STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ROSAIDA HEALTHCARE, INC.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 12-3551RU
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
	)	

FINAL ORDER

On January 4, 2013, Robert E. Meale, Administrative Law Judge of the Division of Administrative Hearings, conducted the final hearing in Tallahassee, Florida.

APPEARANCES

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STATEMENT OF THE ISSUES

The issues are:

1. Did the 2008 amendment of Florida Administrative Code rule 59G-13.082(2) incorporate the Developmental Disabilities Home and Community-Based Services Waiver Billing Code Matrix (Billing Code Matrix)

when the amended rule explicitly incorporated the Developmental Disabilities Home and Community-Based Services Waiver Procedure Codes and Maximum Units of Service (Procedure Codes and Maximum Units of Service), but Respondent filed, as the incorporated document, the Billing Code Matrix with the Joint Administrative Procedures Committee (JAPC), the Department of State, and the Medicaid fiscal agent?

2. If the circumstances described in Issue 1 did not result in the incorporation of the Billing Code Matrix in the 2008 amendment of rule 59G-13.082(2), was the Billing Code Matrix incorporated in the amended rule when, four years after the amendment, the Department of State revised the language of the archived version of rule 59G-13.082(2) to incorporate explicitly the Billing Code Matrix, even though the amended rule submitted to the Department of State in 2008 explicitly incorporated the Procedure Codes and Maximum Units of Service?

3. If the circumstances described in Issues 1 and 2 did not result in the incorporation of the Billing Code Matrix in the 2008 amendment of rule 59G-13.082(2), is the Billing Code Matrix an agency statement constituting a rule that Respondent has not adopted by the rulemaking procedure set forth in section 120.54, Florida Statutes?

4. If the circumstances described in Issue 1 or 2 resulted in the incorporation of the Billing Code Matrix in the 2008 amendment of rule 59G-13.082(2), is the amended rule an invalid exercise of delegated legislative authority?

PRELIMINARY STATEMENT

The inception of this rule challenge is DOAH Case No. 12-2906MPI, which was filed with the Division of Administrative

Hearings on September 5, 2012. As the petitioner in that case, Respondent seeks to recoup Medicaid reimbursements and associated charges totaling $418,563.87, which Respondent contends that it has overpaid Petitioner for companion services for which Petitioner has submitted claims for reimbursement. The undersigned Administrative Law Judge has continued the hearing in DOAH Case No. 12-2906MPI until after the issuance of the Final Order in this rule challenge.

This rule challenge commenced on November 1, 2012, when Petitioner filed its Petition for Administrative Determination that Agency Statement Violates Florida Statutes § 120.54(1) and Is an Invalid Exercise of Delegated Legislative Authority (Petition). The challenged agency statement is the Billing Code Matrix.

The Petition alleges that Respondent conducted an audit of Petitioner's Medicaid billings from December 4, 2008, through December 31, 2010, and determined overpayments and associated charges, as noted above, by applying the Billing Code Matrix to Petitioner's billings. Specifically, the Petition alleges that the Billing Code Matrix, as applied to companion services, directs a Medicaid provider to include on a single billing claim line no more than 24 quarter hours (QH) of service units of companion services. The Petition explains that this is a limitation on the form of the bill, not on the maximum hours of

companion services. In a similar vein, the Petition notes that Respondent has not alleged that the billed services challenged in DOAH Case No. 12-2906MPI were unnecessary or not provided.

Alleging that the Billing Code Matrix is a rule, within the meaning of section 120.52(15), the Petition alleges that Respondent adopted it without complying with the rulemaking procedure, as set forth in section 120.54. The Petition also alleges that the Billing Code Matrix enlarges, modifies, or contravenes the specific provisions of the law implemented.

On November 9, 2012, Petitioner filed a Motion to Amend the Petition. The motion states that, after the Petition had been filed, Respondent claimed that it had incorporated the Billing Code Matrix in Florida Administrative Code Rule 59G-13.082, but mistakenly referred to the Billing Code Matrix as the Procedure Codes and Maximum Units of Service, version January 1, 2008. The motion states that the Procedure Codes and Maximum Units of Service, version November 2003, was the name of the document incorporated in rule 59G-13.082(2) immediately prior to the 2008 amendment. The motion asks for leave to allow Petitioner to amend its initial pleading to allege as additional grounds for invalidating the Billing Code Matrix Respondent's failure to specifically identify the incorporated material, as required by rule 1-1.013(2), and failure to conform to the rulemaking

procedure in attempting to incorporate by reference the Billing Code Matrix.

On November 16, 2012, Respondent filed its Objection to Petitioner's Motion to Amend the Rule Challenge Petition. On the same date, Respondent also filed a Notice of Development of Rulemaking, which references section 120.56(4)(b). This statute provides that a notice of development of rulemaking shall stay any pending challenge to an agency statement as an unadopted rule. On November 16, the Administrative Law Judge thus entered an Order Staying Case and Canceling Hearing.

On November 19, 2012, Petitioner filed its Second Motion to Amend the Petition and a Motion to Vacate Stay and Set Rule Challenge for Hearing. As amended by the Second Motion to Amend, the amended Petition (Amended Petition) restates the earlier allegations about the Billing Code Matrix: i.e., it is an agency statement that is a rule that Respondent has adopted without complying with the rulemaking procedure.

The Amended Petition also alleges that rule 59G-13.082--actually, rule 59G-13.082(2)--is an invalid exercise of delegated legislative authority. The Amended Petition alleges that the rule failed properly to incorporate by reference the Billing Code Matrix.

The Amended Petition requests attorneys' fees and costs under section 120.595.

By Order entered on December 4, the Administrative Law Judge granted the motion for leave to amend and the motion to vacate stay. Section 120.56(4)(b) authorizes the Administrative Law Judge to vacate the stay for good cause. Militating against the statutory stay were two other statutes requiring expedited hearings. First, Petitioner was now also challenging a promulgated rule in a proceeding in which it is entitled to a hearing within 30 days of the filing of the petition, pursuant to section 120.56(1)(c). The stay provided by section 120.56(4)(b) does not apply to the challenge to a promulgated rule, and the challenges to the promulgated rule and unpromulgated rule are obviously linked. Second, in DOAH Case No. 12-2906MPI, Petitioner was entitled to a hearing within 90 days of the initial assignment of an Administrative Law Judge. Although this case had been continued indefinitely, the statutory mandate of an expedited hearing militated in favor of an early resolution of this rule challenge, so the recoupment case could be heard relatively soon.

On December 21, 2012, Respondent filed a Notice of Correction of Scrivener's Error. The notice acknowledges that, after the 2008 amendment, rule 59G-13.082(2) stated that it incorporated by reference the Procedure Codes and Maximum Units of Service, version January 1, 2008. The notice states that the amended rule mistitled the incorporated document as a result of

a scrivener's error and the correct title was the Billing Code Matrix. The notice advises that the Department of State official website had been altered so as to make it appear that the archived version of rule 59G-13.082(2) had explicitly incorporated the Billing Code Matrix. The notice concludes that "the matters complained of in [the Amended] Petition are moot," and "[a]ny continuous pursuit of this matter will be a waste of judicial resources."

At the hearing, Petitioner called two witnesses and offered into evidence 16 exhibits: Petitioner Exhibits 1-16. Respondent called two witnesses and offered into evidence 15 exhibits: Respondent Exhibits 1-15. All exhibits were admitted.

The court reporter filed the transcript on January 25, 2013. The parties filed proposed final orders on February 4, 2013.

FINDINGS OF FACT

1. At all material times, Petitioner has been an enrolled Medicaid provider. From 2002 through November 5, 2012, Petitioner provided companion services to persons with developmental disabilities, pursuant to the home and community-based services waiver program. Companion services are personal services to support the Medicaid recipient in accessing community activities

2. As is typical in the Medicaid program, Petitioner submitted reimbursement claims to Respondent for covered services that it provided to Medicaid recipients, and Respondent promptly paid these claims, subject to later audit. As a result of an audit conducted by Respondent for the period of December 4, 2008, through December 31, 2010, Respondent determined that it was entitled to recoup $418,563.87 in overpayments and associated charges. As a result of this proposed adjustment, Petitioner discontinued operations on November 5.[1]

3. However, Petitioner requested a formal hearing on Respondent's recoupment claim. Respondent transmitted the file to the Division of Administrative Hearings, which assigned it DOAH Case No. 12-2906MPI. This overpayment case was assigned to the undersigned Administrative Law Judge, who continued the final hearing until after the issuance of the Final Order in this rule challenge.

4. During the two years covered by the audit, Petitioner served 89 recipients, of whom about two-thirds received companion services. A substantial portion of the recoupment claim, if not all of it, is attributable to Petitioner's billing of, and Respondent's reimbursing for, companion services.

5. Respondent's recoupment claim is not based on allegations that Petitioner billed companion services that were

not provided or necessary or billed companion services that were in excess of the amount of services authorized by law. The recoupment claim is based on allegations that, consistent with past approved practice, Petitioner billed up to 40 QHs of service units per claim line, but, relying on the Billing Code Matrix, Respondent must disallow either the entire claim or at least all QHs in excess of 24 QHs of service units per claim line.

6. In no way has Respondent singled out Petitioner for audit and recoupment. After determining that it had adopted the Billing Code Matrix in December 2008, Respondent audited every provider that continued to bill more than 24 QHs of service units of companion services per claim line. This amounted to about 700 providers. Respondent's auditor eventually opened 120 cases and found overpayments in every single case--all of them based on the providers' continuing to adhere to the past approved practice of billing more than 24 QHs--but not more than 40 QHs--of service units per claim line, thus placing at issue hundreds of thousands, if not millions, of dollars of reimbursements. At hearing, Respondent's auditor admitted the obvious: providers were clearly continuing to bill companion services under the "old" rule.[2]

7. Adopted in 2006, rule 59G-13.082(1) provided then, as it does now, that it applies to all developmental disabilities

waiver service providers enrolled in the Medicaid program. Notwithstanding its references to rule 59G-13.082, Petitioner does not challenge rule 59G-13.082(1).

8. As adopted in 2006, rule 59G-13.082(2) incorporated by reference the Procedure Codes and Maximum Units of Service, version November 2006, and advised that the incorporated document was available from the Medicaid fiscal agent or Respondent, whose address was supplied. The Procedure Codes and Maximum Units of Service, November 2006 version, allowed Medicaid providers to bill, on a single billing claim line, up to 40 QHs of service units of companion services.

9. As amended in 2008, rule 59G-13.082(2) incorporated by reference the Procedure Codes and Maximum Units of Service, version January 1, 2008, and advised that the incorporated document was available from the Medicaid fiscal agent at its cited website. However, no November 2006 version of the document incorporated in the original rule appears ever to have existed. When filing the "incorporated" document with JAPC, the Department of State, and the Medicaid fiscal agent, Respondent filed the Billing Code Matrix, which is the document that Respondent now claims that it intended to incorporate in 2008. As relevant to this rule challenge, the difference between the Procedure Codes and Maximum Units of Service, version November 2006, and the Billing Code Matrix is that the latter

document reduces from 40 QHs to 24 QHs the maximum number of service units that a provider may input onto a single claim line when billing claims for reimbursement for companion services.

10. Apparently to minimize the number of claim lines, providers routinely included the maximum of 40 QHs per claim line when submitting bills for companion services, as the 2006 version of rule 59G-13.082(2) allowed. In fact, at least prior to 2008, Petitioner received training to bill its companion services with 40 QHs per claim line.

11. The reason for the purported 2008 change is not completely clear. A rule allowing a provider to include 40 QHs per claim line would allow a single claim line to span one day and two-thirds of a second day, if the Medicaid recipient were approved to receive the maximum of 24 QHs per day. A rule allowing a provider to include only 24 QHs per claim line would tend to limit a single claim line to one day, again if the Medicaid recipient were approved to receive the maximum of 24 QHs per day. But if a recipient were approved to receive fewer than the maximum of 24 QHs per day, the 24-QH limitation would not prohibit the provider from spanning more than day's companion services on a single claim line. For instance, for a recipient approved for a maximum of 8 QHs per day, a provider's inclusion of 24 QHs of service units per claim line would span three days of companion services.

12. Authoritative Medicaid documents did not prohibit claim lines spanning more than one day of companion services, at least in 2008. The Developmental Disabilities Waiver Services Coverage and Limitations Handbook, July 2007 version, referred providers seeking "[s]pecific billing instructions and procedures for submitting claims" to chapter 1 of the Florida Medicaid Provider Reimbursement Handbook and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500. The Florida Medicaid Provider Reimbursement Handbook, CMS-1500, version July 2008 (Provider Reimbursement Handbook) clearly restricted a provider to one claim form per Medicaid recipient and one procedure code per claim line, but did not restrict a provider to one day's service per claim line. Provider Reimbursement Handbook, p. 1-9.

13. Instead, for home and community-based waiver services, the Provider Reimbursement Handbook directed the provider to:

> Enter the units of service rendered for the procedure code. If multiple units of the same procedure were performed on the same date of service, enter the total number of units. **If the date of service covers a span of time, i.e. [sic] a month, enter the total number of units for that span of time** (emphasis added).

Id. at p. 1-29. (Because other spans of time, besides one month, could apply, it would appear that the "i.e." should have been an "e.g.")

14. Interestingly, the Provider Reimbursement Handbook touted electronic claim submission, over the submission of paper CMS-1500 claim forms, because the electronic claim submission offered "the advantage of speed and accuracy in processing." Id. at p. 1-47. Emphasizing the accuracy of electronic claim submission, the Provider Reimbursement Handbook assured providers that the electronic system would "[c]orrect data entry errors immediately." Id.

15. Petitioner would probably disagree. During the audit period, Petitioner submitted electronically its billing claims for companion services, these claims routinely included 25-40 QHs of service units per claim line, and the electronic claim program invariably accepted these claims. This fact alone prevented the timely correction of the billing practices of Petitioner and numerous other Medicaid providers or timely recognition by Respondent that it had incorporated the wrong document in its 2008 rule amendment.

16. At the hearing, Respondent's auditor explained that the electronic claim program, which was maintained by the Medicaid fiscal agent, could only accommodate so many "edits," and, during the audit period, the only relevant edit rejected claims only when they exceeded 40 QHs of service units per claim line. In other words, the fiscal agent maintained the edit that was in effect before the 2008 rule amendment. Obviously, the

auditor's explanation misses the point that, at least on a going-forward basis, a new edit was not required: after the purported effective date of a new, lower limit, the 40-QH edit could have been reduced to a 24-QH edit. In June 2012, the fiscal agent reprogrammed the electronic claim program to do just that.

17. Not only did the Medicaid fiscal agent fail to reprogram the edit in the electronic claim program to reflect Respondent's 2008 rule amendment, but a major third-party auditor participating in the Florida Statewide Quality Assurance Program also missed this change. In the middle of the audit period, on January 7, 2010, this third-party auditor, the Delmarva Foundation, issued to Petitioner a "Collaborative Outcomes Review and Enhancement Report" covering Petitioner's waiver services. Among the purposes of the report was to identify any claims that might be subject to recoupment. The report notes, among other things, that Petitioner was meeting the requirements of "Service Authorization/Billing as Authorized."

18. It is not hard to understand how numerous providers, Respondent's Medicaid fiscal agent, and a major quality-control auditor missed Respondent's decision, in 2008, to reduce from 40 QHs to 24 QHs the maximum number of service units that may be included on a claim line when billing companion services. The

2008 rule amendment incorporated what appeared to be only an update of the existing document that governed the billing of reimbursement claims. All affected parties continued to conduct their billing business in conformity with the past approved practice--and the evidence does not suggest that Respondent and its agents contemporaneously informed the providers of the new limit of 24 QHs of service units that could be included in a single claim line.

19. Arguing that the misidentification of the incorporated document was only a "scrivener's error," Respondent contends that the regulated community should be subjected, as of 2008, to the document that Respondent filed with JAPC, the Department of State, and the Medicaid fiscal agent--the Billing Code Matrix. This argument seems to focus upon the ease with which the mistake could have been made, rather than focusing on the extent to which Respondent's carelessness in preparing the 2008 amendment may have precluded effective notice of this change in billing procedure to the provider community or the unfairness of imposing the cost of Respondent's carelessness on the provider community.

20. It is understandable that the modern equivalent of a scrivener--say, a Clerk Typist II--might keystroke "Procedure Codes and Maximum Units of Service," instead of "Billing Code Matrix." To this extent, Respondent's error in preparing the

2008 amendment may be characterized as a "scrivener's error," but this characterization does not receive much weight in resolving the first two issues stated above.

21. There are at least two problems with the scrivener's-error argument. First, the discovery of the filed document--the Billing Code Matrix--is not the equivalent of the discovery of the new law governing the preparation of reimbursement claims. A diligent provider that discovered the Billing Code Matrix at JAPC, the Department of State, or the Medicaid fiscal agent would learn only that Respondent had filed a different document than it had incorporated. If a diligent provider also learned that the incorporated document did not exist, it is still unclear how the provider would get from these facts to the understanding that the Billing Code Matrix now governed. Perhaps the language of the 2008 rule amendment reflected an intent to incorporate the same document that was incorporated in 2006 or a revised document--with a different revision date than January 1, 2008--that may have made inconsequential changes to the November 2006 version of the document. This flaw in Respondent's argument effectively imposes upon the provider community the responsibilities to complete Respondent's unfinished rulemaking exercise from 2008.

22. Second, the notice to providers was insufficient even to impose upon them any duty to find the filed Billing Code

Matrix. Perhaps due to the near-identity in titles between the originally incorporated document and the revision of this document that the 2008 rule amendment explicitly incorporated, as noted above, much of the provider community, as well as the fiscal agent and third-party quality-assurance auditor, missed the 2008 change in their discharge of important responsibilities. The three repositories do not appear to have noticed the discrepancy between the incorporated document and the filed document. Even Respondent apparently failed to notice the obvious flaw in its own rule for four years while it prosecuted numerous, large reimbursement cases based on the Billing Code Matrix.

23. If Respondent had properly identified the Billing Code Matrix in the 2008 rule amendment, the provider community would not have objected, but would have quickly complied with the new billing procedure, because the change--if it had been implemented prospectively with notice to providers--would have had no real financial impact on providers. Because of Respondent's carelessness in its exercise of its rulemaking responsibilities in 2008, the change now would effectively be imposed retroactively upon, and at considerable expense to, providers. Unfortunately, in trying to achieve this result, Respondent is engaged, not in a valiant effort to oppose rapacious Medicaid providers from defrauding the program, but

only to assist Respondent, in overpayment cases, in opposing otherwise-legitimate reimbursement claims for companion services on the sole ground that these claims violated a purported rule change that reduced the number of service units that could be included on a single claim line by 40%.

CONCLUSIONS OF LAW

24. The Division of Administrative Hearings has jurisdiction. Section 120.56(4) applies to an agency statement that constitutes a rule, but which the agency has adopted without complying with the rulemaking procedure. Section 120.56(1) applies to an existing rule.

25. Section 120.56(4) authorizes any person "substantially affected by an agency statement [to] seek an administrative determination that the statement violates s. 120.54(1)(a)." Petitioner is "substantially affected" by Respondent's application of the Billing Code Matrix. If incorporated by the 2008 amendment of rule 59G-13.082(2), the Billing Code Matrix would cause Petitioner a real and sufficiently immediate injury in fact and an injury that would be within the zone of interest that would be protected or regulated. Ward v. Bd. of Trustees, 651 So. 2d 1236, 1237 (Fla. 4th DCA 1995) (per curiam). It is irrelevant that Petitioner has discontinued business operations. Greynolds Park Manor, Inc. v. Dep't of Health & Rehab. Services, 491 So. 2d 1157 (Fla. 1st DCA 1986).

26. Petitioner must prove the material allegations by a preponderance of the evidence. § 120.56(4)(b), Fla. Stat.

27. The first two issues stated above pose the same threshold question--whether Respondent successfully incorporated the Billing Code Matrix in the 2008 amendment of rule 59G-13.082(2).

28. The first issue addresses the question of whether rule 59G-13.082(2), as amended in 2008, incorporated the Billing Code Matrix. The choices are among a document that existed, but was unmentioned in the rule itself; a document that did not exist, but bore, in name, a close resemblance to the document that had been incorporated two years earlier and had governed past approved practice up to the 2008 rule amendment; neither document; and perhaps even the document that had been incorporated two years earlier.

29. Section 120.54(1)(i)1. (2008) allows a rule to incorporate material by reference. It is axiomatic that the attempt to incorporate a document by reference into another document requires the identification of the incorporated document.[3] BGT Group, Inc. v. Tradewinds Engine Services, LLC, 62 So. 3d 1192, 1194-95 (Fla. 4th DCA 2011). The rulemaking process emphasizes notice, so as to provide the regulated community an opportunity for informed participation in the process, see, e.g., section 120.54(2)-(3), and an opportunity to

challenge to a proposed rule on the ground that it is an invalid exercise of delegated legislative authority. § 120.56(1)-(2). These important rights that the legislature has vested in the regulated community cannot be sacrificed, in the name of correcting a scrivener's error, to enable Respondent to shift to this community the costs of its carelessness in amending rule 59G-13.082(2) in 2008.

30. The more obvious means of identifying an incorporated document is its identification in the rule. This is the first identifier that an interested person will find. No one would know to refer to a document repository, unless the rule itself notifies the reader that a document has been incorporated by reference. For statutes, there is not even a requirement to file an incorporated document in some repository, virtual or otherwise.

31. It is impossible to conclude, on these facts, that Respondent incorporated the Billing Code Matrix in the 2008 rule amendment that explicitly incorporated a different document. To relieve Respondent of the consequences of its carelessness and incorporate the Billing Code Matrix would be an exercise in rulemaking, not rule interpretation. Cf. USAA Casualty Ins. Co. v. Threadgill, 729 So. 2d 476, 478 (Fla. 4th DCA 1999) (no insurance contract to reform in case of unilateral mistake). Courts may sometimes judicially repeal statutory language to

lend meaning to a statute. See, e.g., Greenberg v. Cardiology Surgical Assoc., 855 So. 2d 234, 238 (Fla. 1st DCA 2003) (court concluded that legislature inadvertently failed to omit from statute "or $5," so court did it for legislature). Obviously, an Administrative Law Judge is not a court, but, more importantly, the myriad restrictions imposed by the legislature on agencies in their exercise of rulemaking in chapter 120 may account for the absence from the reported case law of courts performing similar repairs to obviously faulty rules.

32. Respondent's failure to have incorporated the Billing Code Matrix in the 2008 amendment of rule 59G-13.082(2) is not remedied by the recent alteration of the "archived" rule maintained on the Department of State official website. The record does not reveal how Respondent managed to cause this revision to the archived rule on the Department of State official website. But the change was ultra vires, if it was made by the Department of State, which would appear to have been necessary given the fact that the website is sponsored by the Department of State.

33. Former section 120.55(1)(e) authorized the Department of State to "[c]orrect grammatical, typographical, and like errors not affecting the construction or meaning of the rules, after having obtained the advice and consent of the appropriate agency, and insert history notes." But this statute would be

inapplicable in the present case. The substitution of the Billing Code Matrix for the Procedure Code and Maximum Units of Service is not a grammatical error. Nor is it a typographical error, notwithstanding a fairly generous view of typographical errors found in Int'l Union of Operating Eng'rs v. Long, 388 572 (Fla. 3d DCA 1980) (dictum) (tortious acts of "Edward Walker" replaced with tortious acts of "local union members"). The better practice is to reserve typographical errors for numbers, which can be easily transposed--see, e.g., Katz v. Katz, 90 So. 3d 909 (Fla. 2d DCA 2012); Chetram v. Singh, 984 So. 2d 614 (Fla. 5th DCA 2008); Rooney v. Rooney, 750 So. 2d 118 (Fla. 2d DCA 1999)--or other brief notations. See, e.g., Stevens v. State of Florida, 502 So. 2d 99 (Fla. 5th DCA 1997) ("F2" typed instead of "F3" for level of felony). A refreshingly precise definition of the term, "typographical error" is "an error in printed or typewritten matter resulting from striking the improper key of a keyboard, from mechanical failure, or the like." Webster's New Universal Unabridged Dictionary (1996).

34. Nor is replacing one document with another document "like" correcting a grammatical or typographical error on the grounds discussed above in connection with scrivener's errors. The error at issue clearly affects the construction or meaning of the rule that Respondent amended in 2008.

35. Additionally, section 120.55(1)(e) was repealed, effective October 1, 2012. Ch. 2012-63, § 5, Laws of Fla. Nothing in the record suggests that Respondent secured the Department of State's cooperation in an under-the-wire exercise of its former authority.

36. Having resolved the first two issues in the negative, the third issue stated above is whether the Billing Code Matrix is an agency statement is a rule that Respondent did not adopt in compliance with the rulemaking procedure. Respondent does not dispute this issue. The Billing Code Matrix, as applied by Respondent, is a rule within the meaning of section 120.52(16), which defines a rule as a "statement of general applicability that implements, interprets, or prescribes law or policy or describes the procedure or practice requirements of an agency . . .." For the reasons noted above, Respondent failed to conform to the rulemaking procedure in adopting, or trying to adopt, the Billing Code Matrix. Respondent has not argued that rulemaking is not feasible or practicable, as provided by sections 120.54(1)(a) and 120.56(4)(b), nor could it.

37. Having resolved the third issue in the affirmative, it is unnecessary to consider the fourth issue stated above.

ORDER

Based on the foregoing,

It is

ORDERED that:

1. Because the 2008 amendment to Florida Administrative Code Rule 59G-13.082(2) failed to incorporate by reference the Billing Code Matrix, the Billing Code Matrix, as applied by Respondent since December 3, 2008, is not an adopted rule, but is an agency statement that constitutes a rule and that Respondent has not adopted by the rulemaking procedure set forth in section 120.54.

2. Pursuant to section 120.56(4)(b), Respondent "must immediately discontinue all reliance upon the Billing Code Matrix or any substantially similar statement as a basis for agency action."

3. The Administrative Law Judge reserves ruling on the request for attorneys' fees and costs, pursuant to section 120.595(4)(a) and (b). If Petitioner still wishes to pursue this claim, it shall file a petition to this effect with the Division of Administrative Hearings, bearing the case number of this rule challenge, within 20 days from the date of this Final Order, or else the Administrative Law Judge shall conclude that Petitioner has withdrawn and waived this claim. If Petitioner files a petition, it will be assigned a new DOAH Case Number and processed as a fee case.

DONE AND ORDERED this 18th day of February, 2013, in Tallahassee, Leon County, Florida.

ROBERT E. MEALE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of February, 2013.

ENDNOTES

1/ The evidentiary record is silent on this point, but § 409.913(27), Fla. Stat., authorizes Respondent to withhold medical assistance reimbursement payments, once it determines and that there is probable cause that an overpayment to a provider has occurred and has alleged same.

2/ About one-third of these opened cases remained open as of the final hearing in this rule challenge. Two of these cases were in litigation--DOAH Case No. 12-2906MPI and DOAH Case No. 12-2594MPI--and the remainder await the outcome of this rule challenge.

3/ This axiom is reflected in Florida Administrative Code rule 1-1.013(2)(a), as Petitioner argues. The predecessor to this rule, rule 1B-30.005, which was in effect in 2008, did not require the rule to identify specifically identify the incorporated material, but the statute did so.

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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 the original notice of administrative appeal with the agency clerk of the Division of Administrative Hearings within 30 days of rendition of the order to be reviewed, and a copy of the notice, accompanied by any filing fees prescribed by law, with the clerk of the District Court of Appeal in the appellate district where the agency maintains its headquarters or where a party resides or as otherwise provided by law.