STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

ALFRED IVAN MURCIANO, M.D.,

Respondent.
_____/

DOAH CASE NO. 13-0795MPI
C.I. NO. 12-0421-000
RENDITION NO.: AHCA-15-0463 -FOF-MDO

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where it was assigned to Administrative Law Judge (ALJ), Todd P. Resavage. On May 22, 2014, the ALJ entered a Recommended Order, recommending that the Agency dismiss its Final Audit Report due to the fact that the Agency did not perform an appropriate peer review. On July 9, 2014, the Agency Clerk entered an Order of Remand, remanding the case back to the ALJ to make findings of fact and conclusions of law on each claim at issue. On July 24, 2014, the ALJ entered an Order Declining Remand. On July 31, 2014, the Agency entered a Partial Final Order that reversed the ALJ's conclusions of law regarding whether the Agency had conducted an appropriate peer review and remanding the case back to the ALJ once again for further fact-finding on all the claims at issue. On August 18, 2014, the ALJ entered another Order Declining Remand. On August 27, 2014, the Agency filed a Petition for Writ of Mandamus with the First District Court of Appeal. On April 29, 2015, the First District Court of Appeal entered an Opinion, treating the Agency's Petition for Writ of Mandamus as a petition for review of a non-final order, finding the ALJ had departed from the essential requirements of law by failing to make factual findings on all of the contested Medicaid claims and remanding the case back to the

ALJ in order for him to do so. On July 7, 2015, the ALJ entered a Recommended Order on Remand, which is attached to this Final Order and incorporated by reference, except where noted infra. At issue in this proceeding is whether the Agency for Health Care Administration ("Agency") is entitled to recover alleged Medicaid overpayments from Respondent for services rendered to Medicaid recipients from September 1, 2008 to August 31, 2010, and whether sanctions and costs should be imposed on Respondent.

RULING ON EXCEPTIONS

Both Petitioner and Respondent filed exceptions to the Recommended Order on Remand with the Agency Clerk within 15 days of the date the Recommended Order was entered.

In determining how to rule upon the parties' exceptions and whether to adopt the ALJ's Recommended Order on Remand in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow Section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

§ 120.57(1)(*l*), Fla. Stat. Additionally, "[t]he final order shall include an explicit ruling on each exception, but an agency need not rule on an exception that does not clearly identify the disputed

portion of the recommended order by page number or paragraph, that does not identify the legal basis for the exception, or that does not include appropriate and specific citations to the record." § 120.57(1)(k), Fla. Stat. In accordance with these legal standards, the Agency makes the following rulings on each party's exceptions:

Petitioner's Exceptions

In its sole exception to the Recommended Order on Remand, Petitioner takes exception to Paragraph 19 of the Recommended Order on Remand, arguing that it is an erroneous legal conclusion. The Agency agrees.

In its Partial Final Order rendered on July 31, 2014, the Agency stated

> The undisputed factual findings demonstrate that Dr. O'Hern is a "peer" of Respondent as defined by section 409.9131(2), Florida Statutes. The statute does not require the Agency's peer to be a carbon copy of Respondent, as the ALJ concluded. Rather, the Agency interprets Section 409.9131(2)(c), Florida Statutes, to mean that the peer must practice in the same area as Respondent, hold the same professional license as Respondent, and be in active practice like Respondent. This interpretation is reasonable, and should have been given deference by the ALJ. Dr. O'Hern is indeed a "peer" of Respondent under the Agency's interpretation of Section 409.9131(2)(c), Florida Statutes, because he too has a Florida medical license, is a pediatrician and had an active practice at the time he reviewed Respondent's records. That Dr. O'Hern did not hold the same certification as Respondent, or have a professional practice identical to Respondent in no way means he is not a "peer" of Respondent.

As the Partial Final Order was not appealed by Respondent, the Agency's conclusions of law on this issue are final.

Alternatively and/or additionally, AHCA finds that the second sentence of Paragraph 19 of the Recommended Order on Remand is an erroneously labeled conclusion of law because the determination whether Dr. O'Hern was a statutorily defined peer and, thus, whether an appropriate peer review was conducted necessarily requires the interpretation of section

409.9131, Florida Statutes. Indeed, the ALJ appears to acknowledge that he is interpreting and applying this statutory section in the text of Paragraph 19. As the single state agency charged with administering the Medicaid program, including section 409.9131, AHCA has substantive jurisdiction over the conclusion of law at paragraph 19 of the Recommended Order on Remand and finds that it can substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency grants Petitioner's exception and rejects the ALJ's conclusions of law in the second sentence of Paragraph 19 (and, by extension, those in Endnote 9 as well), and modifies the first and third sentences Paragraph 19 as follows:

> 19. While Petitioner failed to present any evidence concerning what efforts were undertaken to obtain an appropriate peer to review Respondent's claims, Dr. O'Hern is Respondent's "peer," as the term is defined in section 409.9131(2)(c), Florida Statutes, and as was concluded in the Agency's July 31, 2014 Partial Final Order. ~~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, a~~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.

Respondent's Exceptions

In his first exception (Paragraph 12, Page 7 of Respondent's Exceptions)[1], Respondent takes exception to Paragraph 19 of the Recommended Order on Remand, arguing that all parts of the Recommended Order on Remand that arise from the conclusion that Dr. O'Hern is a qualified peer must be rejected. As stated in the ruling on Petitioner's exception to Paragraph 19 of the Recommended Order on Remand supra, which is hereby incorporated by reference, Dr. O'Hern is a peer of Respondent. In addition, as Petitioner noted in its Response to Respondent's

[1] The Agency did not see anything in Respondent's Exceptions prior to Paragraph 12 on Page 7 of Respondent's Exceptions that could be construed as a valid exception to the Recommended Order, and thus will not rule on any statements or arguments made by Respondent prior to that paragraph. See § 120.57(1)(k), Fla. Stat.

Exceptions, the First District Court of Appeal supported the Agency's conclusions on this issue by finding that "the ALJ departed from the essential requirements of law in declining AHCA's second request to make factual findings on all of the contested claims in light of AHCA's legal conclusion that Dr. O'Hern met the statutory definition of 'peer.'" Ag. for Health Care Admin. v. Murciano, 163 So. 3d 662, 665 (Fla. 1st DCA 2015). Therefore, the Agency denies Respondent's first exception.

In his second exception (Paragraph 13, Page 7 of Respondent's Exceptions), Respondent takes exception to Paragraph 28 of the Recommended Order on Remand, arguing that, because the universe of claims in question were improperly labeled as "office visits" and all services at issue were performed in a hospital, the underlying soundness of the sample universe is questionable. Respondent also argued that the records that served as the basis for the audit sampling were incomplete, thus further diminishing the accuracy and reliability of the sampling methodology. Respondent's arguments are refuted by the record of this case, as demonstrated by Petitioner's Response to Respondent's exceptions. First, in regard to the issue of the claims being improperly labeled as "office visits", Dr. O'Hern testified that he knew the claims arose from impatient services in a hospital setting. See Transcript, Page 76. Second, in regard to the issue of the records reviewed by Dr. O'Hern being incomplete, Dr. O'Hern testified that he reviewed all the medical records the Agency received from Respondent, including those in electronic form. See Respondent's Exhibit 2, Pages 64-65. Respondent also signed a Certificate of Completeness on September 14, 2011, certifying that he had provided the Agency with all of the records pertinent to the claims at issue. See Petitioner's Exhibit 2. Respondent made no demonstration at hearing of how the 63,000 pages of records he produced on a CD as an exhibit were in anyway related to the claims at issue in this matter, much less refuted the Agency's

allegations that Respondent was overpaid for services rendered to the Medicaid recipients at issue in this matter. In contrast, the ALJ's findings of fact are supported by competent, substantial evidence as noted above. Thus, the Agency cannot reject or modify the findings of fact in Paragraph 28 of the Recommended Order on Remand. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Department of Business Regulation, 475 So. 2d 1277, 1281 (Fla. 1st DCA 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). Therefore, Respondent's second exception is denied.

In his third exception (Paragraph 14, Page 8 of Respondent's Exceptions), Respondent takes exception to the findings of fact in Paragraph 33 of the Recommended Order on Remand, arguing that he produced over 63,000 pages of medical records in addition to the ones referenced in Paragraph 33 of the Recommended Order on Remand. As noted in the ruling on Respondent's second exception supra, Respondent does not cite to any competent, substantial evidence in support of his argument. Rather, the competent, substantial evidence of this matter demonstrates that the records received into evidence were the only records produced by Respondent, and Respondent himself attested to this fact. See Petitioner's Exhibit 2. Petitioner bears the burden of proof to prove the overpayment 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). Petitioner submitted its Final Audit Report, along with all of its work papers and all the medical records Respondent supplied to it, establishing a prima facie case that Respondent was overpaid for the services he rendered to Medicaid recipients during the time period at issue. Respondent was free to rebut Petitioner's prima facie case by demonstrating that he provided additional records to Petitioner relevant to

the claims at issue that Petitioner failed to review. However, Respondent made no such demonstration at hearing. Thus, the competent, substantial evidence in this matter supports the ALJ's findings of fact in Paragraph 33 of the Recommended Order on Remand, and the Agency cannot disturb such findings. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Respondent's third exception.

In his fourth exception (Paragraph 15, Pages 8-9 of Respondent's Exceptions), Respondent takes exception to the findings of fact in Paragraph 35 of the Recommended Order on Remand, again arguing that Petitioner failed to review all of the medical records Respondent provided to it. In addition to the Agency's ruling on Respondent's second and third exceptions supra, which are hereby incorporated by reference, the Agency responds to Respondent's fourth exception by noting that Respondent signed a Medicaid Provider Agreement that required Respondent to "keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records AHCA requires for a period of at least five (5) years." Transcript, Pages 64-65; Petitioner's Exhibit 1 at Page 54. Thus, Respondent's argument that he was not required to produce records to rebut the claims denied by the Agency for lack of documentation is erroneous. The ALJ's finding that Respondent failed to submit supporting documentation for 258 claims is wholly supported by the competent, substantial evidence of this matter. See, e.g., Petitioner's Exhibit 5; Respondent's Exhibit 2. Thus, the Agency is prohibited from rejecting or modifying it. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Respondent's fourth exception.

In his fifth exception (Paragraph 16, Pages 9-10 of Respondent's Exceptions), Respondent takes exception to the findings of fact in Paragraph 38 of the Recommended Order on Remand, arguing that because Dr. O'Hern is not a qualified peer, his determinations were invalid and

therefore Respondent was not required to rebut them. The issue of Dr. O'Hern's status as a qualified peer is no longer in dispute. See the ruling on Petitioner's Exception to Paragraph 19 of the Recommended Order on Remand and the ruling on Respondent's first exception supra. As stated in the ruling on Respondent's third exception supra, the Petitioner made a prima facie case that Respondent was overpaid. At that point in time, the burden shifted to Respondent to rebut the Petitioner's case, and, as the ALJ found, Respondent failed to do so. Thus, the ALJ weighed what testimony Respondent presented at hearing, and found that it was not as credible as the evidence Petitioner put forth. See Petitioner's Exhibit 5; Respondent's Exhibit 2. The Agency is not permitted to re-weigh the evidence in order to reach a contrary finding. See § 120.57(1)(*l*), Fla. Stat.; Heifetz, 475 So. 2d at 1281. Therefore, the Agency denies Respondent's fifth exception.

In his sixth exception (Paragraph 17, Page 10 of Respondent's Exceptions), Respondent takes exception to the findings of fact in Paragraph 46 of the Recommended Order on Remand, arguing that because Dr. O'Hern is not a qualified peer his determinations are invalid and Respondent was not required to rebut them. Based on the rulings on Respondent's first, third and fifth exceptions supra, which are hereby incorporated by reference, the Agency denies Respondent's sixth exception.

In his seventh exception (Paragraph 18, Pages 10-11 of Respondent's Exceptions), Respondent takes exception to Endnote 17 of the Recommended Order on Remand, arguing once again that the audit was invalid. Based on the rulings on Respondent's first, third, fifth and sixth exceptions supra, which are hereby incorporated by reference, the Agency denies Respondent's seventh exception.

In his eighth exception (Paragraph 19, Pages 11-12 of Respondent's Exceptions), Respondent takes exception to the conclusions of law in Paragraph 53 of the Recommended Order on Remand, arguing that Petitioner did not proffer a properly supported audit report because Dr. O'Hern is not a qualified peer and thus did not prove Respondent was overpaid by a preponderance of the evidence. The Agency disagrees. In addition, the conclusions of law in Paragraph 53 of the Recommended Order are evidentiary in nature since they involve the ALJ's weighing of evidence, and are thus outside of the Agency's substantive jurisdiction. See Barfield v. Dep't of Health, 805 So.2d 1008 (Fla. 1st DCA 2002). Therefore, the Agency denies Respondent's eighth exception.

In his ninth exception (Paragraph 20, Page 12 of Respondent's Exceptions), Respondent takes exception to the conclusions of law in Paragraph 57 of the Recommended Order on Remand, arguing that since Dr. O'Hern is not a qualified peer Petitioner's overpayment determination is fatally flawed and there can be no pattern. It is the Agency's position that Dr. O'Hern is a qualified peer. See the ruling on Petitioner's Exceptions and Respondent's first exception supra, which are hereby incorporated by reference. Thus, the Agency finds that, while it does have substantive jurisdiction over the conclusions of law in Paragraph 57 of the Recommended Order on Remand because it is the single state agency in charge of administering Florida's Medicaid program, it cannot substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency denies Respondent's ninth exception.

In his tenth exception (Paragraph 21, Page 12 of Respondent's Exceptions), Respondent takes exception to the conclusions of law in Paragraph 58 of the Recommended Order on Remand, arguing that since Dr. O'Hern is not a qualified peer any impositions of costs is inappropriate and unlawful. Based on the reasoning set forth in the ruling on Respondent's ninth

exception supra, which is hereby incorporated by reference, the Agency denies Respondent's tenth exception.

In his eleventh exception (Paragraph 22, Page 13 of Respondent's Exceptions), Respondent takes exception to the ALJ's Recommendation, arguing that Petitioner's overpayment determination is fatally flawed and this action should be dismissed. As emphasized repeatedly throughout the rulings on Respondent's Exceptions supra, the Agency disagrees with Respondent's position on this issue, and thus will not disturb the ALJ's Recommendation. Therefore, the Agency denies Respondent's eleventh exception.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order on Remand.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order on Remand, except where noted supra.[2]

IT IS THEREFORE ADJUDGED THAT:

Respondent is hereby required to repay $1,051,992.99, plus interest at a rate of ten (10) percent per annum as required by Section 409.913(25)(c), Florida Statutes, to the Agency. In addition, the Agency hereby imposes a fine of $6,000 and costs in the amount of $3,349.86 on Respondent. Respondent shall make full payment of the overpayment, fine and costs to the Agency for Health Care Administration within 30 days of the rendition date of this Final Order unless other payment arrangements have been agreed to by the parties. Respondent shall pay by check payable to the Agency for Health Care Administration and mailed to the Agency for

[2] As the Agency noted in its ruling on Petitioner's Exceptions supra, Paragraph 19 of the Recommended Order contains conclusions of law, not findings of fact.

Health Care Administration, Office of Finance and Accounting, 2727 Mahan Drive, Mail Stop 14, Tallahassee, Florida 32308.

DONE and ORDERED this 1st day of August, 2015, in Tallahassee, Florida.

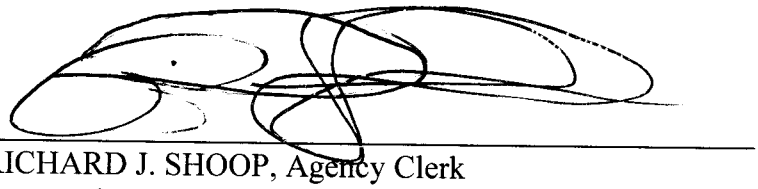
ELIZABETH DUDEK, SECRETARY
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY ALONG WITH THE FILING FEE PRESCRIBED BY LAW WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished to the persons named below by the method designated on this 14th day of August, 2015.



RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
(850) 412-3630

COPIES FURNISHED TO:

Honorable Todd P. Resavage
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(via electronic filing through the Division's website)

Kevin Dewar, Esquire
Assistant General Counsel
(via electronic mail to Kevin.Dewar@ahca.myflorida.com)

William J. Sanchez, Esquire
William J. Sanchez, P.A.
12600 Southwest 120th Street
Suite 102
Miami, Florida 33186
(via electronic mail to william@wsanchezlaw.com)

Steven A. Grigas, Esquire
Michael J. Larson, Esquire
Akerman, LLP
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301
(via electronic mail to steven.grigas@akerman.com,
michael.larson@akerman.com, terry.jay@akerman.com,
michele.rowe@akerman.com and elisa.miller@akerman.com)

William J. Spratt, Jr., Esquire
Akerman, LLP
1 Southeast 3rd Avenue, 25th Floor
Miami, Florida 33131-1700
(via electronic mail to william.spratt@akerman.com)

Medicaid Program Integrity
Office of the Inspector General

Medicaid Accounts Receivable
Finance & Accounting

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
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

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.

COPIES FURNISHED:

William J. Sanchez, Esquire
William J. Sanchez, P.A.
12600 Southwest 120th Street, Suite 102
Miami, Florida 33186
(eServed)

Katherine E. Giddings, Esquire
Akerman LLP
106 East College Avenue, Suite 1200
Tallahassee, Florida 32301

William J. Spratt, Jr.
Akerman LLP
1 Southeast Third Avenue, Suite 2500
Miami, Florida 33131-1714

Debora E. Fridie, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Stop 3
2727 Mahan Drive
Tallahassee, Florida 32308
(eServed)

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

Stuart Williams, General Counsel
Agency for Health Care
Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308
(eServed)

Elizabeth Dudek, Secretary
Agency for Health Care
Administration
2727 Mahan Drive, Mail Station 1
Tallahassee, Florida 32308
(eServed)

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.