STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 15-4728MPI

RICHARD W. BLAKE, DDS,

Respondent.
_____/

RECOMMENDED ORDER

The final hearing in this matter was conducted before J. Bruce Culpepper, Administrative Law Judge of the Division of Administrative Hearings, pursuant to sections 120.569 and 120.57(1), Florida Statutes (2014),[1/] on January 14, 2016, in Tallahassee, Florida.

APPEARANCES

For Petitioner: Ephraim Durand Livingston, Esquire
James Zubko Ross, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: Frank P. Rainer, Esquire
Broad and Cassel
Suite 400
215 South Monroe Street
Tallahassee, Florida 32301

STATEMENT OF THE ISSUE

The issue in this matter concerns the amount of monetary sanctions that the Agency for Health Care Administration may impose on Respondent pursuant to section 409.913, Florida Statutes, and Florida Administrative Code Rule 59G-9.070(7)(e) based on the overpayment of Medicaid reimbursements made to Respondent.

PRELIMINARY STATEMENT

Petitioner Agency for Health Care Administration ("AHCA") conducted a Medicaid audit of Respondent, Richard W. Blake, DDS, a Medicaid provider. The Medicaid audit reviewed Respondent's dates of service from April 1, 2011, through October 31, 2013. On April 8, 2015, AHCA issued a Final Audit Report ("FAR") in which it asserted that Respondent had been overpaid by the amount of $177,717.69 for paid claims that, in whole or in part, the Medicaid program did not cover.

AHCA initiated this action to recover the amount of the overpayment. AHCA also sought to sanction Respondent in the form of an administrative fine, as well as recover investigative, legal, and expert witness costs for conducting the Medicaid audit. By the time of the final hearing, the parties reached a settlement as to the overpayment portion of this case wherein Respondent agreed to pay AHCA the total amount of the overpayment, as well as AHCA's investigative, legal, and expert

costs. Accordingly, this matter only focuses on the amount of the fine that AHCA seeks to impose on Respondent.

Respondent filed a request for administrative hearing on April 22, 2015. On August 21, 2015, AHCA referred the matter to the Division of Administrative Hearings ("DOAH") to conduct a hearing pursuant to sections 120.569 and 120.57(1). Respondent moved to amend his Petition for Formal Administrative Hearing on August 31, 2015, which was granted.

The final hearing was held on January 14, 2016. AHCA presented the testimony of Robi Olmstead from AHCA's Bureau of Medicaid Program Integrity. AHCA's Exhibits 1 through 15, 17, 19 through 21, and 23 were admitted into evidence. Respondent testified on his own behalf and presented the testimony of Sabrina Blake, the office manager for his dental practice. Respondent did not offer exhibits at the final hearing.

The one-volume Transcript of the final hearing was filed on February 5, 2016. At the close of the hearing, the parties were advised of the 10-day timeframe following receipt of the hearing transcript to file post-hearing submittals. Both parties filed proposed recommended orders which were duly considered in preparing this Recommended Order.

FINDINGS OF FACT

1. AHCA is designated as the single state agency authorized to make payments for medical assistance and related services

under Title XIX of the Social Security Act, otherwise known as the Medicaid program. See § 409.902(1), Fla. Stat. AHCA is responsible for administering and overseeing the Medicaid program in the State of Florida. See § 409.913, Fla. Stat.

2. AHCA's Bureau of Medicaid Program Integrity ("MPI") is the unit within AHCA that oversees the activities of Florida Medicaid providers and recipients. MPI ensures that providers abide by Medicaid laws, policies, and rules. MPI is responsible for conducting audits, investigations, and reviews to determine possible fraud, abuse, overpayment, or neglect in the Medicaid program. See §409.913, Fla. Stat.

3. At all times relevant to this proceeding, Respondent was an enrolled Medicaid provider authorized to receive reimbursement for covered services rendered to Medicaid recipients. Respondent had a valid Medicaid provider agreement with AHCA, Medicaid Provider No. 0742236-00. The Medicaid provider agreement is a voluntary contract between AHCA and the provider. As an enrolled Medicaid provider, Respondent was subject to the duly-enacted federal and state statutes, regulations, rules, policy guidelines, and Medicaid handbooks incorporated by reference into rule, which were in effect during the audit period.

4. Pursuant to its statutory authority to oversee the integrity of the Medicaid program, MPI conducted an audit of Respondent's paid claims for Medicaid reimbursement for the

period from April 1, 2011, through October 31, 2013. The audit's purpose was to verify that claims AHCA paid to Respondent under the Medicaid program did not exceed the amount authorized by Medicaid laws, policies, and applicable rules.

5. As a result of the audit, AHCA determined that Respondent was overpaid in the amount of $177,717.69 for services that, in whole or in part, were not covered under the Medicaid program. AHCA also sought to impose sanctions upon Respondent consisting of an administrative fine of $34,192.30,[2/] as well as investigative, legal, and expert witness costs of $1,127.66.

6. Respondent is a dentist specializing in pediatric dentistry. He has practiced for over 43 years. He maintains offices in both Clearwater and Jacksonville, Florida.

7. Respondent's dental practice serves almost exclusively developmentally disabled children. Many of his patients suffer from severe behavioral, emotional, mental, physical, or social handicaps or other medical issues. Respondent's practice is primarily based on referrals of special needs patients who other pediatric and general dentists send to him for treatment. Approximately, 95 percent of Respondent's patients are Medicaid recipients.

8. At the final hearing, AHCA presented the testimony of Robi Olmstead, an AHCA administrator with MPI. Ms. Olmstead's responsibilities include overseeing MPI investigations and

supervising AHCA staff's performance of Medicaid audits. With over 10 years of experience in her position, Ms. Olmstead is very familiar with and knowledgeable about how MPI conducts Medicaid audits. Specifically related to this matter, Ms. Olmstead, in her official capacity with AHCA, signed the FAR that MPI presented to Respondent on April 8, 2015.

9. Ms. Olmstead described MPI's Medicaid audit of Respondent's Medicaid claims.[3/] Using AHCA's data support system, MPI investigators accessed the complete universe of Respondent's Medicaid claims. MPI selected the period from April 1, 2011, through October 31, 2013, as the audit period. MPI calculated the amount of overpayment based on its review of a random sample of 35 recipients for whom Respondent submitted 507 claims during the audit period. AHCA then contacted Respondent and requested that he submit documents to substantiate his Medicaid claims for the 35 recipients.

10. In response to AHCA's request for documents, Respondent provided his records of service and billing for each of the 507 claims for the 35 recipients. AHCA, upon receiving Respondent's records, forwarded them for a peer review. The peer reviewer evaluated the records and prepared worksheets reflecting a determination regarding the nature of the dental services rendered for each claim, and whether such claim was eligible for payment under the Medicaid program. Based on the peer reviewer's

determination, MPI calculated that Respondent had been overpaid for all claims he presented within the audit period by a total of $177,717.69.

11. After determining that Respondent had been overpaid, AHCA prepared and sent to Respondent a Preliminary Audit Report ("PAR"), dated February 12, 2015. The PAR notified Respondent that the audit revealed that he had been overpaid by $177,717.69.

12. On April 8, 2015, AHCA issued the FAR. The FAR served as AHCA's final determination that Medicaid had overpaid Respondent.

13. The FAR set forth the following bases for AHCA's determination that Respondent was overpaid:

a. Documentation Supported a Lower Level of Service ("LL"): The peer review of Respondent's records revealed that the documentation Respondent submitted for payment did not support level of service for some claims. These claims may involve an established patient that Respondent coded as a new patient (which is billed at a higher level). AHCA believed that Respondent should have used a different code for the service he provided. AHCA considered the Medicaid payments made to Respondent for these services in excess of the appropriate amount an overpayment.[4/]

b. No Documentation ("No Doc"): Respondent's records revealed that some medical services for which Respondent billed and received payment were incomplete or lacked sufficient documentation. AHCA considered the Medicaid payments for these services an overpayment.[5/]

c. Not Medically Necessary ("NMN"): The peer review of Respondent's claims revealed that the documentation did not support the medical necessity of some of the claims Respondent presented for payment. (Respondent explained that this category of claims related to occlusal x-rays he obtained from dental patients for whom he also had taken panorex x-rays. The peer review considered these charges duplicative.) Therefore, AHCA considered the Medicaid payments made to Respondent for these claims an overpayment.[6/]

d. Erroneous Coding ("EC"): The peer review of Respondent's claims revealed that some services rendered were erroneously coded on the submitted claim. These services documented one activity, but another billing code was identified. Consequently, AHCA considered Medicaid payments made to Respondent for claims in excess of the appropriate service an overpayment.[7/]

e. Behavioral Management ("BM") Services Not Reimbursable: The peer review of Respondent's claims revealed that Respondent did not adequately explain his claims for BM

services. Respondent should not have requested payment for BM without explaining why BM was used or the specific type of BM techniques utilized for treatment. Furthermore, the peer review determined that Respondent should not have included BM in his claim if he also billed for either sedation or analgesia on the same date of service. AHCA considered Medicaid payments made to Respondent for these BM claims an overpayment.[8/]

14. The FAR also notified Respondent that AHCA had calculated and was seeking to assess a fine of $35,543.54 (since lowered to $34,192.30). Ms. Olmstead explained that, in accordance with section 409.913(15), (16), and (17) and rule 59G-9.070, AHCA must apply sanctions for violations of federal and state laws, including Medicaid policy. AHCA determined to sanction Respondent in the form of an administrative fine.

15. After determining that Respondent had been overpaid for Medicaid claims, AHCA prepared a Documentation Worksheet for Imposing Administrative Sanctions ("Worksheet"). The Worksheet was signed on April 7, 2015, by an AHCA investigator. Ms. Olmstead also signed the Worksheet after she reviewed and approved the form.

16. The Worksheet specified how AHCA calculated the fine it sought to impose on Respondent for the Medicaid claims violations listed above. As noted on the Worksheet, AHCA found a total of 58 claims violated Medicaid laws, policies, and rules. The

specific number of claims in violation were: lower level of service 38; no documentation, 9; not medically necessary, 8; error in coding, 2; and behavior management/illegal documentation, 1.

17. The Worksheet also contained a section that read:

> Confirm that you have considered the following via checking the box:
>
> I have considered the serious & extent of the violation.
>
> I have considered whether there is evidence that the violation is continuing after written notice.
>
> I have considered whether the violation impacted the quality of medical care provided to Medicaid recipients.
>
> I have considered whether the licensing agency in any state in which the provider operates or has operated has taken *any* action against the provider.
>
> If the sanction to be imposed is suspension or termination, I have considered whether the sanction will impact access by recipients to Medicaid services.

The AHCA investigator placed a checkmark by each consideration. AHCA did not use any additional forms or methods to document its consideration of these factors.

18. AHCA did not provide the Worksheet to Respondent with the FAR. The Worksheet is an internal AHCA document the investigator and administrator use to calculate the amount of a

fine. However, AHCA did include in the FAR the final monetary sanction which AHCA calculated on the Worksheet ($35,543.54).

19. Ms. Olmstead stated that AHCA considered Respondent's failure to comply with Medicaid laws a "first offense." Pursuant to rule 59G-9.070(7)(e), AHCA shall impose a $1,000 fine per claim found to be in violation for a first offense. Accordingly, based on the 58 claims reviewed for the audit, AHCA calculated a fine of $58,000.00. Thereafter, rule 59G-9.070(4)(a) instructs AHCA to limit the monetary sanction for a "first offense" violation of Medicaid laws under rule 59G-9.070(7)(e) to twenty percent of the amount of the overpayment. Thus, AHCA reduced the amount of the fine it seeks to impose on Respondent to $34,192.30.

20. Finally, Ms. Olmstead testified that the FAR cited to several documents that AHCA distributes to guide and inform providers of the types of services that the Medicaid program covers and how to correctly bill Medicaid for these services. The documents applicable to this matter are: the 2007 Florida Medicaid Dental Services Coverages and Limitations Handbook; the 2008 Florida Medicaid Provider General Handbook; the 2011 Florida Medicaid Dental Services Coverages and Limitations Handbook; and the 2012 Florida Medicaid Provider General Handbook.

21. Respondent testified on his own behalf. Respondent testified that this Medicaid audit was the first he has

experienced. Prior to this matter, he has never been fined or sanctioned for any violations of the Medicaid program. Respondent also emphasized that this Medicaid audit did not show that he ever rendered sub-quality dental care to any of his patients.

22. Respondent acknowledged that he currently receives the Medicaid Handbooks electronically. Respondent conceded that he is bound to adhere to the Medicaid guidelines in the Handbooks.

23. Respondent offered the following explanations for the claims he submitted which resulted in the overpayments:

a. Not Medically Necessary: Respondent understood that AHCA determined that his claims for occlusal x-rays were considered duplicative. Respondent explained that the occlusal x-rays reveal tooth decay and disease that panorex x-rays do not. Furthermore, Respondent's use of the occlusal x-rays did not result in any harm to his patients. On the contrary, Respondent expressed that these x-rays only enhanced the services and treatment he provided to his patients.

b. Behavioral Management ("BM") Services: The BM fee compensates the provider for the effort and time it takes to prepare a patient for dental treatment or control the patient during treatment. In many cases, if Respondent cannot employ BM techniques, he cannot render effective dental treatment. Respondent charges approximately $35 for BM services.

c. Insufficient Records: Respondent stated that the medical notes and records that his office maintains meet or exceed Florida standards. However, certain of his records apparently did not comply with Medicaid program requirements. Respondent further asserted that AHCA never alleged that he sought payment for services he never delivered or were not completed.

24. Sabrina Blake is the office manager for Respondent's dental practice. As part of her responsibilities, she handles billing practice inquiries. Regarding AHCA's claim of insufficient records to support the BM charges, Ms. Blake explained that Respondent marked "BM" on the patients' records to indicate that a behavior management technique was used. The error was that Respondent did not write out exactly what behavior management technique was used during the treatment. Medicaid rules required additional information or documentation. Therefore, while Respondent's practice did not provide the requisite notation to support a Medicaid payment for BM charges, Respondent did actually provide the service claimed.

25. Respondent stated that AHCA never provided him the opportunity to correct any alleged violations or billing errors. Respondent claims that none of the disallowed charges or medical services were submitted to intentionally obtain an unauthorized

payment from the Medicaid program. AHCA did not produce evidence to contradict Respondent's assertion.

26. Prior to the final hearing, the parties entered into an agreement wherein Respondent agreed to repay to AHCA the full amount of the overpayment Respondent received from the Medicaid program.[9/] Based on the overpayment, AHCA seeks to impose on Respondent an administrative fine of $34,192.30. Accordingly, the primary issue for the undersigned to consider is whether AHCA is authorized under the applicable law to impose on Respondent an administrative sanction in the form of a fine as a result of his violation of Medicaid laws, rules, or policy.

27. Based on the evidence presented at the final hearing, AHCA proved by clear and convincing evidence that Respondent failed to comply with provisions of the Medicaid laws.[10/] As detailed below, section 409.913 and rule 59G-9.070 authorize AHCA to impose a fine on Respondent in the amount of $34,192.30 based on his violations of the Medicaid program. Consequently, a fine of $34,192.30 should be assessed against Respondent.

CONCLUSIONS OF LAW

28. DOAH has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2015).

29. Pursuant to section 409.902(1), AHCA shall make Medicaid payments only for services included in the Medicaid

program. Payments shall only be made on behalf of eligible individuals and shall be made only to qualified providers in accordance with federal requirements for Title XIX of the Social Security Act and provisions of state law.

30. AHCA alleges that Respondent was overpaid in the amount of $177,717.69 for medical services not covered by Medicaid. As stated above, Respondent does not contest AHCA's allegations that he received overpayments from the Medicaid program. Furthermore, the FAR and its supporting work papers constitute conclusive evidence of the overpayment to Respondent. See §409.913(22), Fla. Stat. Accordingly, the material facts in this matter establish that Respondent, from April 1, 2011, through October 31, 2013, violated Medicaid laws, policies, and rules as incorporated in the Medicaid handbooks.

31. AHCA is authorized to recover Medicaid overpayments pursuant to section 409.913(15), (16), and (17). 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.

32. AHCA is further instructed 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. "Medically necessary" goods or services are:

> [A]ny 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 and services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

§ 403.913(1)(d), Fla. Stat.

33. In addition to recoupment of the overpayment, AHCA seeks to impose administrative sanctions on Respondent in the form of a fine of $34,192.30. An action to impose an administrative fine is penal in nature. Accordingly, AHCA bears the burden of proof to demonstrate the grounds for doing so by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla. 1996); see also Fla. Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854 (Fla. 2015).

34. Clear and convincing evidence is a heightened standard that requires more proof than a mere preponderance of the

evidence. Clear and convincing evidence requires that the evidence "must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts at issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established." In re: Davey, 645 So. 2d 398, 404 (Fla. 1994); Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983).

35. As stated in the FAR, AHCA seeks to impose the fine pursuant to sections 409.913(15), (16), and (17) and rule 59G-9.070(7)(e). Section 409.913(15) states in pertinent part:

> (15) The agency shall seek a remedy provided by law, including, but not limited to, any remedy provided in subsections (13) and (16) and s. 812.035, if:
>
> * * *
>
> (e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program;

36. Section 409.913(16) states in pertinent part:

> (16) The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):
>
> * * *
>
> (c) Imposition of a fine of up to $5,000 for each violation. . . . Each instance of improper billing of a Medicaid recipient; . . . each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; . . . and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation.

37. Section 409.913(17) states:

> (17) In determining the appropriate administrative sanction to be applied, or the duration of any suspension or termination, the agency shall consider:
>
> (a) The seriousness and extent of the violation or violations.
>
> (b) Any prior history of violations by the provider relating to the delivery of health care programs which resulted in either a criminal conviction or in administrative sanction or penalty.
>
> (c) Evidence of continued violation within the provider's management control of Medicaid statutes, rules, regulations, or policies after written notification to the provider of improper practice or instance of violation.
>
> (d) The effect, if any, on the quality of medical care provided to Medicaid recipients as a result of the acts of the provider.

(e) Any action by a licensing agency respecting the provider in any state in which the provider operates or has operated.

(f) The apparent impact on access by recipients to Medicaid services if the provider is suspended or terminated, in the best judgment of the agency.

The agency shall document the basis for all sanctioning actions and recommendations.

38. Rule 59G-9.070 states in pertinent part:

(1) Purpose: This rule provides notice of administrative sanctions imposed upon a provider, entity, or person for each violation of any Medicaid-related law.

(2) Applying and reporting sanctions: Notice of the application of sanctions will be by way of written correspondence and the final notice shall be the point of entry for administrative proceedings pursuant to Chapter 120, F.S. Satisfaction of an overpayment following a preliminary audit report will not avoid the application of sanctions at a final audit report unless the Agency offers amnesty pursuant to Section 409.913(25)(e), F.S. The Agency shall report all sanctions imposed upon any provider, entity, or person, or any principal, officer, director, agent, managing employee, or affiliated person of a provider who is regulated by another state entity, regardless of whether enrolled in the Medicaid program, to that other state entity. Sanctions are imposed upon the Final Order being filed with the Agency Clerk.

(3) Definitions:

(a) "Audit report" is the written notice of determination that a violation of Medicaid laws has occurred, and where the violation results in an overpayment, it also shows the calculation of overpayments.

(b) "Claim" is as defined in Section 409.901(6), F.S., and includes the total monthly payment to a provider for per diem payments and the payment of a capitation rate for a Medicaid recipient.

* * *

(e) An "erroneous claim" is an application for payment from the Medicaid program or its fiscal agent that contains an inaccuracy.

(f) "Fine" is a monetary sanction. The amount of a fine shall be as set forth within this rule.

* * *

(h) "Offense" means the occurrence of one or more violations as set forth in a final audit report. For purposes of the progressive nature of sanctions under this rule, offenses are characterized as "first", "second", "third", or "subsequent" offenses; subsequent offenses are any occurrences after a third offense.

* * *

(n) "Sanction" shall be any monetary or non-monetary disincentive imposed pursuant to this rule; a monetary sanction may be referred to as a "fine."

* * *

(q) "Violation" means any omission or act performed by a provider, entity, or person that is contrary to Medicaid laws, the laws that govern the provider's profession, or the Medicaid provider agreement.

1. For purposes of this rule, each day that an ongoing violation continues and each instance of an act or omission contrary to a Medicaid law, a law that governs the provider's profession or the Medicaid

provider agreement shall be considered a "separate violation".

2. For purposes of determining first, second, third or subsequent offenses under this rule, prior Agency actions during the preceding five years will be counted where the provider, entity, or person was deemed to have committed the same violation.

(4) Limits on sanctions.

(a) Where a sanction is applied for violations of Medicaid laws (under paragraph (7)(e) of this rule), for a pattern of erroneous claims (under paragraph (7)(h) of this rule), or shortages of goods (under paragraph (7)(n) of this rule) and the violations are a "first offense" as set forth in this rule, if the cumulative amount of the fine to be imposed as a result of the violations giving rise to that overpayment exceeds twenty-percent of the amount of the overpayment, the fine shall be adjusted to twenty-percent of the amount of the overpayment.

* * *

(7) Sanctions: In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed as follows:

* * *

(e) For failure to comply with the provisions of the Medicaid laws: For a first offense, $1,000 fine per claim found to be in violation. For a second offense, $2,500 fine per claim found to be in violation. For a third or subsequent offense, $5,000 fine per claim found to be in violation (Section 409.913(15)(e), F.S.);

39. Section 409.913(15) and (16) and rule 59G-9.070(7)(e) plainly authorize AHCA to impose a sanction in the form of a fine on Respondent for his violation of Medicaid laws, rules, and policies. Reading the statute and rule together, section 409.913(15)(e) instructs that AHCA "shall" seek a remedy provided by law, including, but not limited to any remedy provided in 409.913(16), if a provider fails to comply with either the provisions of Medicaid provider publications adopted by AHCA rules, Florida or federal laws or regulations governing the Medicaid program, or the provider's Medicaid agreement with AHCA. Section 409.913(16) details the sanctions AHCA "shall" impose for any violation listed in 409.913(15). Section 409.913(16)(c) includes the "[i]mposition of a fine of up to $5,000 for each violation." Rule 59G-9.070(7), which implements section 409.913, provides that, "[i]n addition to the recoupment of the overpayment . . . [AHCA] will impose sanctions as outlined in this subsection." Rule 59G-9.070(7)(e) states: "For failure to comply with the provisions of the Medicaid laws: For a first offense, $1,000 fine per claim found to be in violation."

40. Based on the above statutory authority, AHCA was legally authorized to impose a monetary sanction based on Respondent's failure to comply with provisions of Medicaid provider publications, Florida or federal laws, rules, or regulations, or Respondent's provider agreement with AHCA.

Accordingly, AHCA acted within its statutory authority to impose on Respondent a fine of $34,192.30.

41. Respondent raises several objections to AHCA's imposition of the sanction of an administrative fine. Respondent's arguments, however, fail to persuade that AHCA lacked the statutory authority to impose a fine on Respondent or that AHCA failed to follow the governing Medicaid laws, rules, or policies.

42. First, Respondent asserts that AHCA did not follow proper statutory procedure before deciding to impose the monetary sanction for his violations of the Medicaid program. Respondent argues that, instead of a fine, AHCA should have issued him a notice of noncompliance pursuant to section 120.695(1). Respondent contends that a notice of noncompliance is a more appropriate penalty for his violations and would better achieve the regulatory objectives of the governing statute.

43. Section 120.695 in relevant part provides as follows:

> (1) It is the policy of the state that the purpose of regulation is to protect the public by attaining compliance with the policies established by the Legislature. Fines and other penalties may be provided in order to assure compliance; however, the collection of fines and the imposition of penalties are intended to be secondary to the primary goal of attaining compliance with an agency's rules. <u>It is the intent of the Legislature that an agency charged with enforcing rules shall issue a notice of noncompliance as its first response to a</u>

> minor violation of a rule in any instance in which it is reasonable to assume that the violator was unaware of the rule or unclear as to how to comply with it.
>
> (2)(a) Each agency shall issue a notice of noncompliance as a first response to a minor violation of a rule. A "notice of noncompliance" is a notification by the agency charged with enforcing the rule issued to the person or business subject to the rule. A notice of noncompliance may not be accompanied with a fine or other disciplinary penalty. It must identify the specific rule that is being violated, provide information on how to comply with the rule, and specify a reasonable time for the violator to comply with the rule. A rule is agency action that regulates a business, occupation, or profession, or regulates a person operating a business, occupation, or profession, and that, if not complied with, may result in a disciplinary penalty.
>
> (b) A violation of a rule is a minor violation if it does not result in economic or physical harm to a person or adversely affect the public health, safety, or welfare or create a significant threat of such harm. If an agency under the direction of a cabinet officer mails to each licensee a notice of the designated rules at the time of licensure and at least annually thereafter, the provisions of paragraph (a) may be exercised at the discretion of the agency. Such notice shall include a subject-matter index of the rules and information on how the rules may be obtained. (emphasis added).

44. Despite Respondent's plea for AHCA to consider the fundamental fairness of imposing a fine under the circumstances of Respondent's violations, section 120.695 does not appear to apply in this matter. AHCA initiated this action to recover

Medicaid overpayments pursuant to section 409.913. AHCA charges Respondent with failing to comply with Medicaid laws, rules, or publications under section 409.913(15)(e), not just agency rule 59G-9.070. In addition, it is not reasonable to assume that Respondent was unaware that the Medicaid program necessitates certain documentary requirements in order to be paid for dental services. The evidence establishes that Respondent either received or had reasonable access to all the pertinent Medicaid Handbooks and claims filing guidelines.

45. Further, AHCA did not treat Respondent's actions as a minor rule violation under section 120.695(2)(b). The facts in this matter involve economic harm to the Medicaid program in that Respondent was overpaid by $177,717.69 for dental services that, in whole or in part, the Medicaid program did not cover. Section 120.695 does not compel AHCA to issue a notice of noncompliance for a minor rule violation instead of imposing a fine for violating Medicaid laws under section 409.913(16). Therefore, while this action may be the first time AHCA has sought to sanction Respondent and even if Respondent's actions were inadvertent or unintentional, the provisions of section 409.913 authorize AHCA to impose a fine based on his violations of Medicaid laws.

46. Next, Respondent asserts that AHCA did not properly consider the factors listed in section 409.913(17) before

determining that a fine was the appropriate administrative sanction for Respondent's violations. Respondent correctly reads that section 409.913(17) sets forth six "considerations" that AHCA must apply in determining the appropriate sanction (such as a fine) under section 409.913(16). The statute also directs AHCA to document the basis for the sanction imposed.

47. Based on the information included on the Worksheet AHCA used to calculate the fine, AHCA satisfied section 409.913(17). The Worksheet, on its face, provides AHCA the means to account for the statutorily mandated considerations. The Worksheet explicitly required the AHCA investigator and administrator to assess the following factors before reaching the final sanction amount: the seriousness and extent of Respondent's violation (section 409.913(17)(a)); evidence that the violation continued after AHCA's written notice (section 409.913(17)(c)); whether the violation impacted the quality of medical care provided to Medicaid recipients (section 409.913(17)(d)); and whether the licensing agency in any state in which the provider operates or has operated has taken any action against the provider (section 409.913(17)(e)).[11/] By placing a checkmark next to each factor, the investigator "documented" her consideration. Ms. Olmstead then signed the Worksheet acknowledging that she had reviewed and approved the investigator's final calculation.

48. AHCA does not document its review of section 409.913(17) factors other than on the Worksheet. Section 409.913(17), however, does not place upon AHCA any responsibility other than the general requirement that it "shall document the basis for all sanctioning actions and recommendations." The Worksheet, together with the FAR and its supporting documents, satisfies section 409.913(17).[12/]

49. Respondent also argues that AHCA had the discretion not to impose a monetary sanction under rule 59G-9.070(7)(e). Respondent correctly reads that section 409.913(16) authorizes AHCA the option to impose a range of administrative sanctions based on a violation of section 409.913(15), including suspension or termination from participation in the Medicaid program, a fine of up to $5,000, comprehensive followup reviews, or a corrective action plan. Section 409.913(16), however, mandates that AHCA "shall impose" at least one of these sanctions on a provider. Any discretion that section 409.913(16) allows AHCA pertains only to the type of sanction it chooses to impose. One sanction clearly available was the "[i]mposition of a fine of up to $5,000 for each violation." Therefore, by selecting the fine described in rule 59G-9.070(7)(e) as the sanction for Respondent's failure to comply with the provision of the Medicaid laws, AHCA complied with statutory requirements under section 409.913(16). No provision in section 409.913 prevented AHCA from selecting a fine

from the available sanctions to impose upon Respondent for his violations of Medicaid laws.[13/]

50. Thirdly, Respondent argues that AHCA's actions violate due process and impose an unconstitutionally excessive penalty. However, raising the issue of the constitutionality of the sanctions authorized in section 409.913(16) is inappropriate in this forum. DOAH lacks jurisdiction to declare a statute unconstitutional. See Key Haven Associated Enters. v. Bd of Trs. of the Int. Imp. Trust Fund, 427 So. 2d 153, 157 (Fla. 1982); Sch. Bd. v. Tampa Sch. Dev. Corp., 113 So. 3d 919 (Fla. 2d DCA 2013).

51. Finally, Respondent's argument that the claims he submitted to the Medicaid program which led to the overpayment were not "erroneous" as the term is used in section 409.913(16)(c) is not persuasive. Section 409.913(16)(c) states that "each false or erroneous Medicaid claim leading to an overpayment to a provider is considered a separate violation." The statute does not define the term "erroneous." "Erroneous," however, is a commonly understood word that is defined to mean "containing or characterized by error." MERRIAM-WEBSTER DICTIONARY, at http://www.merriam-webster.com. See Seagrave v. State, 802 So. 2d 281, 286 (Fla. 2001) ("When necessary, the plain and ordinary meaning of words [in a statute] can be ascertained by reference to a dictionary."); see also Raymond

James Fin. Servs. v. Phillips, 110 So. 3d 908, 910 (Fla. 2d DCA 2011) ("It is appropriate to refer to dictionary definitions when construing statutes or rules."); and Verizon Bus. Purchasing, LLC v. State, 164 So. 3d 806, 810 (Fla 1st DCA 2015). AHCA established by clear and convincing evidence that Respondent's claims for which AHCA seeks to impose a fine contained errors.

52. Furthermore, section 409.913(16)(c) authorizes AHCA to impose a fine for "[e]ach instance of improper billing of a Medicaid recipient" and "each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate . . . as determined by competent peer judgment." In addition, section 409.913(1)(e) defines "overpayment" to include "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." The 58 claims that AHCA found in violation of the Medicaid laws fit into one of these categories. Therefore, although Respondent's Medicaid claims may have been inadvertent or a mistake as he argues, the claims still contained inaccuracies which directly led to the overpayment. Accordingly, pursuant to section 409.913, AHCA must impose a fine for each claim in violation.

53. Based on the facts established in this matter, AHCA has proven by clear and convincing evidence that Respondent failed to comply with the provisions of the applicable Medicaid laws, policies, and rules. Accordingly, as detailed above, section 409.913 and rule 59G-9.070(7)(e) allow AHCA to impose an administrative sanction on Respondent in the form of a monetary fine. AHCA further established that the amount of the fine it seeks to impose was properly calculated and authorized under the governing statute and rule. Therefore, it is determined that AHCA should fine Respondent in the amount of $34,192.30.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that AHCA issue a final order imposing an administrative fine of $34,192.30 for Respondent's first offense of violating provisions of Medicaid provider publications adopted by AHCA rules, Florida or federal laws or regulations governing the Medicaid program, or the provider's Medicaid agreement with AHCA.

DONE AND ENTERED this 10th day of March, 2016, in Tallahassee, Leon County, Florida.

J. BRUCE CULPEPPER
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 10th day of March, 2016.

ENDNOTES

[1/] All Statutory references are to the 2014 Florida Statutes, unless otherwise noted.

[2/] After AHCA served the FAR, but before the final hearing, AHCA revised the amount of sanctions sought from $35,543.54 down to $34,192.30.

[3/] AHCA is authorized to initiate audits without stating its basis for doing so. It is required to conduct at least five percent of its audits on a random basis. See § 409.913(2), Fla. Stat.

[4/] See 2007 Dental Services Coverage and Limitations Handbooks, page 2-2, and the 2011 Dental Services Coverage and Limitations Handbooks, page 2-2.

[5/] See 2008 Florida Medicaid Provider General Handbook, pages 5-8 and 2-57, and the 2012 Florida Medicaid Provider General Handbook, pages 5-9 and 2-60.

[6/] See 2008 Florida Medicaid Provider General Handbook, pages 5-4, and the 2012 Florida Medicaid Provider General Handbook, pages 5-4.

[7/] See 2008 Florida Medicaid Provider General Handbook, pages 5-4, and the 2012 Florida Medicaid Provider General Handbook, pages 5-4.

[8/] See 2007 Dental Services Coverage and Limitations Handbooks, page 2-5, and the 2011 Dental Services Coverage and Limitations Handbooks, page 2-6.

[9/] Per the parties' settlement of the overpayment amount prior to the final hearing, Respondent agreed not to require AHCA to present further evidence regarding the alleged overpayment.

[10/] Respondent contends that, while Respondent agreed to pay back to AHCA the full amount of the alleged overpayment, this settlement "does not constitute an admission of wrongdoing or error by any of the parties with respect to this case or any other matter." However, while Respondent does not want the settlement to be considered an admission of guilt, the settlement does not prevent a finding that the documents and testimony AHCA presented at the final hearing establish, by clear and convincing evidence, that the overpayment resulted from Respondent's failure to comply with Medicaid laws.

[11/] Section 409.913(17)(b) required AHCA to consider any prior violations by Respondent. The fact that AHCA classified Respondent's violations as a "first offense" establishes that AHCA determined that Respondent had no prior history of violations or administrative sanctions. Accordingly, AHCA also complied with section 409.913(17)(b).

[12/] In addition, the fact that AHCA entitles its worksheet "DOCUMENTATION WORKSHEET FOR IMPOSING ADMINISTRATIVE SANCTIONS" (emphasis added) bolsters its position that it complies with the documentation requirement of section 409.913(17).

[13/] Furthermore, the fact that the fine under rule 59G-9.070(7)(e) may be levied for a "first offense" indicates that AHCA may fine Respondent in this action despite the fact that his offenses are his first.

COPIES FURNISHED:

Ephraim Durand Livingston, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

Frank P. Rainer, Esquire
Broad and Cassel
215 South Monroe Street, Suite 400
Tallahassee, Florida 32301
(eServed)

James Zubko Ross, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
(eServed)

John F. Loar, Esquire
Broad and Cassel
215 South Monroe Street, Suite 400
Tallahassee, Florida 32301
(eServed)

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

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

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
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.