STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 10-9318MPI

HAL M. TOBIAS,

Respondent.

RECOMMENDED ORDER

Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Tallahassee, Florida, on April 4 and 5, 2011.

APPEARANCES

For Petitioner: Monica Ryan
Jeffries H. Duvall
Assistant General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Station #3
Tallahassee, Florida 32308

For Respondent: George K. Brew
Law Office of George K. Brew,
6817 Southpoint Parkway, Suite 1804
Jacksonville, Florida 32216

STATEMENT OF THE ISSUE

The issue is whether Petitioner can prove Medicaid overpayments to Respondent and, if so, how much Petitioner is entitled to recoup.

PRELIMINARY STATEMENT

By Final Audit Report dated August 16, 2010, Petitioner advised Respondent that it had completed a review of claims for Medicaid services provided from January 1, 2007, through June 30, 2008. Petitioner had determined that it had overpaid Respondent $123,393.06 in claims. Petitioner imposed $5,000 in administrative fines--$4,000 for a violation of Florida Administrative Code Rule 59G-9.070(7)(e) and $1,000 for a violation of Rule 59G-9.070(7)(c)--and $5,658.09 for the cost of audit, pursuant to section 409.913(23)(a), Florida Statutes. The total sought by Petitioner was therefore $134,051.15.

A major part of the dispute involves nerve conduction studies performed by Respondent and billed under the Physician's Current Procedural Terminology Manual (CPT) Code 95904. The Final Audit Report addresses this issue as follows:

> Specifically, sensory nerve conduction threshold tests (sNCT), as stated in the Medicare National Coverage Determinations Manual Chapter 1, Part 2 (Section 160.23) (Rev. 15, 06-18-04), are different and distinct from assessment of nerve conduction velocity, amplitude and latency. It [sic] is also different from short-latency somatosensory evoked potentials. Claims submitted for reimbursement of sNCT as CPT code 95904 (Nerve conduction, amplitude and latency/velocity study, each nerve; sensory) are erroneous and are therefore denied.

On September 28, 2010, Respondent filed its Amended Request for Formal Administrative Hearing.

The court reporter filed the transcript on April 25, 2011. The witnesses and exhibits are identified in the transcript. The parties and one exceptionally enthusiastic witness filed proposed recommended orders by May 17, 2011.

FINDINGS OF FACT

1. Respondent is a licensed physician with an office in Stuart. He is Board-certified in neurology and pain medicine. During the audit period and until recently, Respondent was an enrolled Medicaid provider.

2. The audit in this case involved 237 claims on behalf of 30 recipients. Of these 237 claims, Petitioner determined that 59 were overpayments. After determining the total of these 59 overpayments, Petitioner referred the file to a statistician, who extended these 59 overpayments to the total overpayment shown in the Final Audit Report.

3. The statistician based the extension on generally accepted statistical methods that he explained, at the hearing, to everyone's satisfaction, as evidenced by the fact that no one asked to hear more. During the statistician's testimony, the parties agreed that, if the overpayments in the Final Audit Report are altered in the Final Order, Petitioner will refer the new determinations to a statistician for another extension, based again, of course, on generally accepted statistical methods.

4. Recipients will be identified by the numbers assigned them in Petitioner Exhibit 7. The only recipients addressed are those for whom Petitioner has determined overpayments.

5. Nine billings are at issue with Recipient 1. On March 8, 2007, Respondent saw Recipient 1 and billed a CPT Code 99245 office consultation. Petitioner downcoded this to a CPT Code 99244 office consultation and generated an overpayment of $20.39.

6. The CPT describes these office consultation codes as follows:

> 99244
>
> Office consultation for a new or established patient, which requires these three key components:
> A comprehensive history;
> A comprehensive examination;
> Medical decision making of moderate complexity.
>
> * * *
>
> Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.
>
> 99245
>
> Office consultation for a new or established patient, which requires these three key components:
> A comprehensive history;
> A comprehensive examination;
> Medical decision making of high complexity.

*   *   *

> Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

7. Recipient 1 was the victim of a severe beating at the hands of her husband in July 2006. Petitioner's determinations concerning this case partly arose out of the failure of its consultant to find in Respondent's medical records a date of incident, but Respondent provided this information at the hearing.

8. Recipient 1 suffered fractures of the skull and orbital bone from the spousal battery. Continuously since the incident, she had suffered headaches; vertigo, especially when blowing her nose; memory loss; and a complete inability to use her left hand. The initial office consultation was on March 8, 2007, and Respondent billed it correctly, given the complexity of the medical decisionmaking. She had five diagnoses, and Respondent gave her 11 recommendations. Considerable time and effort were required of Respondent to address her case at this initial office consultation, for which there is thus no overpayment.

9. On March 20, 2007, Recipient 1 underwent an MRI of the brain, for which Respondent billed a CPT Code 70553, which is for brain MRIs with and without dye or contrast. Petitioner downcoded this to a CPT Code 70551, with a reduction of $76.59,

because Respondent had ordered only an MRI of the brain without dye.

10. Respondent produced at hearing a copy of the prescription, which cryptically states: "MRI Brain c /o contrast." The "c" and the "o" have dashes over them. The "c" with a dash is a traditional abbreviation of cum, so it means "with." The meaning of the dash over the "o" is unclear. Lacking a conjunctive symbol in the space between the letters, it appears that the combination means "without," rather than "with" and "without." The downcoding is appropriate, and the overpayment is $76.59.

11. On the same date, Recipient 1 underwent an MRI of the neck and spine without dye. Petitioner denied this billing, which was for $233.47, for lack of medical necessity due to the absence of appropriate pain symptoms, especially radiating pain.

12. At the hearing, Respondent explained that Recipient 1 suffered from moderate to severe stenosis, and he needed to rule out neck involvement in the patient's inability to use her left arm. The neck and spine MRI was medically necessary, so there is no overpayment for this test.

13. On May 2, 2007, Recipient 1 underwent a muscle test, one limb--billed as CPT Code 95860; a sense nerve conduction test--billed as CPT Code 95904; and a motor nerve conduction test--billed as CPT 95903. On the next day, she underwent the

identical tests--all billed under the identical codes. Petitioner denied all of these, and generated overpayments of $40.81, $73.05, $65.60, $40.81, $73.05, and $65.60, respectively.

14. Petitioner denied these tests because Respondent had not ordered them. This does not seem to have been inadvertent on Respondent's part. None of these tests appeared to be part of Respondent's treatment plan for this patient. Petitioner thus determined correctly that these six sums are overpayments.

15. Five billings are at issue with Recipient 3. The first is an office consultation on April 9, 2008. Petitioner has downcoded this from CPT Code 99245 to CPT Code 99244 due to a lack of complexity of decisionmaking. This generates an overpayment of $20.18.

16. Respondent testified that Recipient 3 was a 63-year-old patient with "total body pain." Respondent testified that the patient complained of neck pain, low back pain, and chronic pain, all emanating from a bicycle accident five years earlier that had necessitated the placement of a titanium rod in the patient's leg. However, the eight diagnoses and 18 recommendations do not, on these facts, merit the complexity of decisionmaking claimed by Respondent in his billing. Petitioner has proved an overpayment of $20.18.

17. Recipient 3 raises the issue of the reimbursability of an sNCT administered by Respondent. On April 21, Recipient 3 underwent two procedures billed as sense nerve conduction tests under CPT Code 95904 at $143.70 each. Two days later, Recipient 3 underwent two procedures billed under the same name and CPT Code at $141.70 and $143.70. Petitioner has disallowed all four of these billed amounts.

18. CPT Codes 95900-95904 describe nerve conduction tests that measure the nerve's response to an electrical stimulation in terms of speed, size, and shape. CPT Code 95904 is "nerve conduction, amplitude and latency/velocity study, each nerve; sensory." A procedure meeting the definition of CPT Code 95904 must measure the nerve's response in terms of amplitude and latency/velocity. Amplitude is a measure of size. Latency is a measure of time of travel, so, provided travel distance is known, as it typically is, velocity, or speed, may be derived from latency.

19. The device used by Respondent for all of the sense nerve conduction tests that he billed as CPT Code 95904 was an Axon II device. The inventor of the device testified at the hearing and explained how conventional sense nerve conduction tests, which were developed during World War II, are appropriate for the detection of gross injuries because they detect damage in the large nerve fibers. Fifty to 100 times smaller than

these large fibers are the small nerve fibers, which transmit pain. Among these fibers are the fast-transmitting A-delta fibers and the slow-transmitting fibers are C-fibers. The Axon II focuses on the activity of the A-delta fibers.

20. Originally, the witness produced a neurometer that relied on patient response to the application of increasing voltage to the point that the nerve produced a response in the form of a stimulus. Seven years later, in 2002, the witness added a potentiometer, or voltage meter, to allow what he terms a psychophysical assessment of a sensory nerve conduction test that applies electricity and records amplitude, but not latency or velocity.

21. The witness claims that the A-delta fibers are too small for a useful test of latency or velocity. Among A-delta fibers, the only useful parameter for measurement is amplitude. He added that, similarly, the shape of the signal emanating from the nerve is also irrelevant when dealing with the smaller A-delta fibers.

22. Whatever larger issues of medical necessity that may attach to the Axon II device, the issue in this case is whether it may be billed under Florida Medicaid law, which reimburses only those services designated in Chapter 2, Physician Services Coverage and Limitations Handbook. Pursuant to this requirement, Respondent billed the sNCTs that he performed with

the Axon II device under CPT Code 95904. But, as noted above, this code requires at least a measure of latency and possibly measures of latency and velocity, and the sNCTs do not provide latency or velocity data. Respondent thus miscoded all of the sNCT procedures that he performed in this case.

23. The sNCTs performed with the Axon II device are described by CPT Code 95999, which is assigned to unlisted neurological diagnostic procedures, and Code G0255, which is a unique code for sNCTs. If the sNCTs performed in this case were properly coded only under CPT Code 95999, another issue would emerge because the fee schedule for this code in the Physician Services Coverage and Limitations Handbook bears an "R" code. This means that the provider performing a procedure falling into the residual category of CPT Code 95999 may submit "either documentation of medical necessity for the procedure performed. . . or information . . . in order to review and price the procedure correctly." Physician Services Coverage and Limitations Handbook, p. 3-3.

24. It is unnecessary to determine whether Respondent complied with the "by-report procedure" established for procedures classified within CPT Code 95999, or whether, consistent with the de novo nature of the proceeding, as discussed in the Conclusions of Law, Respondent could first present such evidence at hearing. The Centers for Medicare and

Medicaid Services (CMS) created CPT Code G0255 for sNCTs because it determined that the devices producing this data were not medically necessary, and Medicare and Medicaid would not reimburse claims for these procedures.

25. On March 19, 2004, CMS revised its National Coverage Determinations Manual regarding sNCTs. Noting that these procedures are different from the assessment of nerve conduction velocity, amplitude, and latency, section 160.23 of the manual states that providers may not use codes for tests eliciting nerve conduction velocity, latency, or amplitude for sNCTs. CMS has clearly expressed its intent that, although falling within the residual CPT Code 95999 procedures, sNCTs are ineligible for reimbursement, even by the "by-report procedure."

26. Petitioner thus correctly disallowed the four procedures performed on April 21 and 23, 2008, because they were miscoded and are ineligible for Medicaid reimbursement.

27. Recipient 3 raises another recurring issue. This one concerns an H-Reflex Test, CPT Code 95934. For Recipient 3, it was billed on May 8, 2008, for $27.49. Petitioner properly disallowed the billing because the procedure was not done. Respondent concedes that he never performed an H-Reflex Test on an upper extremity and explains that an inexperienced office worker misconstrued a handwritten mark indicative of a negative to mean that the test had in fact been ordered and conducted.

28. The issue on the H-Reflex Test is not whether Respondent was initially entitled to reimbursement--it was not. The issues are 1) whether this overpayment may be extended to the larger total overpayment determined in this case and 2) whether Respondent has already reimbursed Petitioner for this overpayment of $27.49, if not considerably more. The answer to the first question is no, and the answer to the second question is probably not. The bottom line is that Petitioner may add $27.49 to the total overpayment, but may not include this sum in the extension calculations due to Respondent's timely correction of this billing error.

29. Respondent discovered that his office had wrongly billed this procedure on 28 different occasions, but he (or his wife/office manager) informed Petitioner of this fact prior to the audit. Among the 30 patients randomly selected for the audit, four of them had these incorrect billings for an H-Reflex Test on an upper extremity. For obvious reasons, corrections after the start of an audit may not be allowed, but a timely correction remedies the overbilling, as though it had never taken place.

30. Respondent contends that the situation is even more complicated. Respondent's wife testified that she voided the claims on Petitioner's automated electronic claims paying process, which is the proper procedure, but, for some reason,

all other procedures performed on the same day as the procedure date reported for the H-Reflex Tests were also voided. If so, it would mean that Respondent has already reimbursed Petitioner for the $27.49 erroneous billing, and Petitioner must credit Respondent--and possibly extend the credit--for any other allowable procedures performed on the same date. For Recipient 3 on May 8, 2008, for instance, this would amount to a direct credit of $107.78 for the two other allowable procedures performed on the same day that the H-Reflex Test was reported as performed.

31. Respondent's wife failed to detail these wrongfully aggregated voids, nor did anyone on Petitioner's side of the hearing room have any idea what she was talking about. On this record, it is impossible to credit the testimony so as to require Petitioner to restore the value of other procedures billed on the same date as the H-Reflex Test (here, $107.78), extend this value to a much higher credit, or even restore the value of the H-Reflex Test itself ($27.49).

32. Three billings are at issue with Recipient 6. Two of them are sNCTs billed under CPT Code 95904 for two procedures done on February 27, 2008. They were billed at $141.70 and $143.70, respectively. For the reasons discussed above, these are miscoded and are ineligible for reimbursement, so they are overpayments.

33. The third issue involves an office visit on April 3, 2008, which Respondent billed under CPT Code 99211. Respondent admitted at the hearing that he lacked documentation for this office visit, so Petitioner properly disallowed the $12.48 associated with it.

34. One billing is at issue with Recipient 7. It is a brain MRI with and without dye, which is billed on May 23, 2007, under CPT Code 70553. Petitioner properly disallowed the entire $410.85 because it was obviously double-billed, and Petitioner allowed the "other" procedure.

35. Three billings are at issue with Recipient 9. On November 2, 2007, Respondent billed a neck and spine MRI without dye as CPT Code 72141 and a lumbar spine MRI without dye as CPT Code 72148. On November 13, 2007, Respondent billed a head angiography without dye as CPT Code 70544. Citing a lack of medical necessity, Petitioner denied all of these items, which amount to $233.47, $236.65, and $300.09, respectively.

36. At the time of the procedures in question, Respondent had been seeing this 37-year-old patient for only one month. Another physician had referred the patient, who, for three months, had been suffering from headaches in the right frontal temporal area. The pain was severe enough to cause the patient to go to the hospital emergency room three times. Finally, the emergency room physicians instructed the patient not to come to

the emergency room, and they referred him to a neurologist--who had been dead for two years at the time of the referral.

37. The emergency room physicians had prescribed Dilaudin, but the patient, who was also on a blood thinner, presented to Respondent with the need for a full neurological workup. He was a construction worker and needed to return to work. Respondent ordered the angiography to rule out vascular malformation, which could have caused the headaches and could be fatal. Respondent ordered the MRIs to assess significant anatomical problems and rule out metastatic disease. These three procedures were medically necessary, so there is no overpayment due in connection with them.

38. One billing is at issue with Recipient 11. On January 10, 2007, Respondent billed an office consultation under CPT Code 99243. Petitioner allowed only an office visit, not an office consultation, resulting in an overpayment of $15.33. Respondent has not contested this adjustment, which appears to be correct.

39. Four billings are at issue with Recipient 15. They are sNCTs billed under CPT Code 95904 for two procedures done on March 4, 2008, and two procedures done on March 24, 2008. Two of the procedures were billed at $141.70 and two were billed at $143.70. For the reasons discussed above, these are miscoded and are ineligible for reimbursement, so they are overpayments.

40. Four billings are at issue with Recipient 16. They are sNCTs billed under CPT Code 95904 for two procedures done on January 22, 2008, and two procedures done on March 5, 2008. They are billed the same as those described in the preceding paragraph. They are miscoded and ineligible for reimbursement, so they are overpayments.

41. Three billings are at issue with Recipient 17. They are sNCTs billed under CPT Code 95904 for one procedure done on March 17, 2008, and two procedures done on March 19, 2008. They are billed at $141.70 for two procedures and $143.70 for the third procedure. They are miscoded and ineligible for reimbursement, so they are overpayments.

42. Four billings are at issue with Recipient 20. They are sNCTs billed under CPT Code 95904 for two procedures done one June 24, 2008, and two procedures done on June 30, 2008. They are each billed at $143.70. They are miscoded and ineligible for reimbursement, so they are overpayments.

43. Six billings are at issue with Recipient 21. Four are sNCTs billed under CPT Code 95904 for two procedures done on February 20, 2008, and two procedures done on February 28, 2008. They are each billed at $143.70. They are miscoded and ineligible for reimbursement, so they are overpayments.

44. The other two billings are for H-Reflex Tests of upper extremities--one on March 25, 2008, and one on April 2, 2008.

As noted above, Respondent never performed these tests, but corrected the misbilling prior to the audit. The $27.49 billed for each of these tests may not be extended in determining the total overpayment, but Petitioner may add $54.98 to the total overpayment determination, and Petitioner is not required to credit Respondent for additional sums due to claimed problems in voiding these billings.

45. Four billings are at issue with Recipient 25. They are sNCTs billed under CPT Code 95904 for two procedures done on June 5, 2008, and two procedures done on June 10, 2008. They are each billed at $143.70. They are miscoded and ineligible for reimbursement, so they are overpayments.

46. One billing is at issue with Recipient 26. On February 15, 2007, Respondent billed an office visit under CPT Code 99205, which Petitioner reduced by $16.64 by downcoding it to CPT Code 99204.

47. The CPT Manual describes these office visit codes as follows:

> 99204
>
> Office or other outpatient visit of the evaluation and management of a new patient, which requires these three key components:
> A comprehensive history;
> A comprehensive examination;
> Medical decision making of moderate complexity.

* * *

> 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.
>
> 99205
>
> Office or other outpatient visit of the evaluation and management of a new patient, which requires these three key components:
> A comprehensive history;
> A comprehensive examination;
> Medical decision making of high complexity.
>
> *   *   *
>
> Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

48. Recipient 26 is a 43-year-old with migraines. She has suffered three headaches weekly since fourth grade. An MRI of her lower back in 2004 revealed a herniated disk, and she has pain in her right leg and foot numbness, if she drives too long. The medical decisionmaking was no more than moderately complex, so Petitioner properly downcoded this office visit, resulting in an overpayment of $16.64.

49. Four billings are at issue with Recipient 27. On January 15, 2008, Respondent billed an office visit under CPT Code 99205, which Petitioner reduced by $18.64 by downcoding it to CPT Code 99204.

50. Recipient 27 was referred by her obstetrician and saw Respondent two and one-half months post-partum. She was unable to lift her right arm. She had pain in her right outside shoulder. Her fingers were numb. Based on a physical examination, Respondent detected nerve damage in the axilla, and she reported cervical radiculopathy. The constellation of symptoms suggested three or four problems that obviously required immediate attention to facilitate her caring for her newborn. The medical decisionmaking was highly complex, so there is no overpayment for this office visit.

51. Respondent billed two sNCTs under CPT Code 95904 for two procedures done on January 24, 2008, for $143.70 each. They are miscoded and ineligible for reimbursement, so they are overpayments.

52. Respondent billed an H-Reflex Test under CPT Code 95934 on February 7, 2008, for $27.49. As noted above, Respondent never performed this test, but corrected the misbilling prior to the audit. The $27.49 may not be extended in determining the total overpayment, but Petitioner may add $27.49 to the total overpayment determination, and Petitioner is not required to credit Respondent for additional sums due to claimed problems in voiding these billings.

53. Petitioner conceded error in its disallowance concerning Recipient 28, for whom Respondent billed $41.00 under

CPT Code 95860 for a muscle test conducted on February 21, 2008. See Petitioner's proposed recommended order, paragraph 21. This is therefore not an overpayment.

54. Three billings are at issue with Recipient 29. On February 7, 2007, Respondent billed an office consultation under CPT Code 99245, which Petitioner reduced by $46.24 by downcoding it to CPT Code 99205, which is for an office visit. This was an office visit, not an office consultation, as billed by Respondent, so the downcoding was correct, and there is an overpayment of $46.24.

55. On February 16, 2007, Respondent billed for a neck and spine MRI without dye under CPT Code 72141 and a chest and spine MRI without dye under CPT Code 72146--twice each. Petitioner properly disallowed $357.60 and $305.18 for one pair of these procedures, which obviously were double-billed, so there are overpayments of these amounts.

56. Two billings are at issue with Recipient 30. Respondent billed two sNCTs under CPT Code 95904 for two procedures done on April 14, 2008, for $141.70 and $143.70. They are miscoded and ineligible for reimbursement, so they are overpayments.

57. The Final Audit Report claims that the audit cost $5658.09, but Petitioner failed to produce any evidence on these costs.

CONCLUSIONS OF LAW

58. The Division of Administrative Hearings has jurisdiction over the subject matter. §§ 120.569, 120.57(1), and 409.913(31), Fla. Stat.

59. Petitioner is authorized to seek repayment of overpayments that it may have made for goods or services for which reimbursement under the Medicaid program is available. § 409.913(11), (12)(a), (16)(j), and (31), Fla. Stat.

60. The burden of proof is on Petitioner to prove overpayments by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992); S. Medical Services v. Agency for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995) (per curiam). See also § 409.913(20), Fla. Stat. ("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.") (Emphasis supplied.)

61. Section 409.913(22) provides: "The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." This suggests that an audit report prepared in a manner consistent with all applicable statutory requirements establishes a prima facie case of overpayment. However, the allocation of the burden of proof or burden of going forward with the evidence is

not determinative as to any of the individual alleged overpayments considered in this case. The cited statute covers overpayments, not audit costs, so the inclusion of audit costs in the Final Audit Report does not dispense with the necessity of proving up these costs at the hearing.

62. The hearing is de novo. § 120.57(1)(k), Fla. Stat. In the context of the present case, a de novo hearing means that the provider may introduce evidence that it did not present during the audit. Wistedt v. Dep't of HRS, 551 So. 2d 1236 (Fla. 1st DCA 1989); HBA Corp. v. Dep't HRS, 482 So. 2d 461, 468 (Fla. 1st DCA 1986) (dictum). As noted above, though, it is unnecessary to determine if this principle means that a provider seeking reimbursement for a procedure bearing an "R" code may provide the required documentation, for the first time, at the hearing.

63. Section 409.913(7)(e) and (f), Florida Statutes, requires that providers present claims for reimbursement only in accordance with all Medicaid rules, regulations, and handbooks and for goods and services that are medically necessary, which includes both actual medical necessity and documented medical necessity. This provision incorporates, among other things, the Physician Services Coverage and Limitations Handbook.

64. It is within the scope of this proceeding to determine the applicable facts and whether an otherwise-eligible service

is medically necessary under these facts. It is generally not within the scope of this proceeding to determine whether a procedure itself is medically necessary, regardless of the circumstances surrounding its use with respect to an individual recipient. Although procedures bearing an "R" code may tend to raise issues involving the medical necessity of a procedure itself, as distinguished from the medical necessity of a procedure applied to a specific recipient, CMS has assigned sNCTs a unique code to express its determination that these procedures are not eligible for reimbursement. An overpayment case is not the vehicle for overturning Petitioner's incorporation of this determination into Florida Medicaid law, and Petitioner's concession in its proposed recommended order that the "by-report procedure" is available for an sNCT performed on the Axon II device is unsupported by the applicable authority and wrong.

64. Petitioner has proved the overpayments identified in the Findings of Fact. Using generally accepted statistical methods, as required by section 409.913(20), a qualified statistician may extend the overpayments identified in the Findings of Fact to a total overpayment determination. Overpayments bear interest at the statutory rate set forth in section 409.913(25)(c), "from the date of determination of the overpayment by the agency."

65. Section 409.913(23)(a) allows Petitioner to recover its investigative, legal, and expert witness costs. However, Petitioner has offered no proof of such expenses, so these costs may not be included in the Final Order.

66. Florida Administrative Code Rule 59G-9.070(7)(c) and (e) provides in part:

> SANCTIONS: In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed as follows:
>
> *   *   *
>
> (c) For failure to make available or furnish all Medicaid-related records, to be used in determining whether and what amount should have or should be reimbursed: For a first offense, $2,500 fine per record request and suspension until the records are made available; if after 10 days the violation continues, an additional $1,000 fine per day; and, if after 30 days the violation remains ongoing, termination. For a second offense, $5,000 fine per record request and suspension until the records are made available; if after 10 days the violation continues, an additional $2,000 fine per day; and if after 30 days the violation remains ongoing, termination. For a third or subsequent offense, termination. [Section 409.913(15)(c), F.S.]; [and]
>
> *   *   *
>
> (e) For failure to comply with the provisions of the Medicaid laws: For a first offense, $1,000 fine per claim found

> to be in violation. For a second offense, $2,500 fine per claim found to be in violation. For a third or subsequent offense, $5,000 fine per claim found to be in violation. [Section 409.913(15)(e), F.S.][.]

67. Petitioner has proved that at least four of Respondent's claims violated Florida Medicaid law. Petitioner thus may impose a $4,000 administrative fine under rule 59G-9.070(7)(e). However, Petitioner has not proved that Respondent failed to make available specific Medicaid records, so Petitioner may not impose a $1,000 administrative fine rule 59G-9.070(7)(c).

RECOMMENDATION

It is

RECOMMENDED that:

1. Petitioner submit the file to a statistician for an extension, using generally accepted statistical methods, of the redetermined overpayments, as set forth in the Findings of Fact, to a total overpayment determination.

2. Petitioner issue a Final Order determining that Petitioner is entitled to recoup the total overpayment determined in the preceding paragraph, statutory interest on this sum from the date of the Final Order, and a $4,000 administrative fine for multiple violations of Florida Administrative Code Rule 59G-9.070(7)(e).

DONE AND ENTERED this 19th day of May, 2011, in Tallahassee, Leon County, Florida.

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

Filed with the Clerk of the
Division of Administrative Hearings
this 19th day of May, 2011.

COPIES FURNISHED:

George Kellen Brew, Esquire
Law Office of George K. Brew
6817 Southpoint Parkway, Suite 1804
Jacksonville, Florida 32216

L. William Porter, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Monica Ryan, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Jeffries H. Duvall, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Elizabeth Dudek, Secretary
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Justin Senior, General Counsel
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

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.