all Medicaid-related information to the authorized state and federal agencies upon the request of AHCA.

28. The Florida Medicaid Provider General Handbook provides that the provider must notify Medicaid of any change of address. The notification must include the new business and mailing address, the physical location if different, the providers' previous address, and the effective date. If first class mail to a provider's physical address is returned, Medicaid will suspend claim payments to the provider or the provider's group by that provider. After 30 days, the suspended

claims will be denied if the provider has not taken corrective action.

29. AHCA has the burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence. See South Medical Services, Inc. v. Agency for Health Care Admin., 653 So. 2d 440 (Fla. 3d DCA 1995) and Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

30. Section 409.913, Florida Statutes, provides in part as follows:

> 409.913 Oversight of the integrity of the Medicaid program.--
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> (14) The agency may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections (12) and (15) and s. 812.035, if:
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> * * *
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> (b) The provider has failed to make available or has refused access to Medicaid-related records to an auditor, investigator, or other authorized employee or agent of the agency, the Attorney General, a state attorney, or the Federal Government;
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> * * *
>
> (15) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (14):
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> * * *

(c) Imposition of a fine of up to $5,000 for each violation. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation.

* * *

(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.

* * *

31. Section 409.913, Florida Statutes (2008), provides, in part, as follows:

409.913 Oversight of the integrity of the Medicaid program.--

* * *

(25)(c) 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.

32. AHCA can make a prima facie case by proffering a properly supported audit report, which must be received in evidence. See Maz Pharmaceuticals, Inc., s/b/s/ Maz Pharmacy v. Agency for Health Care Administration, Case No. 97-3791 (DOAH March 20, 1998) and Full Health Care, Inc. v. Agency for Health Care Administration, Case No. 00-4441 (June 25, 2001).

33. AHCA established that Dr. Valente over-billed as follows:

Category 1	$1,602.00
Category 2	$1,000.00
Category 3	$2,748.02
Total	$5,350.02

RECOMMENDATION

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

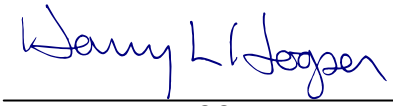
RECOMMENDED that the Agency for Health Care Administration enter a final order requiring Dr. Grace Valente, M.D.:

(1) to pay the sum of $5,350.02 for the purpose of reimbursing improperly billed Medicaid services;

(2) to pay a fine of $1,500 for failing to provide medical records in a timely fashion; and

(3) to pay interest at the rate of 10 percent per annum on the sum of $5,350.02, from March 21, 2008, the date of the final audit report; and interest at the rate of 10 percent per annum on the sum of $1,500 from the date the final order is entered, until the sums are paid completely.

DONE AND ENTERED this 9th day of February, 2009, in Tallahassee, Leon County, Florida.



HARRY L. HOOPER
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Filed with the Clerk of the
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this 9th day of February, 2009.

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.