STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs. Case No. 12-1447MPI

BAY REGIONAL AND INTERNATIONAL
INSTITUTE OF NEUROLOGY/
DR. RADHAKRISHNA RAO,

Respondent.
_____/

RECOMMENDED ORDER

On December 16 through 18, 2013, an administrative hearing in this case was held in Tallahassee, Florida, before William F. Quattlebaum, Administrative Law Judge, Division of Administrative Hearings.

APPEARANCES

For Petitioner: Karen A. Brodeen, Esquire
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For Respondent: Frank P. Rainer, Esquire
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STATEMENT OF THE ISSUES

Whether the Bay Regional and International Institute of Neurology/Dr. Radhakrishna Rao (Respondent) received Medicaid overpayments that the Agency for Health Care Administration, Office of Inspector General, Bureau of Medicaid Program Integrity (Petitioner), is entitled to recover, and whether a fine should be imposed against Respondent.

PRELIMINARY STATEMENT

By Final Audit Report (FAR) dated June 1, 2011, the Petitioner asserted that the Respondent, a Medicaid provider, had received an overpayment of $110,712.09 for charges filed by the Respondent with the Medicaid program. The FAR stated that the Petitioner intended to seek repayment of the alleged overpayment, to impose an administrative fine of $24,642.42 and to assess costs of $7,336.12.

By letter dated June 20, 2011, the Respondent disputed the alleged overpayment and requested a formal administrative hearing. The Petitioner forwarded the request to the Division of Administrative Hearings (DOAH), where it was designated as DOAH Case No. 11-3313MPI and assigned to Administrative Law Judge (ALJ) J.D. Parrish. An administrative hearing was scheduled for October 3 and 4, 2011.

On September 6, 2011, the parties filed a Joint Motion to Relinquish Jurisdiction to permit the parties to pursue a

resolution of the dispute. ALJ Parrish granted the motion in an Order dated September 16, 2011, and the DOAH file was closed.

On April 10, 2012, the Petitioner filed a Motion to Reopen the case. The Motion was granted by ALJ Parrish, and the case was reopened as DOAH Case No. 12-1447MPI. An administrative hearing was scheduled for July 2 and 3, 2012. For a variety of reasons, the hearing was continued and rescheduled before it eventually commenced on December 16, 2013.

The case was transferred to the undersigned ALJ on December 9, 2013.

At the hearing, the Petitioner presented the testimony of Fred Becknell, Jennifer Ellingsen, Blanca Notman, Dr. Fred Huffer and Dr. Harry Abram. Official recognition was taken of relevant statutes, rules and documents identified as Petitioner's Exhibits A through C, K and L. The Petitioner's Exhibits E through J (pages 403 through 409 only), N, P and Q were admitted into evidence. The Respondent testified on his own behalf and presented the deposition testimony of Dr. Jose Foradada. The Respondent's Exhibits 5, 6, 9, 10, 17, 24 and 25 were admitted into evidence.

Volume I of the Transcript of the hearing was filed on January 10, 2014. Volumes II through VI of the Transcript were filed on January 14, 2014.

On February 25, 2014, the parties filed proposed recommended orders that have been considered in the preparation of this Recommended Order.

The Petitioner's Proposed Recommended Order states that the Respondent failed to file the deposition testimony of Dr. Jose Foradada. The transcript of a deposition of Dr. Foradada taken on October 22, 2013, was included in the materials filed with DOAH prior to the hearing and was transferred to the undersigned ALJ as part of the case file on December 9, 2013.

The Respondent's Proposed Recommended Order includes Proposed Findings of Fact related to charges dated 7/25/08, for a patient identified as Recipient No. 8. At the hearing, the Petitioner stipulated that the disallowance of the charge had been withdrawn and that it was no longer considered to be an overpayment.

For reasons unknown, the Respondent in this case has been identified as Bay Regional and International Institute of Neurology/Dr. Radhakrishna Rao. There is no evidence that anyone other than Dr. Rao was involved in the provision of medical treatment relevant to this proceeding. References in this Recommended Order to the Respondent are to Dr. Rao unless otherwise specified.

When this dispute was initially referred to DOAH in 2011, the Petitioner was seeking to impose a fine of $24,642.42. At

the commencement of the hearing, the Petitioner announced that the proposed fine had been incorrectly calculated and that, based on the rules in effect during the audit period, the Petitioner was seeking to impose a fine of $3,500. Thereafter, the parties recessed to discuss remaining factual disputes, a substantial number of which were resolved at that time or during the hearing. This Recommended Order addresses only the charges that remained in dispute at the conclusion of the hearing.

FINDINGS OF FACT

1. The Medicaid program (Medicaid) is a federal and state partnership that funds health care services for qualified individuals.

2. The Petitioner is the state agency charged with administering the provisions of Medicaid in Florida.

3. The Respondent owns and operates the Bay Regional and International Institution of Neurology. At all times material to this case, the Respondent was a duly-licensed Florida physician who participated as a provider in Medicaid pursuant to a Medicaid Provider Agreement executed between himself and the Petitioner.

4. The Respondent specializes in neurology and pediatric neurology. Many of the Respondent's patients are medically complex developmentally disabled persons with neurological issues. A portion of his practice serves patients who receive services through enrollment in Children's Medical Services

Network (CMS) or who have "aged out" of CMS and remain as the Respondent's patients.

5. The Petitioner is legally authorized to monitor the activities of Medicaid providers and to recover "overpayments." Overpayments include reimbursement for services that are not medically necessary, as verified by records existing at the time of service.

6. The Petitioner's Bureau of Medicaid Program Integrity (MPI) routinely audits providers.

7. The Petitioner was authorized by section 409.9131(5)(a), Florida Statutes (2010),[1/] to use a variety of "accepted and valid" methods in determining whether overpayments have been made, and the Petitioner "may introduce the results of such statistical methods and its other audit findings as evidence of overpayment."

8. The Petitioner used a single-stage cluster sample technique to select a sample of Medicaid recipients for review from the Respondent's total billings during the audit period. Cluster sampling is a common and well-accepted sampling methodology, and the evidence is sufficient to establish that it produced a valid group of Medicaid recipients for review.

9. After the claims review was complete, the Petitioner then applied an extrapolation technique to calculate the alleged overpayment. The Petitioner presented sufficient evidence to

establish that the extrapolation technique produced a valid calculation of the overpayment at issue in this case.

10. By a certified letter dated July 27, 2010, the Petitioner notified the Respondent that an audit was being conducted for the period from July 1, 2007, through June 30, 2009 (the "audit period"), and requested relevant documentation related to the Medicaid program recipients identified therein. The documents requested specifically included "eeg reports and hospital records for inpatient services." The letter stated that the failure to provide all Medicaid-related records would result in sanctions.

11. By transmittal letter dated September 2, 2010, the Respondent forwarded to the Petitioner "nearly complete" copies of records related to the audit.

12. By a certified letter to the Respondent dated January 4, 2011, the Petitioner issued a preliminary audit report alleging that the Respondent received an overpayment of $115,393.14 during the audit period.

13. By transmittal letter dated February 4, 2011, previous legal counsel for the Respondent forwarded to the Petitioner "the entire medical files and documentation" for the recipients identified as part of the audit sample.

14. On June 1, 2011, the Petitioner issued the FAR, alleging that the Respondent had received an overpayment of

$110,712.09 during the audit period. The FAR also advised that a fine of $24,642.42 and audit costs of $7,336.12 were being assessed, which brought the total amount due from the Respondent to $142,690.63.

15. As previously stated, the parties resolved a significant portion of the disputed charges at the commencement of the hearing. The remaining disputed charges are for a variety of extended electroencephalogram (EEG) services. Extended EEG monitoring is commonly referred to as "long-term monitoring" (LTM). A standard EEG takes about 30 minutes to complete, including the testing period, while an LTM occurs over a 24-hour period, or longer. LTMs are billed in units of 24-hour periods.

16. The coding of claims for Medicaid reimbursement purposes is set forth in the "Current Procedural Terminology" (CPT) codebook. The CPT codes relevant to this dispute are as follows:

> CPT Code 95951: Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalogram (eeg) and video recording and interpretation (e.g., for presurgical localization), each 24 hours.
>
> CPT Code 95956: Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalogram (eeg) recording and interpretation (each 24 hours).
>
> CPT Code 95813: Electroencephalogram (eeg); extended monitoring, greater than one hour.

17. Applicable Medicaid regulations require that "medical necessity" be documented by specific records made at the time the services were provided, and that the records fully identify the medical basis and the need for the services. In other words, a provider must document the rationale for conducting an LTM at the time of making the decision to perform the extended study.

18. The Petitioner has asserted that the Respondent failed to submit sufficient documentation to establish that the disputed charges identified herein were for "medically necessary" services. As to this specific issue, the Petitioner presented the testimony of Dr. Abram, and the Respondent testified on his own behalf and presented the deposition testimony of Dr. Foradada. The following recipient-specific Findings of Fact are based on the testimony of Dr. Abram, which was persuasive and has been credited.

Recipient #3

19. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #3 on 11/02/07. The charge of $144.15 was paid by Medicaid and is not disputed.

20. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #3 on 11/02/07 and for the two following dates of 11/03/07 and 11/04/07. The Respondent billed Medicaid $463.44 for each date,

for a total of $1,390.32. The Petitioner has asserted that these charges are overpayments.

21. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #3 fail to document the medical necessity for the services. Accordingly, the charges totaling $1,390.32 were improperly billed to Medicaid.

Recipient #6

22. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #6 on 11/28/08. The charge of $186.61 was paid by Medicaid and is not disputed.

23. The Respondent also billed Medicaid for CPT Code 95956 ("Eeg Monitoring, Cable/Radio") services provided to Recipient #6 on 11/28/08 and 11/29/08, each in an amount of $505.63, for a total of $1,011.26. The Petitioner has asserted that these charges are overpayments.

24. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #6 fail to document the medical necessity for the services. Accordingly,

the charges totaling $1,011.26 were improperly billed to Medicaid.

Recipient #17

25. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #17 on 07/06/07. The charge of $185.89 was paid by Medicaid and is not disputed.

26. The Respondent also billed Medicaid for CPT Code 95956 ("Eeg Monitoring, Cable/Radio") services provided to Recipient #17 on 07/06/07 and on the two following dates of 07/07/07 and 07/08/07. The Respondent charged Medicaid $488.29 for each date, for a total of $1,464.87. The Petitioner has asserted that these charges are overpayments.

27. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #17 fail to document the medical necessity for the services. Accordingly, the charges totaling $1,464.87 were improperly billed to Medicaid.

Recipient #20

28. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #20 on 04/29/08. The charge of $186.61 was determined by the Petitioner

to be an overpayment, and the Respondent has not challenged the determination.

29. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #20 on 04/29/08 and on the two following dates of 04/30/08 and 05/01/08. The Respondent charged Medicaid $597.65 for each date. The Petitioner has asserted that the records do not document the medical necessity for the second and third dates of service and, therefore, has determined the total disputed charge of $1,195.30 to be an overpayment.

30. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #20 fail to document the medical necessity for the second and third dates of service. Accordingly, the charges totaling $1,195.30 were improperly billed to Medicaid.

Recipient #22

31. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #22 on 02/01/08. The charge of $186.60 was determined by the Petitioner to be an overpayment, and the Respondent has not challenged the determination.

32. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #22 on 02/01/08 and on the two following dates of 02/02/08 and 02/03/08. The Respondent charged Medicaid $597.64 for each date. The Petitioner has asserted that the records do not document the medical necessity for the second and third dates of service and, therefore, determined the total disputed charge of $1,195.28 to be an overpayment.

33. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #22 fail to document the medical necessity for the second and third dates of service. Accordingly, the charges totaling $1,195.28 were improperly billed to Medicaid.

Recipient #24

34. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #24 on 10/05/07. The charge of $144.15 was determined by the Petitioner to be an overpayment, and the Respondent has not challenged the determination.

35. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #24 on 10/05/07 and on the two following dates of 10/06/07 and

10/07/07. The Respondent charged Medicaid $463.44 for each date. The Petitioner has asserted that the records do not document the medical necessity for the second and third dates of service and, therefore, determined the total disputed charge of $926.88 to be an overpayment.

36. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #24 fail to document the medical necessity for the second and third dates of service. Accordingly, the charges totaling $926.88 were improperly billed to Medicaid.

Recipient #25

September 2007

37. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep") provided to Recipient #25 on 09/26/07. The charge of $144.15 was determined by the Petitioner to be an overpayment, and the Respondent has not challenged the determination.

38. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #25 on 09/26/07 and on the two following dates of 09/27/07 and 09/28/07. The Respondent charged Medicaid $463.44 for each date. The Petitioner has asserted that the records do not document the

medical necessity for the third date of service and, therefore, determined the total disputed charge of $463.44 to be an overpayment.

March 2009

39. The Respondent billed Medicaid for a standard EEG (CPT Code 95819, "Eeg, Awake and Asleep") provided to Recipient #25 on 03/24/09. The charge of $139.77 was determined by the Petitioner to be an overpayment, and the Respondent has not challenged the determination.

40. The Respondent also billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services provided to Recipient #25 on 03/24/09 and on the two following dates of 03/25/09 and 03/26/09. The Respondent charged Medicaid $463.44 for each date. The Petitioner has asserted that the records do not document the medical necessity for the second and third dates of service and, therefore, determined the total disputed charge of $926.88 to be an overpayment.

41. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #25 fail to document the medical necessity for the dates of service that were determined as overpayments by the Respondent. Accordingly, the

charges of $463.44 and $926.88 were improperly billed to Medicaid.

Recipient #27

42. For services rendered to Recipient #27 on 09/25/08, the Respondent billed Medicaid $186.61 for a standard EEG (CPT Code 95819, "Eeg, Awake And Asleep"), $213.94 for CPT Code 95813 ("Eeg, Over 1 Hour") and $597.65 for CPT Code 95951 ("Eeg Monitoring/Videorecord").

43. CPT Code 95951 provides for a 24-hour monitoring period and the charge of $597.65 for 09/25/08 was paid by Medicaid. Because Medicaid paid the $597.65 charge for CPT Code 95951, the Petitioner has determined that the charge of $213.94 on the same date for CPT Code 95813 ("Eeg, Over 1 Hour") was an overpayment. The Respondent has challenged the determination, but no credible evidence was offered to demonstrate any medical necessity for both services to have been performed on 09/25/08.

44. The charge of $186.61 on 09/25/08 for CPT Code 95819 ("Eeg, Awake And Asleep") was determined by the Petitioner to be an overpayment, and the Respondent has not challenged the determination.

45. The Respondent billed Medicaid for CPT Code 95951 ("Eeg Monitoring/Videorecord") services for each of the next two service dates, 09/26/08 and 09/27/08.

46. The Respondent charged Medicaid $597.65 for each date. The Petitioner has asserted that the records do not document the medical necessity for the charges on these dates and, therefore, determined the total disputed charge of $1,195.30 to be an overpayment.

47. Although at the hearing the Respondent testified as to the medical condition of the patient and his rationale for ordering the services, the documentation maintained at the time the disputed services were rendered to Recipient #27 fail to document the medical necessity for the dates of service that were determined as overpayments by the Petitioner. Accordingly, the charges of $213.94 and $1,195.30 were improperly billed to Medicaid.

CONCLUSIONS OF LAW

48. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2013).

49. The burden of proof is on the Petitioner to prove the material allegations by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

50. The Petitioner is authorized by section 409.913 to monitor the activities of Medicaid providers and to recover "overpayments" of Medicaid claims. Overpayments are defined as

"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." In relevant part, "abuse" is defined as "reimbursement for goods or services that are not medically necessary or that fail to meet professionally recognized standards for health care."

51. The determination of medical necessity is based on the records that exist at the time the service is provided. The Respondent is charged with the responsibility for assuring not only that claims for payment are for services that are medically necessary, but also that the medical necessity is "fully and properly" documented. Section 409.913(7) provides, in relevant part, 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:
>
> * * *
>
> (b) Are Medicaid-covered goods or services that are medically necessary.

* * *

> (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.

52. The audit report, if accompanied by supporting work papers, is "evidence of the overpayment." § 409.913(22), Fla. Stat. Absent credible evidence to the contrary, the audit report and work papers establish the total overpayment. In this case, the Petitioner met the burden of establishing that the disputed charges referenced herein were not properly billed to Medicaid and are overpayments that may be recovered by the Petitioner.

53. As previously noted, the Petitioner announced at the commencement of the hearing that the proposed fine had been reduced to $3,500. The revision was based on a fine of $500 for alleged violations of the version of Florida Administrative Code Rules 59G-9.070(7)(c) and (e) in effect during the audit period. In order to impose a fine in this case, the Petitioner must establish the violations by clear and convincing evidence. Dep't of Banking & Fin. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996). The evidence is insufficient to warrant imposition of a fine in this case.

54. Section 409.913(17) provides as follows:

> (17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:
>
> (a) The seriousness and extent of the violation or violations.
>
> (b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.
>
> (c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.
>
> (d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.
>
> (e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.
>
> (f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

55. The issue in the case presented for hearing was whether the records that existed at the time of disputed services were sufficient to establish that the services were medically necessary. Dr. Abram persuasively opined that the records provided to the Petitioner during the audit period were insufficient to establish that the disputed services were

medically necessary. However, the evidence presented by the Respondent was sufficient to establish that there was at least a reasonable argument to the contrary. Nothing in section 409.913(17) suggests that the imposition of a fine in this case would be appropriate.

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 finding a Medicaid overpayment of $9,983.47 as set forth herein, to be added to the overpayment amount associated with the stipulated disposition of disputed charges resolved during the hearing by the parties.

Pursuant to section 409.913(23), the Petitioner is entitled to recover all investigative, legal and expert witness costs. Jurisdiction is retained to determine the amount of appropriate costs, if the parties are unable to agree. Within 30 days after entry of the final order, either party may file a request for a hearing on the amount. Failure to request a hearing within 30 days after entry of the final order shall be deemed to indicate that the issue of costs has been resolved.

DONE AND ENTERED this 24th day of April, 2014, in Tallahassee, Leon County, Florida.

William F. Quattlebaum

WILLIAM F. QUATTLEBAUM
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of April, 2014.

ENDNOTE

[1/] Unless otherwise noted, all statutory references are to Florida Statutes (2010).

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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.