STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

RADHAKRISHNA K. RAO AND BAY REGIONAL AND INTERNATIONAL INSTITUTE OF NEUROLOGY,

Petitioners,

vs. Case No. 12-2813RU

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

FINAL ORDER

A duly-noticed hearing was held in this matter on May 6, 2013, in Tallahassee, Florida, before Suzanne Van Wyk, an administrative law judge assigned by the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUE

Whether Respondent, the Agency for Health Care Administration (AHCA or the agency), has any agency statements with regard to reimbursement of Medicaid expenses by physician providers for long-term electroencephalographic monitoring which are agency rules, as defined in section 120.52(16), Florida Statutes, but have not been adopted as rules in violation of section 120.54(1)(a), Florida Statutes, and if so, whether costs and attorney's fees should be awarded.

PRELIMINARY STATEMENT

Petitioner, an authorized provider of Medicaid services, was audited by Respondent's Office of Medicaid Program Integrity for the claims period July 1, 2007, through June 30, 2009, and found to be in violation of certain Medicaid provider policies. Respondent prepared a Final Audit Letter on June 1, 2011, informing Petitioner that he was overpaid $110,712.09 for services provided during the audit period and imposing fines and costs.

On July 1, 2011, Petitioner timely requested an administrative hearing challenging Respondent's determination of overpayments and imposition of fines and costs. That proceeding is pending as Division of Administrative Hearings (Division) Case No. 12-1447MPI (the Overpayment Case).

On August 17, 2012, Petitioner filed the instant Unadopted Rule Challenge alleging that the agency's determination of overpayment was based, at least in part, on policies regarding the medical necessity of long-term monitored electroencephalograms (LTM EEGs), which constitute agency rules that have not been adopted pursuant to section 120.54 in violation of section 120.54(1)(a).

This unadopted rule challenge was initially assigned to Administrative Law Judge Errol H. Powell, and the hearing was scheduled for November 30, 2012. Petitioner's Motion to Consolidate the unadopted rule challenge with the Overpayment Case was denied. On November 28, 2012, Respondent filed a Motion for Summary Final Order and Expedited Ruling, alleging Petitioners had, both in their pre-hearing stipulation and in deposition the preceding day, conceded they were not bringing a non-rule policy challenge. Respondent filed a contemporaneous Emergency Motion for Continuance.

Following a telephonic hearing on the motions, Judge Powell granted the Motion for Continuance, canceled the final hearing, placed the case in abeyance, and ordered the parties to file a status report by January 4, 2013. Further, the administrative law judge ordered Respondent to file an Amended Motion for Summary Final Order by December 21, 2012, and ordered Petitioner to file a response thereto on or before January 4, 2013.

Petitioners subsequently filed amendments to their pre-hearing stipulation. Respondent withdrew the Motion for Summary Final Order, filed the deposition transcript of Petitioner Rao, and filed a Motion for Clarification seeking to compel Petitioners to clarify the statements alleged to be attributed to AHCA. By Order dated January 30, 2013, Judge Powell granted the Motion for Clarification, ordered Petitioners to file a Second Amended Pre-hearing Stipulation by February 4, 2013, and allowed further discovery. The Order required the parties to provide, by February 7, 2013, dates for re-scheduling the final hearing. The final hearing was re-scheduled for May 6, 2013.

This case was transferred to the undersigned on April 3, 2013. The final hearing commenced as scheduled on May 6, 2013. The parties offered the testimony of Michael Bolin, AHCA Administrator, Bureau of Medicaid Services; Fred Becknell, AHCA Medicaid Program Integrity Administrator; Dr. Radhakrishna Rao, Petitioner; and Dr. Harry S. Abram, the AHCA peer reviewer for the underlying Overpayment Case. Dr. Rao was accepted as an expert in neurology and Dr. Abram was accepted as an expert in neurology and pediatric neurology.

Petitioners' Exhibits P-1 through P-6 and P-6a were admitted into evidence, as were Respondent's Exhibits R-1 through R-13. At final hearing, the undersigned sustained objection to the introduction of Respondent's Exhibit R-14, the

deposition transcript of Dr. Rao, but admitted Exhibit R-14 on Respondent's Motion to Recognize Deposition Transcript following the hearing.

At the close of the final hearing, the parties agreed to file Proposed Final Orders within 40 days following the date the Transcript was filed with the Division. The two-volume Transcript of the final hearing was filed on May 22, 2013, after which Petitioners filed a Motion for Extension of time to file Proposed Final Orders by June 18, 2013. The Motion was granted. The parties timely filed Proposed Final Orders on June 18, 2013, which have been considered by the undersigned in preparing this Final Order.

FINDINGS OF FACT

1. Petitioner, Dr. Radhakrishna Rao, is a pediatric neurologist licensed to practice in the State of Florida, and was, at all times relevant hereto, an authorized provider of Medicaid Services pursuant to a Non-Institutional Provider Agreement with AHCA.

2. Petitioner, Bay Regional and International Institute of Neurology, Inc., is a corporation established by Dr. Rao through which he provides pediatric neurological services to patients.

3. AHCA is the state agency responsible for administering the Florida Medicaid Program (Medicaid). Medicaid is a

federally funded state-administered program that provides health care services to certain qualified individuals.

4. AHCA is authorized to recover Medicaid overpayments, as appropriate. § 409.913(1)(e), Fla. Stat.[1/]

5. One method AHCA uses to discover Medicaid overpayments is by auditing billing and payment records of Medicaid providers. Such audits are performed by staff in the agency's Bureau of Medicaid Program Integrity (MPI).

A. The Overpayment Case

6. In 2010, MPI detection unit staff identified Petitioners' Medicaid billings for potential review. Fred Becknell, AHCA MPI Administrator, reviewed the information from the detection unit, determined an audit of Petitioners' Medicaid billings was merited, and assigned the case to an investigator. The time period from 2007 to 2009 was identified as the audit period.

7. The investigator generated a random sample of 30 Medicaid patients treated by Petitioners during the audit period based on MPI standard statistical methodologies. AHCA notified Petitioners of its decision to audit their Medicaid billings and requested all medical records for the randomly selected patients during the audit period.

8. As required by section 409.9131(5)(b), AHCA referred Petitioners' records for peer review.

9. Section 409.9131(2)(d) defines "peer review" as follows:

> [A]n evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

10. Dr. Harry Abram conducted the peer review in this case. Dr. Abram is a pediatric neurologist licensed to practice in the State of Florida. He is a staff neurologist at Nemours Children's Clinic in Jacksonville, Florida; Director of the Clinic's Pediatric Neurophysiology Laboratory; and Assistant Professor of Pediatrics and Neurology at Mayo Medical School. Dr. Abram has been practicing in the pediatric neurology specialty for approximately 20 years.

11. Dr. Abram has been under contract with AHCA as a peer reviewer of Medicaid claims for neurological services since 2007.

12. Dr. Abram initially reviewed Petitioners' claims on October 13, 2010. For this review, Dr. Abram was provided each sample claim, the relevant patient records for the audit period, the Medicaid Provider General Handbook, the Medicaid Physician Services and Limitations Handbook, copies of relevant statutes,

and the Current Procedural Terminology Codebook, 2007 edition (CPT). The CPT provides standard medical billing codes for specific medical treatments and procedures.

13. On November 8, 2010, Dr. Abram reported his findings to the MPI staff nurse in a letter. Dr. Abram summarized the following pertinent concerns with Petitioners' billings:

> Inappropriate and overuse of long term EEG studies (95951 and 95956). These are specialized studies used to classify, quantify and localize seizures in patients with suspected intractable epilepsy. Provider rarely ordered standard EEG's (95916 or 95919) which should be obtained initially as standard practice.

14. Following receipt of Dr. Abram's summary and notes for review, MPI staff prepared and delivered to Dr. Rao a Preliminary Audit Report (PAR). In response to the PAR, Dr. Rao sent additional records to MPI staff, which were forwarded to Dr. Abram for further review.

15. Dr. Abram completed his second review of Petitioners' claims in April and May of 2011. He made no change to his initial findings based upon the second review.

16. In its Final Audit Report (FAR) dated June 1, 2011, AHCA notified Dr. Rao that the MPI unit had determined that he was overpaid by $110,712.09 for Medicaid Services provided during the audit period. In explanation, the FAR provides, in pertinent part:

> (010) Medicaid policy requires that services performed be medically necessary for the diagnosis and treatment of an illness. You billed and received payments for services for which the medical records, when reviewed by a Medicaid physician consultant, indicated that the services provided did not meet the Medicaid criteria for medical necessity. The claims which were considered medically unnecessary were disallowed and the money you were paid for these procedures is considered an overpayment.

17. The FAR also imposed on Petitioners a fine of $24,642.00 for violations of Medicaid rules, and assessed administrative costs of $7,336.12 for the audit.

B. Electroencephalography

18. At the heart of Petitioners' challenge are the claims for treatment of patients using long-term monitoring electroencephalogram, or LTM EEG. An EEG is a diagnostic tool in which electrodes are placed on the patient's scalp and the leads are connected to a recording device. The EEG continuously records brain waves and is used in diagnosis and treatment of seizure disorders.

19. A standard, or resting, EEG usually records only 20-30 minutes of brain activity. Standard EEG is usually conducted in the physician's office or clinic.

20. An ambulatory, or LTM, EEG is conducted in the home setting where the electrode leads are connected to a recording device worn by the patient, such as a backpack, and brain waves

are recorded during regular daily activity. LTM EEG may be performed for 24, 48, or 72 hours, or for longer periods.

21. A LTM EEG can be billed to Medicaid at a higher maximum rate than a standard EEG.

22. CPT code 95951 corresponds to LMT EEG with video recording, while CPT code 95956 corresponds to LMT EEG without video.

C. The Non-Rule Policy Challenge

23. Petitioners have twice amended their position statement to articulate the agency statements which they allege constitute non-rule policy. In the second amendment to the joint pre-hearing stipulation, Petitioners allege that the following statements attributed to AHCA are unadopted rules which must be adopted pursuant to section 120.56(4).

(1) A LTM EEG must be preceded by a resting EEG; and,

(2) LTM may only be ordered if the medical record contains documentation that there are concerns of spells, seizures, events of uncertain origin, anticonvulsant medications or intractable epilepsy.

24. In Petitioners' Proposed Final Order, they frame the issue as follows:

> Whether well developed general medical standards as to when long term electroencephalographic monitoring (LTM EEG) is medically necessary and that have common acceptance in the field of neurology and which are used by AHCA as a basis for

> overpayment and monetary fines is an agency statement of general applicability that implements, interprets, or prescribes law or policy in violation of section 120.54(1)(a), Fla. Stat. (2012).

25. Petitioners argue, in essence, that AHCA has not engaged in rulemaking to adopt "well developed general medical standards" as indications of, and prerequisites for, LTM EEG in order to put Medicaid providers on notice that their billings will be measured by those standards and that billings outside of those standards will be deemed overpayments.

26. As a qualified Medicaid provider, Dr. Rao is aware that Medicaid will only cover medical goods and services which are medically necessary.

27. "Medically necessary" is defined in section 409.913(1)(d) as follows:

> [G]oods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the same specialty or subspecialty as the physician under review. Such determination must be based upon the

information available at the time the goods or services were provided.

1. LTM EEG Preceded by Standard EEG

28. Obtaining a standard EEG prior to ordering a LTM EEG is a generally accepted medical practice. Dr. Rao testified that in his practice, he orders a LTM EEG when the results of a patient's standard EEG are abnormal, inconclusive, or suspicious.

29. As such, Dr. Rao acknowledges this well-recognized medical standard.

30. In his review of the sample claims, Dr. Abram determined that many of the claims for LMT EEG were not medically necessary because the medical records did not document a resting EEG had been performed prior to LTM EEG.

31. Dr. Abram testified that there may be circumstances in which a LTM EEG is warranted, although not preceded by a standard EEG, but he would expect the medical records to well document the necessity of the procedure. In his peer review of Dr. Rao's medical records, he found no such documentation.

2. Indications for LTM EEG

32. LTM EEG is a professionally accepted diagnostic tool. However, there is no single standard symptomatic indication for its use. Dr. Rao testified he uses LTM EEG for patients who present with many types of neurological conditions, including

shaking, sleep disorders, crying during the night, seizures, and syncope (fainting), among others.

33. Dr. Abram disallowed as not medically necessary Petitioners' Medicaid claims for LTM EEG where Petitioners' medical records did not indicate the patient had a history of seizures, spells, established epilepsy, or indications of altered awareness. For example, Dr. Abram found as not medically necessary claims for LTM EEG when the medical records indicated concerns of headache, backache, and other non-seizure related symptoms. He did allow LTM EEG claims for Dr. Rao's patients with epilepsy.

34. In August 2012, Dr. Rao held a telephonic provider-to-peer conference with Dr. Abram to discuss Dr. Abram's determinations regarding the level of care, medical necessity, and appropriateness of care provided by Dr. Rao to the randomly selected patients during the audit period. Dr. Rao testified that during the conference, Dr. Abram stated that LTM EEG is indicated only for intractable epilepsy.

35. Dr. Rao's testimony is hearsay, which is insufficient alone to support any finding.

36. At first blush, Dr. Abram's November 8, 2010, letter to MPI staff appears to corroborate Dr. Rao's hearsay statement. In the letter, Dr. Abram states, "[LTM EEGs] are specialized

studies used to classify, quantify and localize seizures in patients with suspected intractable epilepsy."

37. The letter clearly uses the word "suspected" to modify "intractable epilepsy"; as such, the letter is not a statement limiting use of LTM EEG to patients with diagnosed epilepsy. Further, the letter itself is merely a summary of Dr. Abram's findings.

38. Dr. Abram painstakingly reviewed between 125 and 140 patient encounters during the audit period based upon his considerable experience, education, and training to determine the medical necessity, appropriateness, and quality of care provided as compared with the level of care customarily furnished based on recognized health standards. With regard to Dr. Rao's use of LTM EEG, Dr. Abram based his findings on whether LTM EEG would provide benefit or alter management of the patient's symptoms after reviewing the patient's specific medical records, including physical examinations, history, symptoms, and other diagnostic test results.

39. No evidence was presented as to the agency's peer review of any other Medicaid provider audits. While Petitioners introduced a list of other MPI cases for which Dr. Abram conducted the peer review, they introduced no evidence of his findings, conclusions, or determinations.

40. Dr. Abram testified that he makes every effort to be consistent when peer reviewing each provider's records, as well as in reviewing each encounter within a patient's records.

CONCLUSIONS OF LAW

41. The Division of Administrative Hearings has jurisdiction over the parties and subject matter in this proceeding pursuant to sections 120.56(4), 120.569, and 120.57(1), Florida Statutes (2012).

42. AHCA is the agency with the statutory duty to provide oversight of the Florida Medicaid program, and to ensure the integrity of the program, including requiring "repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them . . . ." § 409.913(11), Fla. Stat.

43. Petitioners are "persons" within the meaning of section 409.913(1)(f) and are subject to the jurisdiction and regulation of the MPI Office.

44. An agency statement that comes within the definition of a rule must be adopted according to rulemaking procedures. Envtl. Trust, Inc. v. Dep't of Envtl. Prot., 714 So. 2d 493 (Fla. 1st DCA 1998); Christo v. Dep't of Banking & Fin., 649 So. 2d 318 (Fla. 1st DCA 1995). Section 120.54(1)(a) provides in relevant part:

> Rulemaking is not a matter of agency discretion. Each agency statement defined as a rule by s. 120.52 shall be adopted by the rulemaking procedure provided by this section as soon as feasible and practicable.

45. Subsection 120.56(4) provides that a person substantially affected by an agency statement that comes within the definition of a rule, but which has not been adopted by rulemaking procedures, may challenge that statement.

46. In order to prove standing, Petitioners must show that: 1) the agency statement of policy will result in a real or immediate injury in fact; and 2) the alleged interest is within the zone of interest to be protected or regulated. Jacoby v. Fla. Bd. of Med., 917 So. 2d 358, 360 (Fla. 1st DCA 2005).

47. Petitioners have standing to bring this proceeding pursuant to paragraph 120.56(4)(a). The statements at issue, such as they exist, factored into AHCA's determination that Petitioners were overpaid by Medicaid during the audit period. AHCA seeks recoupment of the overpayment amount as well as fines and administrative costs.

48. Under subsection 120.56(4), a petitioner has the burden to prove that the statement constitutes a rule and that the agency has not adopted the statement by rulemaking procedures. Sw. Fla. Water Mgmt. Dist. v. Charlotte Cnty., 774 So. 2d 903, 908 (Fla. 2d DCA 2001). Under section 120.56(4)(b),

the burden to prove that rulemaking is not feasible or not practicable then falls upon the agency.

49. AHCA has not adopted the statements attributed to AHCA by the Petitioners, or any similar statements, by rulemaking procedures.

50. The merit of AHCA's allegations that Petitioners billed Medicaid during the audit period for services which were not medically necessary is not at issue in this proceeding. Whether AHCA can prove that Dr. Rao ordered LTM EEGs without first ordering standard EEGs or ordered LTM EEGs when they were not indicated by particular medical standards will be determined in the pending overpayment case. The only issue here is whether or not the alleged statements constitute rules.

51. Subsection 120.52(16) defines "rule" in relevant part as follows:

> 'Rule' means each agency statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency and includes any form which imposes any requirement or solicits any information not specifically required by statute or by an existing rule.

52. The challenged agency statements formed the basis, at least partially, for AHCA's determination that Petitioners received Medicaid overpayments, as well as its demand for recoupment of said overpayments and imposition of fines and

costs. As such, the statements form one of the bases for AHCA's administrative complaint against Petitioners.

53. The challenged agency statements are not rules as defined in section 120.52(16). It is well-established that allegations in an agency administrative complaint meant to enforce regulatory statutes do not constitute agency statements defined as rules. See George Marshall Smith v. Alex Sink et al., Case No. 07-4746RU (DOAH Jan. 25, 2008), aff'd, 993 So. 2d 522 (Fla. 1st DCA 2008)(allegations in Department of Financial Services complaint against the Petitioner for selling unregistered securities in violation of chapter 517, Florida Statutes, are not agency statements defined as rules); United Wisconsin Life Ins. v. Dep't of Ins., Case No. 01-3135RU (DOAH Nov. 27, 2001), aff'd, 831 So. 2d 239 (Fla. 1st DCA 2002)(particular allegations in the Department of Insurance complaint against Petitioner for committing unfair and deceptive practices in violation of chapter 626, Florida Statutes, are not agency statements defined as rules).

54. The First District Court precedent continues to be followed by the Division. See Dayspring Village, Inc. v. Ag. for Health Care Admin, Case No. 13-1836RU (DOAH June 24, 2013)(allegations in AHCA's administrative complaint that Petitioner, a licensed Assisted Living Facility "failed to provide adequate and appropriate health care consistent with the

established and recognized standards within the community by allowing diabetic residents to use the same glucometer without disinfecting or cleaning the glucometer device" was not an agency statement defined as a rule).

55. The fact that AHCA did not specifically restate in the FAR the peer reviewer's findings, but rather alleged that Petitioners received reimbursement for services which were not determined to be medically necessary after peer review is a distinction without a difference. The peer reviewer's statements were relied upon by the agency as findings to support its FAR, seek reimbursement, and impose fines and costs.[2/]

56. Petitioners argue that the statements made by Dr. Abram are rules because they are "generally applicable," having been applied consistently by Dr. Abram as a peer reviewer in other Medicaid provider audits. Petitioner did not prove, however, that Dr. Abram's statements have been applied to any other provider peer reviews.

57. Assuming, arguendo, that Petitioner had proven that Dr. Abram consistently applies the alleged statements as facts which support a finding of medical necessity in MPI peer reviews, that alone does not elevate the statements to the stature of agency policy with the force and effect of law.

58. Whether an agency statement is a rule turns on the effect of the statement, not on the agency's characterization of

the statement. See Dep't of Admin. v. Harvey, 356 So.2d 323, 325 (Fla. 1st DCA 1977). "Repetition of the practice in drafting administrative complaints in other disciplinary cases does not change the character of the act, thus mandating establishment of the agency's statements or policies as rules by proper adoption . . . ." George Marshall Smith v. Alex Sink et al., Case No. 07-4746RU (DOAH Jan. 25, 2008); aff'd, 993 So. 2d 522 (Fla. 1st DCA 2008).

59. In recent years, the First District Court of Appeal has re-emphasized that agency statements that are not self-executing and do not by their own effect create rights, require compliance, or otherwise have the direct and consistent effect of law are not rules. See Ag. for Health Care Admin v. Custom Mobility, Inc., 995 So. 2d 984 (Fla. 1st DCA 2008); Dep't of Fin. Servs. v. Capital Collateral Reg'l Counsel-Middle Region, 969 So. 2d 527 (Fla. 1st DCA 2007).

60. Likewise, where application of agency policy is subject to the discretion of agency personnel, the policy is not a rule. See Coventry First, LLC v. Off. of Ins. Reg., 38 So. 3d 200, 204 (Fla. 1st DCA 2010)(quoting McDonald v. Dep't of Banking & Fin., 346 So. 2d 569, 581 (Fla. 1st DCA 1977)).

61. The medical standards at issue in this case are not self-executing and require the exercise of discretion in their application. As was the case in Custom Mobility, the statements

at issue do not, in and of themselves, "establish that the service provider owes money." 995 So. 2d at 987. Rather, the medical standards of practice must be applied on a case-by-case basis to determine whether the services provided were medically necessary, and provided both an appropriate level of care and standard of care "customarily furnished by the physician's peers and to recognized health care standards . . . ."
§ 409.9131(2)(d), Fla. Stat.

62. In the case at hand, Dr. Abram "applied" the standards to each of over 100 Medicaid claims Dr. Rao made during the audit period. He exercised his discretion as to whether to apply them based on the specifics of each patient's medical records. As Dr. Abram testified, there may be specific circumstances when a LTM EEG is warranted without a preliminary standard EEG, or when a LTM EEG is ordered for non-seizure related symptoms, but Dr. Abram found no documentation to support those indications in the specific files reviewed.

63. Where an agency's unpromulgated guidelines are applied without discretion to determine the rights of licensees, they may constitute agency statements defined as rules. See Dep't of Rev. v. Vanjaria, 675 So. 2d 252, 255 (Fla. 5th DCA 1996)(tax assessment procedures in agency training manuals not simply a direct application of statute; procedures afforded no discretion to auditors and created the agency's entitlement to taxes while

adversely affecting property owners); Premier Ins. Grp. v. Off. of Fin. Reg., Case No. 12-1201RU (DOAH July 5, 2012)(concluding that the Office's practice of excluding federal income taxes from excess profits calculation, which affords auditors no discretion in its application, has the direct and consistent effect of law). The facts at hand are clearly distinguishable.

64. Florida operates the Medicaid program pursuant to section 409.902, which provides, in pertinent part:

> [Medicaid] payments shall be made, subject to any limitations or directions provided for in the General Appropriations Act, only for services included in the program, shall be made only on behalf of eligible individuals, and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and the provisions of state law.

AHCA is charged by the Legislature to implement MPI "to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate." § 409.913, Fla. Stat. Medicaid Program Integrity is an important policy of the State of Florida, and one which ensures compliance with federal mandates as well.

65. As well-stated in United Wisconsin, Case No. 01-3135RU, FO at 27-28:

> 65. [The statutory provisions which form the basis for the Administrative Complaint],

> are taken together, statutes which prohibit described conduct. They are penal in nature. Some sections . . . provide for criminal sanctions. They are announcements of policy enacted into law by the Florida Legislature. They represent policy of the state. Because the Department is the agency charged with implementing these statutes, the Department is free to allege facts which might prove to be violations of these statutes, without resort to explanatory rules.

66. The proper forum for resolution of the matters contained in the FAR, as well as the agency's findings supporting the FAR, is the underlying Overpayment Case.

FINAL ORDER

Upon consideration of the above findings of fact and conclusions of law, it is

ORDERED:

That the Petition of Dr. Radhakrishna Rao and Bay Regional and International Institute of Neurology to Challenge Unadopted Rules is dismissed.

DONE AND ORDERED this 30th day of August, 2013, in Tallahassee, Leon County, Florida.

SUZANNE VAN WYK
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of August, 2013.

ENDNOTES

[1/] Except as otherwise indicated, all references to statutes and rules are to the versions in effect in 2011, the time the statements alleged to be unadopted rules substantially affected Petitioners by virtue of Respondent's Final Audit Letter.

[2/] Petitioners argued that the statements were ripe for rulemaking, in part because neither the PAR nor the FAR put Dr. Rao on notice that he was required to comply with statements such as "A resting EEG must always precede a LTM EEG" and "LTM EEG is indicated only in patients whose medical records documents problems with spells, seizures, or intractable epilepsy." He argued that rulemaking would allow for input into those standards and put physicians on notice of those standards. First, Petitioners' due process rights are not at issue in this proceeding. Second, Petitioners' arguments seem disingenuous given Dr. Rao's testimony that he usually orders an LTM EEG when the standard EEG results are abnormal, inconclusive, or suspicious.

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NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review pursuant to section 120.68, Florida Statutes. Review proceedings are governed by the Florida Rules of Appellate Procedure. Such proceedings are commenced by filing one copy of a Notice of Administrative Appeal with the agency clerk of the Division of Administrative Hearings and a second copy, accompanied by filing fees prescribed by law, with the District Court of Appeal, First District, or with the District Court of Appeal in the appellate district where the party resides. The Notice of Administrative Appeal must be filed within 30 days of rendition of the order to be reviewed.