STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

Case No. 15-3877MPI

vs.

VYASA RAMCHARAN, DMD,

Respondent.
_____/

RECOMMENDED ORDER

D. R. Alexander, Administrative Law Judge of the Division of Administrative Hearings (DOAH), conducted the final hearing in this matter on February 9 and 10, 2016, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Ephraim D. Livingston, Esquire
Joseph G. Hern, Jr., Esquire
Agency for Health Care Administration
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For Respondent: Bruce D. Lamb, Esquire
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STATEMENT OF THE ISSUES

The issues are whether the Agency for Health Care Administration (AHCA) is entitled to repayment of $1,152,237.19

in Medicaid reimbursements that it made to Respondent pursuant to section 409.913(11), Florida Statutes; the amount of sanctions, if any, that should be imposed pursuant to sections 409.913(15) through (17); and the amount of any investigative, legal, and expert witness costs that AHCA is entitled to recoup pursuant to section 409.913(23).

PRELIMINARY STATEMENT

On April 24, 2015, AHCA issued a Final Audit Report (FAR) in which it asserted that Respondent, Vyasa Ramcharan, a Medicaid provider, had been overpaid $1,152,237.19 for services performed from January 1, 2011, through June 30, 2013, that in whole or in part are not covered by Medicaid. The FAR also sought to impose an administrative fine of $88,000.00 as a sanction for violating Florida Administrative Code Rule 59G-9.070(7)(e) and to recoup investigative, legal, and expert witness costs. Respondent timely requested a hearing and the matter was referred by AHCA to DOAH to resolve the dispute.

At hearing, AHCA presented the testimony of three witnesses. AHCA Exhibits 1 through 16 were accepted in evidence. Respondent testified on his own behalf and presented the testimony of two witnesses. Respondent's Exhibits 1 through 8 were accepted in evidence. A ruling on Exhibits 13 and 14 was reserved. The objection is sustained. See § 409.913(22), Fla. Stat.

A three-volume Transcript of the hearing has been prepared. Proposed recommended orders (PROs) were filed by the parties, and they have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

A. Background

1. AHCA is designated as the state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. This program is designated as the Medicaid Program. See § 409.902(1), Fla. Stat.

2. Respondent is a dentist licensed to practice dentistry in the State of Florida. His specialty is oral surgery.

3. This case involves a Medicaid audit of Respondent, which relates to dates of service from January 1, 2011, through June 30, 2013 (the audit period).

4. During the audit period, Respondent was enrolled as a Medicaid provider and had a valid Medicaid provider agreement with AHCA. He provided services in a seven-county area in Central Florida, with the vast majority of patients being referred from general practice dentists.

5. As an enrolled Medicaid provider, Respondent was subject to federal and state statutes, regulations, rules, policy guidelines, and Medicaid handbooks incorporated by

reference into rule, which were in effect during the audit period.

6. Pursuant to section 409.913, AHCA's Bureau of Medicaid Program Integrity conducted an audit of Respondent's paid Medicaid claims for medical goods and services to Medicaid recipients. The audit was performed after a dental peer in another case identified errors in coding and billing for medically unnecessary bone grafting. AHCA then ran a report of all providers billing those codes and determined that Respondent was one of the five highest utilizers of the bone grafting codes in the State of Florida. In fact, his use of the codes was significantly higher than the Department of Oral and Maxillofacial Surgery at the University of Miami.

7. After a review of Respondent's records was completed, on April 24, 2015, AHCA issued a FAR, alleging that Respondent was overpaid $1,152,237.19 for certain services that in whole or part are not covered by Medicaid. In addition, the FAR informed Respondent that AHCA was seeking to impose a fine of $176,000.00 as a sanction for violation of rule 59G-9.070(7)(e) and to recover its costs pursuant to section 409.913(23). Due to a calculation error, the sanction amount was later reduced to $88,000.00. The claims which make up the overpayment of $1,152,237.19 were filed and paid to Respondent prior to the institution of this action. The auditor who conducted the

investigation and prepared the FAR is no longer employed by AHCA and did not testify. However, his supervisor, Robi Olmstead, who oversees all comprehensive audits such as this, testified at hearing and confirmed that except for an error in calculating the penalty, the investigator followed all required procedures. The audit was properly conducted.

8. In the section of the FAR entitled "Findings," AHCA sets forth the bases for the overpayment determinations. AHCA concluded that "medical necessity for some claims submitted was not supported by the documentation" and payments made to Respondent for these services are considered an overpayment. Pet'r Ex. 4, p. 87. It also concluded that "some services rendered were erroneously coded on the submitted claim," and that after the "appropriate dental code was applied[,] [t]hese dental services are not reimburseable by Medicaid." Id., p. 88.

9. Respondent then requested an administrative hearing to contest the overpayment determination, imposition of sanctions, and recovery of costs.

B. The Sample Program Used by AHCA

10. AHCA has established a process in Medicaid audit cases to review a statistically valid sample of the claims submitted to the Medicaid program. The claims sample program is a random sample program developed for this type of audit. The evidence supports a finding that the program is statistically valid.

11. Using its data support system, AHCA assessed the complete universe of Medicaid claims paid to Respondent and selected the period from January 1, 2011, through June 30, 2013, as the audit period. The program then selected a random sample of the universe of claims, consisting of 35 recipients for whom 332 claims were filed during the audit period. All recipients were under 26 years of age.

12. The sample program was reviewed, tested, and validated by Dr. Huffer, a professor of statistics at Florida State University. His analysis demonstrated that the random sample is appropriate, and the calculation and amount of the overpayment are correct.

13. After Respondent produced documents to substantiate those claims, they were forwarded to the peer for review. The peer is a Florida licensed physician who is of the same specialty or subspecialty and licensed under the same chapter as Respondent. In this case, the peer reviewer was Dr. James A. Davis, Jr., a board-certified oral surgeon in Tallahassee who is licensed under the same chapter and is the same specialty (oral surgeon) as Respondent. Dr. Davis has certificates of residency in both anesthesiology and oral maxillofacial surgery from the University of Miami School of Medicine. His practice includes complicated surgery, trauma surgery, corrective jaw surgery, facial surgery, pathology, and reconstruction of the face. He

also has extensive experience with the routine surgeries at issue in this case, including the extraction of third molars (wisdom teeth), bone grafts, and excision of cysts. All of his patients are private pay; however, he has occasionally provided free services to Medicaid-eligible patients.

14. After the records of the 35 recipients were reviewed by Dr. Davis, AHCA determined that an overpayment of $53,469.99 was made. The program then applied that overpayment to all claims in the universe, resulting in a total overpayment of $1,152,257.19.

C. Medical Necessity and Other Relevant Requirements

15. To be eligible for coverage by Medicaid, a service must be "medically necessary," which is defined in section 409.13(1)(d) as follows:

> "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice.

16. AHCA is the final arbiter of medical necessity for purposes of determining Medicaid reimbursement. Id.

17. The statute requires that determinations of medical necessity be made by a licensed physician employed by or under

contract with AHCA, also known as a peer reviewer, based on information available at the time the goods and services are provided. Id. Respondent contends that Dr. Davis is not a qualified peer reviewer within the meaning of the law because he is not a "licensed physician," i.e., a medical doctor. However, Dr. Davis has the same license and specialty as Respondent, he is board-certified, and he has additional certifications from a medical school. Dr. Davis is a qualified peer reviewer for Respondent's oral surgery practice.

18. Respondent's expert on medical necessity and coding, Dr. Lehrer, is an associate professor at Nova Southeastern University Dental School. He is not an oral surgeon but has been teaching in the oral surgery department of the school since 2015. He does not teach how to perform a bone graft, and he has performed fewer than 25 bone grafts in his 30-year career, none since 2010. His primary teaching responsibilities relate to prosthetics (crowns and bridges) and restorative dentistry (fillings and cavities), procedures not at issue in this proceeding.

19. Rule 59G-1.010(59) refers to CPT codes, which are Current Procedural Terminology codes developed by the American Medical Association. The codes identify specific services rendered by providers for purposes of determining whether the service is covered by Medicaid. The American Dental Association

has also published dental procedure codes that describe various services. See Pet'r Ex. 12. However, the dental codes have not been expressly adopted by AHCA, and there is no requirement that they be used when billing Medicaid. In fact, the Medicaid program will not pay for claims submitted using these codes.

20. To ensure that services rendered by the provider are correctly billed to and paid by Medicaid, the provider must identify the services by referring to the specific CPT 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.

D. Were the Services Medically Necessary?

21. After extracting the wisdom teeth of 32 recipients, Respondent billed Medicaid for performing bone grafts on the sockets of each recipient. A bone graft entails the placement of bony material (real or synthetic) on the site of the wound (socket) to facilitate bone regeneration. During the audit period, an oral surgeon was generally reimbursed less than $100.00 for the simple extraction of a wisdom tooth, but was reimbursed as much as $1,150.00 if bone grafts were performed. For 14 recipients, Respondent also billed Medicaid for removal of benign tumors or cysts after the teeth were extracted. The FAR alleges that these procedures were not medically necessary.

Given the magnitude of the alleged overcharges, it is not surprising that the testimony on this issue is sharply in dispute.

22. In reviewing the claims, Dr. Davis did not use the definition of medical necessity set forth in sections 409.913(1) and 409.9131(2). See Finding of Fact 15. Instead, he relied upon the definition of medical necessity published by the American Association of Oral and Maxillofacial Surgeons (AAOMS). It reads in pertinent part as follows:

> . . . the need for an item or service or services for the diagnosis, prevention and/or treatment and follow up care of the diseases, injuries and congenital developmental defects that affect the hard and soft tissues of the oral and maxillofacial complex.

23. Dr. Davis testified that he is familiar with the statutory definition of medical necessity and characterized it as being "very similar" to the definition he used, with only "slight variations." He testified that his definition is consistent with the medical standards used by oral surgeons over the last 30 years. Respondent contends the statutory definition is broader and includes services that "correct, cure, alleviate, or preclude deterioration of a condition that . . . causes pain or suffering, or results in illness or infirmity," and these are not encompassed within Dr. Davis' definition. While the two definitions are not identical, services for the "diagnosis,

prevention and/or treatment and follow up care" of a recipient would logically include those that correct, cure, alleviate, or preclude deterioration of a condition for which the recipient is being treated. The use of the AAOMS definition, rather than the statutory definition, did not affect Dr. Davis' analysis of the claims in any significant way.

i. Bone Grafts

24. Bone grafting is performed after the extraction of a wisdom tooth when it is necessary to preserve the bone volume, architecture (structure), or integrity at the extraction site. At issue here are two types of procedures: (1) bone grafts of the nasal, maxillary, or malar areas, and (2) bone grafts of the mandible. Through its peer, AHCA contends that the procedures were not medically necessary, and the procedure Respondent performed consisted only of placing collagen, a "foundation" material, in the socket, which does not constitute a bone graft "in the strictest sense."

25. Dr. Davis found no fault regarding the removal of teeth. However, he opined that it is "very unusual and unnecessary to graft a third molar socket on a routine basis," as Respondent did for every patient whose teeth were extracted. He stated that most sockets will regenerate on their own, especially in patients less than 26 years of age, who have more regenerative capacity. Here, every recipient in the sample was

less than 26 years old. He added that post-operative issues "rarely" occur when molars are extracted, but if they do, the surgeon can easily perform a graft at a later time. Dr. Davis explained that if the surgeon is concerned about the healing status of the recipient, follow-up care can be given to the patient to ensure the long-term healing process. Except for one or two cases where a patient had immediate post-operative problems, Dr. Davis found no instance in Respondent's records where long-term follow-up care was provided.

26. Based on almost 40 years of experience in performing bone grafts, Dr. Davis opined that an immediate graft at the time of extraction normally occurs only on functional teeth, not molars, or when a patient has a high likelihood of a periodontal defect in the area where he just operated. Patients with minor periodontal problems before the surgery frequently improve just by taking out the molars. In sum, Dr. Davis found no evidence in the patient records to support the bone grafts.

27. Dr. Davis admitted, however, that in a few cases, it can sometimes take as long as three or four years for an extraction site to improve to a normal state, and that it is much more difficult to provide follow-up care to Medicaid patients because of their transient nature. Even so, these considerations do not justify a bone graft on a routine basis.

28. Besides recapping each patient's records, in which he reaffirmed his treatment of the patients, Respondent explained that "if appropriate," he routinely performs bone grafts at the time of extraction for several reasons. First, in "many" cases, patients experience cold sensitivity after an extraction due to "short term exposure of the tooth roots," and a bone graft will prevent patients from "having the three or four months of cold sensitivity." Second, a bone graft assists "the patient [in] return[ing] to a healthy state or achiev[ing] a healthy state sooner," especially if there are periodontal issues. Finally, Respondent testified that "some of the [current] research" dispels the notion that younger patients "return to normal" within a year or two. He pointed out that research also demonstrates that younger patients are prone to developing periodontal issues and that grafting of molar sites is now routine. Given these considerations, he concluded that oral surgeons "have a duty" to perform a bone graft after the extraction.

29. According to Dr. Lehrer, bone grafting is appropriate after the extraction of a wisdom tooth in order to maintain the level of the bone, reduce sensitivity, and eliminate pocket depths. He opined that based on his review of the records, all bone grafts were appropriate and medically necessary. However,

the testimony of Dr. Davis has been credited as being the most persuasive on this issue.

30. The preponderance of the evidence supports a finding that it is not medically necessary to perform a bone graft to alleviate a patient's cold sensitivity for a few months, to speed up a recovery process for a young patient that normally takes only a short period of time, or to address periodontal problems that may or may not occur in the future. Stated differently, under the circumstances presented here, a bone graft after every molar extraction is not medically necessary to prevent, cure, or alleviate a condition "that threatens life, causes pain or suffering, or results in injury or illness" of the patient.

31. On the second issue concerning the graft, Dr. Davis opined that Respondent did not perform a bone graft because he simply placed collagen, a foundation material, in the socket, which he characterized as "a mere dressing" on the wound. In Dr. Davis' practice, and based upon his experience as an oral surgeon, he does not use foundation materials or consider them to be a graft material. He agrees, however, that synthetic materials that are mineralized or ceramic can also be used as an artificial bone substitute to facilitate the healing of bone.

32. Respondent testified that while he used foundation collagen material as the base material in all of his grafts, in

some patients he was able to harvest leftover bony material, which was added to the foundation material. Dr. Lehrer also opined that using a collagen-based grafting material enhances bone growth and is an appropriate material for bone grafts. While the use of collagen as a base material presents a close question, the undersigned is persuaded that there is less than a preponderance of the evidence to support a finding that Respondent's use of collagen, when intermixed with harvested boney material, was inappropriate. The use of collagen only as a base material was not appropriate.

ii. Excision of Cysts or Lesions

33. The FAR also contends there was insufficient documentation to show that cysts were present in any of the 14 recipients, or to demonstrate that their removal was medically necessary. A cyst is an epithelial sac usually containing fluid that is normally covered or wrapped in a connective tissue layer. If a cyst exists, it is present when a molar extraction occurs. While most appear radiographically, some do not show up on typical X-rays, such as Panorex film, but clearly appear on a CT scan. In this case, Respondent performed Panorex radiographs on each recipient. Evidence of cysts appeared on none of his X-rays.

34. Based on his experience, the lack of radiographic evidence, and the fact that the tissue removed was not submitted

for biopsy, Dr. Davis saw no evidence that cysts were present in the recipients. He characterized the number of cysts removed by Respondent as "incredulous," and pointed out that they numbered more than he had observed in his practice over the past 30-plus years.

35. Although Respondent's records included a note in the operating report describing the removal of a cystic structure, Dr. Davis stated that a normal follicular sac (the connective tissue surrounding the tooth) appears to be a cystic structure, but this does not mean that a cyst is present. If a follicle is thick, red, infused with blood, contains puss, or is otherwise unusual, the follicle raises a red flag that Dr. Davis automatically has biopsied. Otherwise, further surgical steps are not taken. If a biopsy is indicated in the case of an indigent patient, or a private pay patient does not wish to incur a biopsy charge, Dr. Davis will have the patient return in three months for follow-up.

36. Respondent testified that when he extracts a wisdom tooth, the follicle is removed and then examined. He lays it on a gauze pad for examination. Based on his experience, he determines if there is any likelihood of malignant tissue. In every case, he concluded that because the cystic tissue or inflamed lesion was already removed, the problem was cured, and there was no need to send it to a pathologist and incur

additional expense. He also pointed out that Medicaid discourages oral surgeons from biopsy, presumably because of the cost.

37. While financial concerns for the patients are real, they do not justify removal of a follicle based on the belief that it may be a cyst. There is a preponderance of the evidence to support a finding that, for the 14 recipients in question, the excision of benign tissue was not medically necessary.

E. Coding of Services

38. The FAR alleges that:

> some services rendered were erroneously coded on the submitted claim. The appropriate dental code was applied. These dental services are not reimbursable by Medicaid. Payments made to you for these services are considered an overpayment.

Pet'r Ex. 4, p. 88.

39. Respondent submitted claims for bone grafts under CPT codes 21210 and 21215, which relate to "[g]raft, bone; nasal, maxillary or malar areas (includes obtaining graft," and "[m]andible (includes obtaining graft)," respectively. Pet'r Ex. 14, p. 263. He also submitted claims for removal of cysts under CPT codes 21030 and 21040, which are "[e]xcision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage," and "[e]xcision of benign tumor or cyst of mandible, by enucleation and/or curettage," respectively. Id. at p. 264.

40. Dr. Davis considered the coding issue to be "the least of [his] concerns" in this case. He admitted that "I am not an expert on codes," he is only "vaguely familiar with the coding," and in his practice someone else in the office normally coded his services. He also acknowledged the codes used by Respondent were correct "in the broadest sense," but opined that the dental codes "would be more appropriate" and "the better codes" because they describe "exactly what is being done," and "they are dental procedures that he is performing."

41. As to the removal of cysts, Dr. Davis opined that dental codes D7450 and D7451 would be more appropriate, as they relate to the excision of a benign lesion of the upper and lower jaw. As to bone grafts, he opined that dental code D7953 would be more appropriate, as it applies specifically to socket reconstruction of a dental extraction.

42. Dr. Davis agreed, however, that oral surgeons are permitted to bill Medicaid using CPT codes, and there is no directive, guidance, or mandate that instructs oral surgeons to use the dental codes rather than the CPT codes. In this case, Dr. Davis used dental codes because the nurses at ACHA provided him with those codes to use during his review. While Dr. Davis correctly noted that dental codes more accurately describe the services being performed by oral surgeons, Medicaid guidelines

and AHCA regulations, as now written, do not bar Respondent from using the CPT codes.

43. Mr. Dicksen, Respondent's expert in billing and coding, established that the billing for the procedures in question was adequate to support the billing and the use of the billing codes was appropriate. He also verified that the Medicaid program in Florida does not pay for claims submitted using the dental codes.

44. Petitioner did not establish by a preponderance of the evidence that the claims submitted by Respondent were erroneously coded.

F. Administrative Sanctions

45. Administrative sanctions (fines) shall be imposed for failure to comply with the provisions of Medicaid law. For the first offense, rule 59G-9.070(7)(e) authorizes AHCA to impose a penalty in the amount of $1,000.00 per violation. AHCA seeks to impose a fine of $88,000.00 for 88 separate violations identified in the FAR. While repayment for inappropriate claims should be made, the undersigned is persuaded that the factual grounds for imposing a sanction for each claim are not present.

G. Investigative, Legal, and Expert Witness Costs

46. Section 409.913(23) provides that AHCA is entitled to recover all investigative, legal, and expert witness costs if

the agency ultimately prevails. At this time, the total costs are unknown.

H. The Prior Audit

47. In 2005, AHCA performed an overpayment review of Respondent for services provided from January 1, 2002, through December 31, 2004. The audit was triggered due to a high volume of bone grafts and excision of cysts performed by Respondent during that audit period. He also used the same billing codes as were used in this audit period. The peer ultimately determined that all payments were appropriate, and it was recommended that the matter be closed. This was confirmed in a letter to Respondent dated October 7, 2005, in which AHCA stated as follows:

> In his report, the Medicaid dental consultant stated, "I found the records to be complete, very well presented, with detail. All radiographs were excellent quality and all treatments were very explicit and identified on the radiographs." No overpayment was determined in the peer review.

Resp. Ex. 8.

48. However, AHCA did not use a qualified peer reviewer in that case, as it contracted with a pediatric dentist in Jacksonville to review the records, rather than someone of the same specialty, i.e., an oral surgeon. This was because most of the recipients were pediatric patients and AHCA's practice at

that time was to use general practitioners as peers, no matter what the specialty. AHCA took the position at hearing that due to this mistake, the results of that audit are not binding on the current audit.

49. Respondent contends, however, that he relied on the results of the 2005 audit in continuing his practice of routinely performing bone grafts on every molar extraction, performing excision of cysts without a biopsy on a routine basis, and using the same billing codes for those procedures. He testified that had AHCA informed him that he was performing medically unnecessary procedures, or using the incorrect billing codes, he would have made changes as requested. Based upon his reliance on those representations to his detriment, Respondent contends that AHCA is now estopped from attempting to recoup the Medicaid payments. AHCA did not address this issue at hearing or in its PRO.

CONCLUSIONS OF LAW

50. AHCA has the burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence. See, e.g., S. Med. Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharm. v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

51. Although AHCA bears the ultimate burden of persuasion, section 409.913(22) provides that "[t]he audit report, supported

by agency papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, AHCA can make a prima facie case by proffering a properly supported audit report, which must be received in evidence. See Maz Pharm., Inc. v. Ag. for Health Care Admin., Case No. 97-3791 (Fla. DOAH Mar. 20, 1998; Fla. AHCA June 26, 1998).

52. AHCA is authorized to impose sanctions on a provider, including administrative fines. § 409.913(16), Fla. Stat. To impose an administrative fine, AHCA must establish by clear and convincing evidence the factual grounds for doing so. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996); Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854, 857 (Fla. 2015).

53. AHCA is authorized to "require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished." § 409.913(11), Fla. Stat.

54. AHCA established a prima facie case, and proved by a preponderance of the evidence, that Respondent should not have been paid for any bone graft or cyst removal claims. Thus, AHCA is entitled to reimbursement from Respondent for the claims he billed for these services.

55. There is less than a preponderance of evidence to support the allegation that Respondent improperly coded his claims filed with AHCA.

56. AHCA may impose an administrative fine on Respondent for each violation of any Medicaid-related law. See Fla. Admin. Code R. 59G-9.070(7)(e). In this case, a fine is not warranted.

57. AHCA is entitled to recoup its investigative, legal, and expert witness costs. See § 409.913(22), Fla. Stat.

58. Respondent contends that, based on the findings in the 2005 audit upon which he relied, the doctrine of equitable estoppel bars AHCA from asserting its claims. The theory of estoppel is an application of the rules of fair play. Estoppel is established by proving: (1) a representation as to a material fact that is contrary to a later asserted position; (2) reliance on that representation; and (3) a change in position detrimental to the party claiming estoppel caused by the representation and reliance thereon. Kuge v. State, Dep't of Admin., 449 So. 2d 389 (Fla. 3d DCA 1984). Against a state agency, however, equitable estoppel will be applied only under exceptional and rare circumstances. N. Am. Co. v. Green, 120 So. 2d 603 (Fla. 1950). The doctrine is not applicable in transactions which are forbidden by statute or which are contrary to public policy. See, e.g., Dade Cnty. v. Bengis Assoc., Inc., 257 So. 2d 291 (Fla. 3d DCA 1972); Salz v. Dep't

of Admin., 432 So. 2d 1376 (Fla. 3d DCA 1983). And the courts have consistently refused to apply estoppel against the state on the basis of unauthorized or mistaken acts or representations of state officers or employees. See, e.g., Austin v. Austin, 350 So. 2d 102 (Fla. 1st DCA 1977).

59. Even if the 2005 audit, conducted by a general practitioner and not an oral surgeon, is not a mistaken act on the part of ACHA, allowing payment of Medicaid claims in this case would be contrary to, and forbidden by, section 409.913. That provision provides, in part, that AHCA has a statutory obligation to "recover overpayments and impose sanctions, as appropriate," ensure "that billing by a provider to the agency is in accordance with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law," and "require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them." At the same time, it would be contrary to public policy, i.e., the integrity of the Medicaid program. In sum, because the transactions in question are forbidden by statute and contrary to public policy, the doctrine of equitable estoppel does not apply.[1/]

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Respondent was overpaid, and is liable for reimbursement to AHCA, for claims submitted for bone grafts and excision of cysts during the audit period; finding that an administrative fine should not be imposed; and remanding the matter to DOAH for an evidentiary hearing on the recovery of AHCA's costs, if necessary.

DONE AND ENTERED this 30th day of March, 2016, in Tallahassee, Leon County, Florida.

D. R. Alexander

D. R. ALEXANDER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of March, 2016.

ENDNOTE

[1/] Respondent's reliance on the case of Johnson Professional Nursing Home, Inc. v. Department of Health and Rehabilitative Services, Case No. 82-278 (Fla. DOAH Aug. 19, 1982, Fla. HRS Sept. 17, 1982), in which, coincidentally, the Recommended Order was authored by the undersigned, is misplaced. There, HRS determined in its Final Order that there were no exceptional circumstances that would justify the invocation of the doctrine in favor of the nursing home. That Order was not appealed.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days of the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will render a final order in this matter.