STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 13-0795MPI

ALFRED IVAN MURCIANO, M.D.,

Respondent.
_____/

RECOMMENDED ORDER ON REMAND

This case came before Administrative Law Judge Todd P. Resavage for final hearing by video teleconference on January 21, 2014, at sites in Tallahassee and Miami, Florida.

APPEARANCES

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

For Respondent: William J. Sanchez, Esquire
William J. Sanchez, P.A.
2600 Southwest 120th Street, Suite 102
Miami, Florida 33186

STATEMENT OF THE ISSUES

The issues for determination are whether Respondent must reimburse Petitioner an amount up to $1,051,992.99, which sum Respondent received from the Florida Medicaid Program in payment of claims arising from his treatment of pediatric patients

between September 1, 2008, and August 31, 2010; and whether Petitioner is entitled to sanctions in the amount of $210,398.60, and costs of $3,349.86.

PRELIMINARY STATEMENT

Petitioner, Agency for Health Care Administration, is the agency responsible for administering the Florida Medicaid Program. Respondent, Alfred Ivan Murciano, M.D., is a Medicaid provider.

After completing a review of Respondent's claims for Medicaid reimbursement for dates of service during the period of September 1, 2008, through August 31, 2010 ("the audit period"), Petitioner issued a Final Agency Audit Report ("FAR") on January 8, 2013, wherein it alleged that Respondent had been overpaid $1,051,992.99 for services that in whole or in part were not covered by Medicaid. The FAR further provided that Petitioner was seeking sanctions in the amount of $210,398.60, and costs of $3,349.86.

The FAR advised Respondent that he had the right to request a formal or informal hearing pursuant to section 120.569, Florida Statutes. Respondent timely requested a formal hearing on the matter. On March 5, 2013, Petitioner referred the matter to the Division of Administrative Hearings ("DOAH") where it was assigned to the undersigned.

The final hearing was initially scheduled for June 3, 2013. On May 23, 2013, the parties filed a Joint Motion for Continuance, which was granted, and the final hearing was ultimately rescheduled for January 21, 2014.

On January 14, 2014, the parties filed unilateral prehearing statements. The parties commonly stipulated that, during the audit period, Respondent operated as an authorized Medicaid provider and had been issued Medicaid provider number 0632431-00. Additionally, the parties stipulated that, during the audit period, Respondent had a valid Medicaid provider agreement.

Both parties were represented by counsel at the hearing, which went forward as planned. The final hearing Transcript was filed on February 19, 2014. The identity of the witnesses and exhibits and the rulings regarding each are as set forth in the Transcript.

On March 18, 2014, Respondent filed an Unopposed Motion for Extension of Time to File Proposed Recommended Orders. Said motion was granted and the parties were ordered to submit proposed recommended orders on or before April 24, 2014. The parties timely filed proposed recommended orders, which were considered in preparing this Recommended Order.

The undersigned issued a Recommended Order on May 22, 2014, dismissing the Final Audit Report ("FAR") on the grounds that

Dr. O'Hern was not Respondent's "peer" as defined by section 409.9131(2)(c), Florida Statutes. Thereafter, Petitioner issued an order remanding the matter to the undersigned for additional factual findings, citing "exceptional circumstances." The undersigned entered an order declining remand. Petitioner then entered a Partial Final Order and again remanded to the undersigned "to make factual findings regarding all the claims at issue in this matter with the understanding that Dr. O'Hern is a 'peer' of respondent as defined by Section 409.9131(2)(c), Florida Statutes." The undersigned declined remand.

Petitioner then filed a Petition for Writ of Mandaums with the First District Court of Appeal requesting said court to direct the undersigned to make factual findings with regard to each Medicaid claim identified in the FAR. The appellate court treated the writ as a petition seeking review of non-final agency action as permitted by section 120.68(1), Florida Statutes. The appellate court remanded the case to the undersigned with directions to make factual findings on each of the contested Medicaid claims.[1/]

Unless otherwise indicated, all rule and statutory references are to the versions in effect at the time of the audit period.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for, inter alia, administering the Florida Medicaid Program.

2. Respondent is, and at all times relevant was, a physician licensed to practice medicine in Florida. Respondent was certified by the American Board of Pediatrics in General Pediatrics in 1989. Additionally, Respondent was certified by the American Board of Pediatrics in Pediatric Infectious Diseases in 2005. Respondent's practice is solely hospital-based and exclusive to pediatric infectious disease. Respondent evaluates, and provides care and treatment to, patients in Level III Neonatal Intensive Care Units ("NICU") and Pediatric Intensive Care Units ("PICU") in Miami-Dade, Broward, and Palm Beach County, Florida, hospitals.[2/] Respondent has never been the subject of any disciplinary proceedings.

3. At all times material to this proceeding, Respondent was an enrolled Medicaid provider authorized to receive reimbursement for covered services rendered to Medicaid recipients. As a Medicaid provider, Respondent is obligated to present claims that are "true and accurate" and reflect services that are provided in accordance with all Medicaid "rules, regulations, handbooks, and policies and in accordance with federal, state, and local law." § 409.913(7)(e), Fla. Stat.

4. To ensure that services rendered by a provider are correctly billed to and paid by Medicaid, the provider must identify the services by referring to specific codes corresponding to the specific procedure or service rendered. If services rendered are incorrectly coded on a provider's billing submittals, they may be determined ineligible for payment by Medicaid. Petitioner has adopted several documents by rule through incorporation by reference, to instruct providers on the proper methodology for submitting claims.

5. Pertinent to this case, the documents incorporated by reference are the Florida Medicaid Provider General Handbook,[3/] the Florida Medicaid Physician Services Coverage and Limitations Handbook,[4/] and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.[5/] Additionally, Florida Administrative Code Rule 59G-1.010(59) defines "CPT-4 procedure codes" as "the Physicians Current Procedural Terminology, Fourth Edition, CPT, which is a systematic listing and coding of procedures and services that is published yearly by the American Medical Association." In this proceeding, the parties stipulated to the admission of the 2008, 2009, and 2010 CPT codes, which were in effect during the audit period.

Description of the Audit and Overpayment Determination

6. Exercising its statutory authority to oversee the integrity of the Medicaid program, Petitioner identified

Respondent as a Medicaid provider who had submitted a high volume of claims for inpatient recipients. Accordingly, Petitioner conducted a review or audit to verify the claims paid by Medicaid during the audit period.

7. On or about September 14, 2011, Petitioner issued a request for records letter to Respondent. Said correspondence notified Respondent that Petitioner was in the process of completing a review of claims Respondent billed to Medicaid during the audit period to determine whether the claims were billed and paid in accordance with Medicaid policy. The request identified 30 of Respondent's patients and requested copies of the patients' Medicaid-related records, including all hospital records. The requested records were to be submitted within 21 days.

8. Respondent provided certain records responsive to the September 14, 2011, request for records.[6/] Upon receipt, Petitioner organized the submitted records and provided the same to a reviewing nurse, Blanca Nottman. The reviewing nurse preliminarily inspected the same to determine if any policy violations were apparent and noted any findings.

9. Ms. Nottman, in turn, provided the records and notations to Petitioner's "peer coordinator." The peer coordinator maintains a list of all the peers that have a contract with Petitioner. A peer "means a Florida licensed physician who is,

to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice." § 409.9131(2)(c), Fla. Stat.[7/]

10. The peer coordinator then forwarded all records and documents provided by Respondent to Richard Keith O'Hern, M.D., to conduct a peer review of Respondent's claims. Section 409.9131(2)(d), defines a peer review as follows:

> an 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 care standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

11. Dr. O'Hern was certified, in 1979, by the American Board of Pediatrics in General Pediatrics. Dr. O'Hern completed a one-year infectious disease fellowship during his training at the University of Florida in 1977-78. Dr. O'Hern retired from a private general pediatric practice in December 2012. During his thirty-seven year career, he provided care and treatment to approximately 80,000 babies, of which approximately 16,000 were sick with infectious disease issues.[8/]

12. During his career, Dr. O'Hern was on three hospital medical staffs, and estimated that his practice involved working

in the hospital setting approximately 10-20 percent of the time, with the balance in his office.

13. Dr. O'Hern was never certified by the American Board of Pediatrics in pediatric infectious diseases and would not, at the time of the review, have been eligible to become certified in pediatric infectious diseases. Additionally, Respondent provided unrefuted testimony that Dr. O'Hern would not be permitted to treat Respondent's patients at Level III NICUs and PICUs.

14. Rather than examine the records of all recipients served by Respondent during the audit period, a random sample of 30 recipients (patients) was reviewed. For these patients, Respondent identified 701 reimbursements from Petitioner to Respondent during the audit period. At hearing, Petitioner presented evidence specific to three of the 30 patients. A review of the three patients is instructive.

15. Patient 1 was born premature at 33 weeks' gestation, with a birth weight of three pounds, seven ounces, and was two months old at time of the subject hospitalization. At birth, Patient 1's medical condition necessitated placement in the NICU for three weeks and required nasogastric tube feeding. During the hospitalization under review, the patient's discharge diagnoses included, inter alia, septicemia and streptococcal meningitis. During the hospitalization, Respondent provided pediatric infectious disease care to the recipient.

16. Patient 2 was born on January 27, 2009, at 27 weeks' gestation. At the time of the subject admission, Patient 2 was 37 days old, with an adjusted gestation age of 32 weeks two days, weighing 1.040 kg (approximately two pounds five ounces). The admitting diagnoses were prematurity, possible sepsis, respiratory distress, and a femoral fracture. Respondent provided care and treatment concerning a pediatric infectious disease condition, sepsis. The patient was not discharged from the hospital until July 28, 2009.

17. Patient 3 was born prematurely on July 15, 2009. On August 27, 2009, the child was 43 days old with an adjusted gestation of 32 weeks five days and weighed 1.180 kg (approximately two pounds ten ounces). The admitting indications were prematurity, possible sepsis, and respiratory distress. Respondent provided care and treatment concerning potential sepsis, a pediatric infectious disease medical condition.

18. Consistent with the above-findings concerning Patients 1-3, Respondent testified that his typical patient/recipient is premature and weighs approximately 500 grams (approximately one pound). Respondent explained that his patients are immune-compromised and that patients under 28 weeks' gestation do not possess an independent immune system. Respondent opined that the greatest cause of morbidity or mortality among these pediatric patients is infectious diseases.

19. Petitioner failed to present any evidence concerning what efforts were undertaken to obtain an appropriate peer to review Respondent's claims. The undersigned finds that Dr. O'Hern was not a statutorily-defined peer of Respondent, and, therefore, it follows that an appropriate peer review was not performed before formal proceedings (the FAR) were initiated against Respondent, as required by section 409.9131(5)(b).[9/] Notwithstanding, as directed by the First District Court of Appeal, the undersigned hereby complies with the Mandate to make factual findings on each of the contested Medicaid claims.

20. Dr. O'Hern received copies of the medical records submitted by Respondent and "copies of the worksheets that Medicaid uses to determine the appropriateness of medical reimbursement." For each of the thirty patients, whose encounters were under review for the audit period, Dr. O'Hern reviewed the patient's noted complaint; whether the patient was a new or existing patient; whether the patient was inpatient or outpatient; the medical history, physical exam, and assessment of the patient; and the amount of time spent with the patient. Dr. O'Hern would then, based upon the above information, "determine the level of coding that leads to reimbursement."

21. Upon completion of his review, Dr. O'Hern notated his findings and returned the same to the peer coordinator, who in turn, provided them to the reviewing nurse. The reviewing nurse

then "comes up with a review finding that gives the reason for the adjusted or denied claim." As there were findings for adjusting or denying Respondent's claims, Jennifer Ellingen, an investigator for Petitioner, prepared a Preliminary Audit Report ("PAR").

22. On April 18, 2012, Petitioner issued the PAR to Respondent. The PAR advised Respondent that Petitioner had completed a review of claims for Medicaid reimbursement for the audit period, and a preliminary determination had been made that Respondent was overpaid $1,051,992.99 for claims that in whole or in part were not covered by Medicaid. The overpayment calculation was made as follows:

> A random sample of 30 recipients respecting whom you submitted 701 claims was reviewed. For those claims in the sample, which have dates of service from September 1, 2008, through August 31, 2010, an overpayment of $72,500.45 or $103.42432240 per claim, was found. Since you were paid for a total (population) of 11,688 claims for that period, the point estimate of the total overpayment is 11,688 x $103.42432240=$1,208,823.48. There is a 50 percent probability that the overpayment to you is that amount or more.[10/]

23. The following explanation in the PAR was provided as the basis for Petitioner's overpayment determination:

> REVIEW DETERMINATIONS
>
> Medicaid policy defines the varying levels of care and expertise required for the evaluation and management procedure codes for

> office visits. The documentation you provided supports a lower level of office visit than the one for which you billed and received payment. This determination was made by a peer consultant in accordance with Sections 409.913 and 409.9131, F.S. The difference between the amount you were paid and the correct payment for the appropriate level of service is considered an overpayment.
>
> Medicaid policy specifies how medical records must be maintained. A review of your medical records revealed that some services for which you billed and received payment were not documented. Medicaid requires documentation of the services and considers payments made for services not appropriately documented an overpayment.

24. The PAR notified Respondent that he could (1) pay the identified overpayment within 15 days and wait for the issuance of the final audit report ("FAR"); (2) submit further documentation in support of the claims within 15 days; however, such additional documentation may "be deemed evidence of non-compliance with [Petitioner's] initial request for documentation;" or (3) not respond, and wait for the issuance of the final audit report.

25. The PAR further notified Respondent that the findings contained in the PAR were preliminary in nature, and that it was not a final agency action.

26. Respondent opted to submit further documentation in support of his claims. Upon doing so, the process repeated itself, with the reviewing nurse, now Karen Kinser,[11/] reviewing

all of the submitted documentation, which was then forwarded to Dr. O'Hern for an additional review.

27. On January 8, 2013, Respondent issued a FAR. The amount previously determined as overpayment in the PAR remained unchanged in the FAR. The FAR further documented that a fine in the amount of $210,398.60 had been applied and costs had been assessed in the amount of $3,349.86.

28. The sampling for the audit performed in the FAR is pursuant to accepted and valid statistical methodologies and consistent with generally accepted statistical models.

29. The FAR advised Respondent that, pursuant to section 409.913(23), Petitioner was entitled to recover all investigative, legal, and expert witness costs. Petitioner presented unrefuted testimony that the costs associated with the audit were $3,349.86.

30. As noted above, upon receipt of the FAR, Respondent timely requested a formal hearing.

The Specific Claims/Codes at Issue

A. Lack of Documentation.

31. Petitioner's September 14, 2011, demand letter requested the "Medicaid-related documents," including all hospital records, to substantiate the billing for the 30 identified recipients of the audit. Respondent, pursuant to the demand letter, was advised that the "failure to provide all

Medicaid-related records in compliance with this request will result in the application of sanctions, which include, but are not limited to, fines, suspension and termination."

32. Petitioner attached to the demand letter another document entitled "Certification of Completeness of Records." This document defined the requested documents as follows:

> Medicaid-related records are records related to the provider's business, profession, or to a Medicaid recipient. They are the records necessary to determine a provider's entitlement to payments under the Medicaid program. All documentation that relates to the Medicaid payments and Medicaid recipients under review should be submitted in response to the Agency's request for records.

33. Respondent provided voluminous records for the 30 selected recipients. Approximately 2,100 pages of medical records were received in evidence.

34. Ms. Kinser credibly testified that the reviewing nurse, when conducting her review, may note a lack of documentation for a specific date. The peer, when conducting his review, may agree or disagree with that notation.[12/]

35. Here, after review by Dr. O'Hern, it is documented on the worksheets[13/] and the review determinations spreadsheet compiled by Jennifer Ellingsen, that on 258 occasions Respondent failed to submit the requisite supporting documentation to support his billing. In each instance, the entirety of the amount paid was determined to be an overpayment. Aside from the

volume of records provided, Respondent's evidentiary presentation failed to specifically rebut any claim denied on the basis of "no documentation."

B. Consultation Codes.

36. The review determinations spreadsheet reveals that, on 216 occasions, Respondent submitted billing for inpatient physician consultations for "subsequent services," under the CPT Codes 99232 or 99233.[14/] The CPT Handbook section for "Inpatient Consultations" provides, in pertinent part, as follows:

> The following codes are used to report physician consultations provided to hospital inpatients, residents of nursing facilities, or patients in a partial hospital setting. Only one consultation should be reported by a consultant per admission. Subsequent services during the same admission are reported using subsequent hospital care codes (99231-99233) . . . .

37. The "Subsequent Hospital Care" section of the CPT Handbook provides as follows:

> All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition and response to management) since the last assessment by the physician.
>
> **99231 Subsequent hospital care**, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
>
> - **A problem focused interval history;**
> - **A problem focused examination;**

- **Medical decision making that is straightforward or of low complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.

99232 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **An expanded problem focused interval history;**
- **An expanded problem focused examination;**
- **Medical decision making of moderate complexity.**

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.

99233 Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:

- **A detailed interval history;**
- **A detailed examination;**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other providers or agencies are provided

> consistent with the nature of the problem(s) and the patient's and/or family's needs.
>
> Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

38. For each of the 216 submissions wherein Respondent utilized CPT codes 99232-99233 (moderate or high complexity), Dr. O'Hern determined the appropriate code for reimbursement was CPT Code 99231 (low complexity). Despite providing general testimony that the treatment he provided to the recipients, collectively, was highly complex, Respondent failed to present sufficient evidence that Dr. O'Hern's downward adjustment from CPT Codes 99232 or 99233 to CPT Code 99231 for any particular recipient encounter was erroneous.

C. Critical Care Codes.

39. On every occasion that Respondent billed for critical care services, Dr. O'Hern disallowed the same. The CPT Code defines "critical care" as follows:

> Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent

> further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and /or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.[15/]
>
> Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

40. Dr. O'Hern reviewed Respondent's billing utilizing the following analysis: 1) consultant versus attending physician; 2) critical care versus noncritical care; 3) problem focused versus detail; and 4) documentation of care, including missing records and "rogueness of material presented."

41. Dr. O'Hern concluded that Respondent was a consulting physician and not the attending physician for every recipient, and, therefore, Respondent's billing for critical care was denied. Dr. O'Hern opined that "the administration of critical

care is done by the attending physician, unless, specifically, in the medical record, that they transferred that responsibility to another physician or to a consultant." He expanded on this opinion as follows:

> But, again, the attending physician is the responsible physician, and according to the documentation that has been provided to the medical community, if you're not responsible for the moment-to-moment direct patient care in all aspects of that baby's care, you're not providing critical care.[16/]

42. Respondent attempted to challenge this opinion during the cross examination of Petitioner's witness, Ms. Kinser. Ms. Kinser was directed to language contained in the 2009 CPT Code that provides "[t]he reporting of pediatric and neonatal critical care services is not based on time or the type of unit (eg., pediatric or neonatal critical care unit) and it is not dependent upon the type of provider delivering the care." Ms. Kinser opined that said passage requires critical care codes to be utilized solely by the attending physician; however, the attending physician need not be a neonatologist as long as the physician was "directing the care."

43. As defined above, critical care is the "direct delivery" by a physician(s) of medical care for a critically ill or critically injured patient. Although neither party has provided the undersigned with a working definition of "direct delivery," Dr. O'Hern and Ms. Kinser base their opinions on the

construction that only an attending physician may directly deliver medical care for critically ill or injured patients.

44. The Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §30.6.12, published by the Department of Health and Human Services-Centers for Medicare & Medicaid Services, incorporates the CPT definitions of critical care and critical care services, as well as general evaluation and management payment policies that impact payment for critical care services. Said publication provides that:

> Providing medical care to a critically ill patient should not be automatically deemed to be a critical care service for the sole reason that the patient is critically ill or injured. While more than one physician may provide critical care services to a patient during the critical care episode of an illness or injury each physician must be managing one or more critical illness(es) or injury(ies) in whole or in part.
>
> EXAMPLE: A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitroglycerine infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.

45. Petitioner seeks to limit reimbursement of critical care services to an attending physician who is directing all aspects of the patient's care. This limitation is questionable as the definition of critical care services references "physician(s)," and the above-referenced manual advises that more

than one physician may provide critical care services during a critical care episode.

46. Notwithstanding, Respondent failed to present sufficient evidence for the undersigned to find that Petitioner's interpretation is erroneous. Furthermore, with respect to any contested recipient billing, Respondent failed to present sufficient evidence for the undersigned to find that Respondent was providing critical care services that were necessary to treat and manage the critical illness(es) or injury (ies) of the recipient, in whole or in part, in rebuttal of Dr. O'Hern's testimony.[17/]

CONCLUSIONS OF LAW

47. DOAH has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes.

48. Section 409.913(7)(e), Florida Statutes, provides that a Medicaid provider is obligated to present claims that are "true and accurate" and reflect services that are provided in accordance with all Medicaid "rules, regulations, handbooks, and policies and in accordance with federal, state, and local law."

49. Petitioner is authorized to recover Medicaid overpayments and to impose sanctions as appropriate. § 409.913, Fla. Stat. An "overpayment" includes "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." § 409.913(1)(e), Fla. Stat.

50. Section 409.913(11) requires Petitioner to "deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them . . . ."

51. The burden of proof is on Petitioner to prove the material allegations by a preponderance of the evidence. S. Medical Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992). The sole exception is that the standard of proof is clear and convincing evidence for the fine that Petitioner seeks to impose. Dep't of Banking & Fin. v. Osborne Sterne & Co., 670 So. 2d 932, 935 (Fla. 1996).

52. Although Petitioner bears the ultimate burden of persuasion, section 409.913(22) provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of overpayment."

53. Petitioner proffered a properly supported audit report, and the same was received in evidence. Petitioner established a prima facie case of overpayment and proved, by a preponderance of the evidence, that Respondent was overpaid in the amount claimed in the FAR.

54. Petitioner is authorized to impose sanctions on a provider, including administrative fines. § 409.913(16), Fla. Stat. In the FAR, Petitioner notes that the FAR shall serve as notice of the following sanction(s): "A fine of $210,398.60 for violation(s) of Rule Section 59G-9.070(7)(e), F.A.C." The version of Florida Administrative Code Rule 59G-9.070(e) in effect during the audit period provides as follows:

> SANCTIONS: Except when the Secretary of Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed for the following:
>
> * * *
>
> (e) Failure to comply with the provisions of the Medicaid provider publications that have been adopted by reference as rules, Medicaid laws, the requirements and provisions in the provider's Medicaid provider agreement, or the certification found no claim forms or transmittal forms for electronically submitted claims by the provider or authorized representative. [Section 409.913(15)(e),F.S.];

55. Florida Administrative Code Rule 59G-9.070(10) GUIDELINES FOR SANCTIONS, provides in pertinent part, as follows:

> (c) A violation is considered a:
>
> 1. First Violation, if, within the five years prior to the alleged violation date(s), the provider, entity, or person has not been deemed by the Agency in a prior Agency action to have committed the same violation;
>
> * * *

> (i) Sanction and disincentives shall apply in accordance with this rule, as set forth in the table below:
>
> * * *
>
> (7)(e) Failure to comply with the provisions of Medicaid laws.
>
> First violation: a $500 fine per provision, not to exceed $3,000 per agency action. For a pattern: a $1,000 fine per provision, not to exceed $6,000 per agency action.

56. Rule 59G-9.070(2)(r) provides that a "pattern" as it relates to paragraph (7)(e) of this rule is sufficiently established if within a single Agency action: a) the number of individual claims found to be in violation is greater than 6.25 percent of the total claims that were reviewed to support the Agency action; or b) the overpayment determination by the Agency is greater than 6.25 percent of the amount paid for the claims that were reviewed to support the Agency action.

57. The undersigned's independent review of the Overpayment Calculation Using Cluster Sampling reveals that the total payments to Respondent for the recipient population was $1,369,361.97 and Petitioner determined Respondent was overpaid $1,051,992.99. Said overpayment determination by Petitioner is greater than 6.25 percent of the amount paid for the claims that were reviewed to support Petitioner's action, and, therefore, constitute a "pattern." Accordingly, it is determined that

sanctions consisting of a $6,000 administrative fine should be imposed for violations of Rule 59G-9.070(7)(e).

58. Pursuant to section 409.913(23)(a), Petitioner is entitled to recover investigative, legal, and expert witness costs, if it ultimately prevails. The agency has the burden of documenting the costs, which include salaries and employee benefits and out-of-pocket expenses. § 409.913(23)(b), Fla. Stat. Here, the requested costs include the time of Petitioner's investigator, the reviewing nurses, and the peer. It is determined that Petitioner is entitled to recover $3,349.86 in costs.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration issue a Final Order finding that Respondent was overpaid, and therefore is liable for reimbursement to AHCA, the total amount of $1,051,992.99; imposing an administrative fine of $6,000; and recovering $3,349.86 in costs.

DONE AND ENTERED this 7th day of July, 2015, in Tallahassee, Leon County, Florida.

TODD P. RESAVAGE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 7th day of July, 2015.

ENDNOTES

[1/] The First District Court of Appeal issued the Mandate on May 15, 2015.

[2/] Hospital units providing neonatal care are classified according to the intensity and specialization of the care which can be provided. Florida Administrative Code Rule 59C-1.042(2)(g)(3) defines Level III Neonatal Intensive Care Services, in pertinent part, as follows:

> Services which include the provision of continuous cardiopulmonary support services, 12 or more hours of nursing care per day, complex neonatal surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization, shall be classified as Level III neonatal intensive care services . . . . A facility with a Level III neonatal intensive care service that does not provide treatment of complex major congenital anomalies that require the services of a pediatric surgeon, or pediatric cardiac catheterization and cardiovascular surgery shall enter into a written agreement with a

> facility providing Level III neonatal intensive care services in the same or nearest service area for the provision of these services.

[3/] Incorporated by reference in Florida Administrative Code Rule 59G-5.020(1).

[4/] Incorporated by reference in Florida Administrative Code Rule 59G-4.230(1).

[5/] Incorporated by reference in Florida Administrative Code Rule 59G-4.001(1).

[6/] The record is silent as to when any particular medical record was provided to Petitioner for review.

[7/] A "peer" is further defined in Florida Administrative Code Rule 59G-1.010(197) as "a person who has equal professional status with a Medicaid provider or a specific type or specialty. Where a person with equal professional status is not reasonably available, a peer includes a person with substantially similar professional status."

[8/] The undersigned was unable to locate any evidence indicating Dr. O'Hern's experience treating premature infants with infectious disease medical issues.

[9/] The undersigned recognizes that Petitioner is not required to retain a reviewing physician who has the exact credentials as the physician under review. To the contrary, Petitioner's obligation in this regard is met when it retains a reviewing physician who is, to the maximum extent possible, of the same specialty or subspecialty as the physician under review. The undersigned has concluded that Dr. O'Hern is not of the same specialty as Respondent. As Petitioner failed to present any evidence concerning what efforts were undertaken to obtain an appropriate peer to review Respondent's claims, the undersigned is compelled to conclude Dr. O'Hern is not a peer.

[10/] To extrapolate the total probable overpayment to Respondent for all claims, Petitioner applied the statistical formula for cluster sampling.

[11/] Ms. Kinser is a Registered Nurse Consultant with Respondent's Medicaid Integrity Program and is also certified by the American Academy of Professional Coders.

[12/] According to Jennifer Ellingsen, the reviewing nurse can deny certain claims that are "black and white," such as billing that occurs after business hours. The reviewing nurse cannot deny claims on the grounds of medical necessity or level care.

[13/] A listing of all claims in the medical sample by recipient name.

[14/] Excluding those claims denied for "no documentation."

[15/] Pursuant to the CPT Code, the same definitions for critical care services apply for the adult, child, and neonate.

[16/] Dr. O'Hern's reference to "the documentation that has been provided to the medical community" is not specifically identified in the record.

[17/] While the record contains thousands of pages of medical records, the interpretation of those records to determine whether the medical services provided by Respondent amount to critical care services requires expert medical testimony present in this record.

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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.