STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 18-5269MPI

MARY CECILIA CROSBY, D.D.S.,

Respondent.
_____/

RECOMMENDED ORDER

Pursuant to notice, a formal administrative hearing was conducted before Administrative Law Judge Mary Li Creasy by video teleconference with locations in Lauderdale Lakes and Tallahassee, Florida, on February 7 and 8, 2019.

APPEARANCES

For Petitioner: Joseph G. Hern, Esquire
Susan Sapoznikoff, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: Dennis Vandenberg, Esquire
Peterson Bernard
1550 Southern Boulevard, Suite 300
West Palm Beach, Florida 33406

STATEMENT OF THE ISSUES

Whether during the relevant audit period, Respondent, Mary Cecilia Crosby, D.D.S. ("Dr. Crosby"), an oral and maxillofacial surgeon, was overpaid for services that, in whole

or in part, were not covered by Medicaid, were not medically necessary, were improperly coded, or were insufficiently documented; and, if so, in what amount and what is the appropriate penalty.

## PRELIMINARY STATEMENT

This case involves a Medicaid Audit by Petitioner, Agency for Health Care Administration ("AHCA"), of Dr. Crosby's practice for dates of service from July 1, 2011, through December 31, 2014. During the audit period, Dr. Crosby was an enrolled Medicaid provider and had a valid Medicaid provider agreement. Pursuant to AHCA's Final Audit Report ("FAR"), dated April 18, 2016, in MPI Case ID 2015-0005032, AHCA sought repayment from Dr. Crosby in the amount of $862,226.96 as a Medicaid overpayment for paid claims that, in whole or in part, are not covered by Medicaid. AHCA sought to impose a fine of $50,000.00 as a sanction for violations of Florida Administrative Code Rule 59G-9.070(7)(e). AHCA also claims that Respondent should pay investigative, legal, and expert witness costs, pursuant to section 409.913(23), Florida Statutes. After some revisions post-FAR, AHCA seeks $841,666.43 from Respondent as a Medicaid overpayment; seeks to impose upon Respondent a sanction fine of $49,000.00 for violation of rule 59G-9.070(7)(e); and also seeks payment of costs pursuant to section 409.913(23).

The matter was referred to the Division of Administrative Hearings ("DOAH") on September 21, 2016, and was opened as DOAH Case No. 16-5513MPI. The parties filed a Joint Motion for Relinquishment of Jurisdiction so that the parties could complete discovery of all relevant witnesses while exploring settlement arrangements. The undersigned issued an Order Closing File and Relinquishing Jurisdiction back to AHCA on January 3, 2017, with leave to reopen the matter in the event that after discovery was complete, disputed issues of material fact remained.

The parties were unable to successfully negotiate a resolution. On September 5, 2018, AHCA filed a Motion to Reopen Proceedings, which was granted over objection, and DOAH Case No. 18-5269MPI was assigned. Respondent filed an Objection to Petitioner's Motion to Reopen Proceedings before the Division of Administrative Hearings and Respondent's Request for Remand to the Fifteenth Judicial Circuit for Jury Trial, which was denied after a telephonic hearing on the motion on October 1, 2018.

The final hearing of this matter was conducted as scheduled by video teleconference on February 7 and 8, 2019.

AHCA presented the testimony of two witnesses: Robi Olmstead, AHCA Administrator; and the deposition testimony of John H. Hardeman, D.D.S., M.D., who was accepted as an expert

in oral and maxillofacial surgery. AHCA Exhibits 1 through 24 were admitted into evidence without objection.

Dr. Crosby testified on her own behalf and presented the testimony of Robert E. Marx, D.D.S., who was accepted as an expert in oral and maxillofacial surgery. Respondent's Exhibits 1 through 8 were admitted into evidence with no objection.

The two-volume Transcript of the final hearing was filed with DOAH on February 27, 2019. Both parties timely filed their proposed recommended orders, which were taken into consideration in the drafting of this Recommended Order.

Except as otherwise indicated, citations to Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect at the time of the alleged violations.

## FINDINGS OF FACT

### The Parties

1. This case arises from an AHCA Medicaid audit of Dr. Crosby for services provided and paid for during the period July 1, 2011, through December 31, 2014.

2. Dr. Crosby is an oral and maxillofacial surgeon, licensed to practice in Florida, who began her dental practice in 1987 after receiving her dental degree from Ohio State University College of Dentistry and a certificate for oral and

maxillofacial surgery from Columbia University. Dr. Crosby maintains her practice in Royal Palm, Florida.

3. AHCA does not contend that Dr. Crosby provided poor quality of care. It also does not claim that her billings were fraudulent.

4. The Florida Legislature has designated AHCA as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act ("Medicaid program"). AHCA oversees and administers the Medicaid program for the State of Florida. § 409.913, Fla. Stat. AHCA investigates and audits Medicaid providers to identify and recoup overpayments for services rendered to Medicaid recipients. The Legislature also empowered AHCA to impose sanctions and fines against providers that received overpayments. § 409.913, Fla. Stat.

5. In the Medicaid program, providers bill AHCA for services rendered and AHCA pays the bills, also called claims. Later AHCA audits the claims. This audit includes examination of whether the services were proper, whether the amounts billed were correct, and whether Medicaid covers the services provided. If AHCA determines that it overpaid a provider, AHCA seeks reimbursement of the funds.

6. The Medicaid program follows a process of record collection, records analysis, provider input, and rebuttal from

the provider before reaching its final determination of amounts overpaid. AHCA issues a FAR, sometimes amended, stating its determination and the reasons for it. If the provider disputes AHCA's final determination, it may request a formal administrative hearing.

The Audit Process

7. AHCA audited Dr. Crosby's claims and agency payments made during the period July 1, 2011, through December 31, 2014 (the "audit period").

8. During the audit period, Dr. Crosby was an enrolled Medicaid provider subject to the requirements of the Medicaid provider agreement. The Medicaid provider agreement is a contract between AHCA and the provider. It requires the Medicaid provider to comply with all state and federal laws establishing and regulating the Medicaid program. This includes Florida Medicaid Provider General Handbooks ("Provider General Handbooks") that are incorporated by reference into rules. The agreement required Dr. Crosby to maintain medical records and make those records available to AHCA in a systematic and orderly manner for review. The records must be accessible, legible, and comprehensive.

9. AHCA uses a statistical sampling and extrapolation process for conducting Medicaid audits. Administrator Robi Olmstead provided the framework by which this audit was

opened, investigated, reviewed, and reported. The process involves identifying and analyzing a randomly selected number of claims paid during the audit period. AHCA extrapolates the results of the analysis of the selected claims to the amount of claims paid during the audit period to determine the amount of overpayment, if any. The process of statistical sampling and the statistical methods used to establish the validity of the overpayment calculation in this case is an accepted and valid process that complies with section 409.913(20).

10. AHCA's application of this process in this case is consistent with the requirements of all applicable versions of the Provider General Handbooks and Dental Services Coverage and Limitations Handbooks ("Dental Handbooks"), Current Dental Terminology ("CDT") manual definitions, Current Procedural Code ("CPC") definitions, Florida Statutes regulating dentistry, and dental standards of care to guide his evaluation. AHCA's application of the claims sample program resulted in the selection of the records of 35 of Dr. Crosby's patients.

11. AHCA then asked Dr. Crosby to submit records and other documents to support her claims for the 35 patients. Dr. Crosby provided documents, including her medical records and billing records. Agency employees and a contracted expert, John H. Hardeman, D.D.S., M.D., reviewed the records. Dr. Hardeman is a Florida-licensed medical doctor and dentist, who is board-

certified in oral and maxillofacial surgery. Dr. Crosby stipulated and agreed that Dr. Hardeman meets the requirements and qualifications of a "peer" as defined in section 409.9131. Dr. Hardeman's testimony is credible.

The Audit Reports

12. AHCA preliminarily concluded that it had overpaid Dr. Crosby $862,226.96. AHCA advised Dr. Crosby of its conclusion in a Preliminary Audit Report ("PAR"). This report and its attached worksheets explicated AHCA's rationale for its conclusions. AHCA provided Dr. Crosby an opportunity to provide additional records to support her claims, and to explain the questioned billings, but Dr. Crosby provided no further records.

13. AHCA issued the FAR, seeking repayment from Dr. Crosby in the amount of $862,226.96 as a Medicaid overpayment for paid claims that, in whole or in part, are not covered by Medicaid. AHCA sought to impose a fine of $50,000.00 as a sanction for violations of rule 59G-9.070(7)(e). AHCA also claims that Respondent should pay investigative, legal, and expert witness costs, pursuant to section 409.913(23).

14. Prior to the final hearing, AHCA performed further revisions and seeks $841,666.43 from Dr. Crosby as a Medicaid overpayment; seeks to impose upon Respondent a reduced fine of $49,000.00 for violation of rule 59G-9.070(7)(e); and also seeks payment of costs pursuant to section 409.913(23).

15. The FAR identified four categories of shortcomings, resulting in reductions in payments for claims, under the heading "Findings" as follows:

> 1. The 2008 and 2012 Florida Medicaid Provider General Handbooks, page 5-4, state that when presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to present a claim for goods and services that are medically necessary. A review of your medical records by a peer consultant in accordance with Sections 409.913 and 409.9131, F.S. revealed that the medical necessity for some claims submitted was not supported by the documentation. Payments made to you for these services are considered an overpayment. (NMN)
>
> 2. The 2008 and 2012 Florida Medicaid Provider General Handbooks, page 5-4, require that when presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to present a claim that is true and accurate and is for goods and services that have actually been furnished to the recipient. A review of your medical records revealed 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. (ERROR IN CODING)
>
> 3. The 2008 Florida Medicaid Provider General Handbook, pages 2-57 and 5-8 and the 2012 Florida Medicaid Provider General Handbook, pages 2-60 and 5-9, define incomplete records as records that lack documentation that all requirements or conditions for service provision have been met. A review of your medical records revealed that the documentation for some services for which you billed and received

payment was incomplete or was not provided. Payments made to you for these services are considered an overpayment. (INSUFFICIENT/NO DOC)

4. The 2007 Dental Services Coverage and Limitations Handbook, page 2-1 through 2-4, and pages 3-1 through 3-8, and the 2011 Dental Services Coverage and Limitations Handbook, page 2-1 through 2-5, state that only those services designated in the applicable provider handbook and fee schedule are reimbursed by Medicaid after the correct code was assigned. Payments made to you for these services are considered overpayments. (NOT A COVERED SERVICE).

Bone Grafting--Coding Issues

16. Most of the claims in dispute in this case involve whether procedures identified by Dr. Crosby as bone grafting, following the extraction of molars or wisdom teeth, were medically necessary or properly coded as procedures covered by Medicaid.

17. The Florida Medicaid Dental Program, at the time of the audit, was limited in scope in the services and treatments available. The program does not cover preventive care.

18. For the procedures in question, Dr. Crosby used CPC codes 21210 and 21215, which are codes for face bone and lower jaw bone grafts, respectively. Dr. Hardeman opined that the appropriate code for the procedures performed by Dr. Crosby is CDT Code D7953, which is not a Medicaid-covered procedure.

19. CPC Code 21210 is for a graft in the upper jaw and described as "[g]raft, bone: nasal, maxillary or malar areas (includes obtaining graft)." CPC Code 21215 is for a graft in the lower jaw and described as "[m]andible (includes obtaining graft)."

20. Significantly, the CPC manuals in effect during the years of the audit provide an introduction to the graft codes which states:

> Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, or other tissues through separate skin/fascial incisions should be reported separately unless the code descriptor references the harvesting of the graft or implant (eg., includes obtaining graft). (Emphasis added).

21. CDT Code D7953 states as follows:

> bone replacement graft for ridge preservation--per site
>
> Osseous autograft, allograft or non-osseous graft is placed in an extraction site at the time of the extraction to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Membrane, if used should be reported separately.

22. In laymen's terms, CPC codes 21210 and 21215 are for complex bone grafting involving a fairly extensive surgical procedure, including the harvesting of bone from the patient's body or that of a cadaver, and filling in or reconstructing a

portion of the jaw. These codes apply when the bone grafting procedures are required because of traumatic or genetic defects and relate to large areas of reconstruction, not a single socket. None of the recipients who received bone grafts coded as CPC 21210 and 21215 had a traumatic injury.

23. The Coding Guide for CPC codes 21210 and 21215, respectively, state that these grafts "may be held in place with wires, plates or screws" and the graft "shall be firmly positioned with wires, plates or screws". Dr. Crosby did not use plates, wires, or screws in any of the bone grafting procedures at issue.

24. Dr. Crosby did not harvest any bone from any recipient but purchased the bone putty material from a manufacturer. Her belief, that taking putty out of a jar for a graft, constitutes "obtaining graft" is inconsistent with the CPC explanation of grafts for purposes of codes 21210 and 21215. These codes clearly require harvesting the bone material.

25. Dr. Hardeman credibly testified that the procedures performed, with one exception, which was then allowed by AHCA post-FAR, were socket or ridge preservation grafts more appropriately coded as D7953. However, D7953 is a dental code that is not available for billing to Medicaid. That code is not present in the Dental General Fee Schedules or the Dental

Oral/Maxillofacial Surgery Fee Schedules for any of the years of the audit period.

26. Dr. Hardeman explained that it would take a competent oral surgeon from 15 to 20 minutes to remove impacted wisdom teeth and "just a few brief moments" to perform the bone grafting procedures Dr. Crosby billed to Medicaid and which are the subject of this audit. However, Dr. Crosby billed and received payment from Medicaid for bone grafting procedures at rates as high as $2,256.56.

Agreements Reached During Final Hearing

27. At final hearing, Dr. Crosby testified on her own behalf and presented the testimony of her expert witness, Dr. Robert Marx, D.D.S., who is also an oral and maxillofacial surgeon. Despite the claims in the Petition for Formal Administrative Hearing and the Amended Joint Prehearing Stipulation, at the final hearing, further agreement was reached on certain claims.

28. Recipient 10, claims 5 through 12, were withdrawn because Dr. Crosby acknowledged the records/claims were actually for someone other than the recipient (they belonged to a sibling of the recipient). These claims were properly denied by AHCA.

29. Also, in his final hearing testimony, Dr. Marx agreed with Dr. Hardeman's conclusions that AHCA properly denied the claims for the following:

a. Recipient 4, claim 2;

b. Recipient 5, claims 3, 13, 15, and 18[1/];

c. Recipient 10, claim 2;

d. Recipient 13, claim 2;

e. Recipient 16, claim 7;

f. Recipient 17, claim 4;

g. Recipient 18, claim 4;

h. Recipient 20, claim 2;

i. Recipient 24, claim 5;

j. Recipient 27, claim 7;

k. Recipient 27, claim 13;

l. Recipient 30, claim 3;

m. Recipient 30, claim 4;

n. Recipient 30, claim 5;

o. Recipient 30, claim 7;

p. Recipient 31, claim 4;

q. Recipient 31, claim 6;

r. Recipient 34, claim 4; and

s. Recipient 34, claim 13.

30. In addition, Dr. Crosby also conceded the following claims which had been disallowed by Dr. Hardeman, even though her expert, Dr. Marx disagreed:

a. Recipient 27, claim 6; and

b. Recipient 34, claim 3.

31. To the extent that Dr. Marx agreed with Dr. Hardeman, the undersigned upholds their findings, even if disputed by Dr. Crosby. To the extent that Dr. Crosby conceded claims, the undersigned accepts that testimony, which is supported by that of Dr. Hardeman.

Remaining Disputed Claims

32. Eliminating the claims conceded at the final hearing leaves the following claims for determination:

a. Recipient 5, claim 25 (code 41150--denied as error in coding and not a covered service).

b. Recipient 10, claim 3 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

c. Recipient 10, claim 4 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

d. Recipient 11, claim 5 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

e. Recipient 15, claim 10 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

f. Recipient 15, claim 11 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

g. Recipient 16, claim 8 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

h. Recipient 20, claim 1 (denied for lack of documentation).

i. Recipient 21, claim 1 (denied for lack of documentation).

j. Recipient 21, claim 4 (error in coding--payment was reduced, but not denied).

k. Recipient 23, claim 4 (code 21215--denied as error in coding and not a covered service).

l. Recipient 23, claim 5 (code 21215--denied as error in coding and not a covered service).

m. Recipient 24, claim 4 (code 21210--denied as error in coding and not a covered service).

n. Recipient 24, claim 5 (code 21210--denied as error in coding and not a covered service).

o. Recipient 27, claim 8 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

p. Recipient 27, claim 12 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

q. Recipient 29, claim 6 (code 41150--denied as error in coding and not a covered service).

r. Recipient 34, claim 12 (code 21215--denied as error in coding, not medically necessary, and not a covered service).

Specific Claims

Recipient 5, Claim 25, and Recipient 29, Claim 6

33. Recipient 5, claim 25, and Recipient 29, claim 6, both concern claims billed for "Reconstruction of a Tongue Fold."

AHCA denied these claims based on error in coding and the procedures not being covered by Medicaid. With regard to these claims, Dr. Hardeman testified that Dr. Crosby billed code D41520, which is very specific in its language and requires an incision and rearrangement of tissues. However, the procedure she actually performed was a maxillary frenectomy, which only involves cutting the muscle attachments. Because there was no documentation showing Dr. Crosby made an incision and rearranged the tissues in a Z-plasty formation, Dr. Hardeman opined that code 40806 was more appropriate.

34. Dr. Marx testified that the code used was proper because Dr. Crosby had to place a stitch, even though that code calls for repositioning of tissue, which Dr. Crosby admittedly did not do.

35. The testimony of Dr. Hardeman was more credible than that of Dr. Marx with regard to this issue. AHCA properly adjusted payment for these claims.

Recipient 10, Claims 3 and 4

36. Dr. Crosby coded the procedures as CPC code 21215, grafts in the lower jaw of a 14-year-old patient. However, Dr. Crosby did not "obtain a graft" from this patient. Rather she opened a jar and removed putty to place in the socket after removal of impacted wisdom teeth.

37. Dr. Hardeman testified that a bone graft was not warranted, even for the preservation of the ridge. Younger patients tend to heal better. The current standard of care is not to perform grafting in patients less than 26 years old. Dr. Hardeman relies on the position papers ("white papers") of the American Association of Oral and Maxillofacial Surgeons ("AAOMS").

38. Dr. Marx disagreed and opined that the 26-year-old cut-off has been disregarded in the last 15 years and that using grafting material leads to complete bone regeneration. According to Dr. Marx, younger patients will get complete healing without grafting material but they will not get complete bone regeneration. Dr. Marx offered no evidence in support of this theory. Dr. Hardeman's testimony regarding the medical necessity of grafting in younger patients is more credible and accepted.[2/]

39. Code D7953 is the appropriate code for these procedures, and AHCA properly adjusted payment for these claims.

Recipient 11, Claim 5

40. This claim involves the extraction of tooth 17, an impacted third molar with an enlarged follicle. Both experts agree that grafting was appropriate to preserve tooth 18. However, Dr. Hardeman explained that this was a ridge preservation graft and should have been coded D7953 rather

than 21215. Dr. Marx offered no contradictory testimony. AHCA properly adjusted payment for this claim.

Recipient 15, Claims 10 and 11

41. Both claims involve the removal of wisdom teeth from the lower jaw of a 17-year-old. Both experts agree that grafting was appropriate. Again, the dispute centers on the appropriate coding. The experts disagreed regarding the extensiveness of the reconstruction needed. However, because Dr. Crosby did not harvest any graft material from the patient, these procedures were miscoded, and AHCA properly adjusted payment for these claims.

Recipient 16, Claim 8

42. This procedure involved extraction of a molar in the lower jaw and a graft. Dr. Hardeman testified he would not have used a graft for this tooth, but did not explain why. Dr. Marx testified that "if Dr. Crosby had to remove bone to get out the roots and such, then it would be justifiable, but I would have her testify to that, not me."

43. During her testimony, Dr. Crosby agreed with Dr. Marx that this claim should be allowed, but provided no explanation.

44. Insufficient testimony and evidence was provided to decide whether this procedure was medically necessary. However, given the fact that Dr. Crosby did not harvest bone for any of

the claims in dispute in this audit, code 21215 is not appropriate, and AHCA properly adjusted payment for this claim.

Recipient 20, Claim 1; Recipient 21, Claim 1

45. AHCA denied claim 1 (limited oral evaluation; problem focused) on Recipients 20 and 21 based on insufficient medical documentation of the evaluation.

46. Dr. Hardeman testified that the necessary components of an evaluation that need to be documented are the medical history, review of symptoms, a review of the data, and an assessment leading to a plan of action.

47. For Recipient 20, claim 1, there was only a notation that the risks were mentioned to the mother. Missing were the chief complaint, a brief medical history of the patient, a review of systems, a review of data (such as X-rays or tests), and a treatment plan. Dr. Marx's explanation, that this amount of information is unnecessary for a limited oral exam, was not credible.

48. For Recipient 21, claim 1, the notes and the treatment provided did not match. The notes reflect Dr. Crosby performed a limited exam for teeth 1, 16, and 32. However, on the treatment date, teeth 31 and 32 were removed.

49. AHCA properly adjusted the payment for these claims.

Recipient 21, Claim 4

50. AHCA reduced payment by $14.00 on claim 4 (tooth root removal) on Recipient 21 based on an error in coding. Dr. Hardeman testified that D7250 was inappropriate and D7210 was appropriate due to the initial status of the tooth.

51. CDT Code 7250 is for the "surgical removal of residual tooth roots (cutting procedure) and "includes cutting of soft tissue and bone, removal of tooth structure, and closure."

52. CDT Code 7210 is for "surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated," and "includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure."

53. Which code applies depends on how much tooth, if any, is present at the beginning of the procedure. If tooth is present above the gum line, the appropriate code is D7210. If only roots remain, the code is D7250.

54. Dr. Marx offered no testimony on this claim. Dr. Crosby explained that she used D7250 because the decay was so extensive that there was virtually no tooth left. However Dr. Hardeman credibly testified that the X-ray taken before the procedure for the tooth showed some tooth remaining. AHCA properly adjusted the payment for this procedure.

Recipient 23, Claims 4 and 5

55. This claim involves the appropriate coding for the removal of two side-by-side molars (teeth 1 and 2) in the upper jaw of a 30-year-old. Dr. Crosby used CPC code 21215 for both procedures. Dr. Marx testified that this coding was appropriate for one tooth but not both. The removal of the two teeth created a jaw defect because the teeth occupied a "fair amount of bone," and was more than a socket defect.

56. However, as with Recipients 10 and 15 discussed above, no harvesting of bone was done. CDT Code 7953 is the appropriate code for the kind of graft used here. AHCA properly adjusted the payment for these procedures.

Recipient 24, Claims 4 and 5

57. These claims involve the removal of teeth 1 and 2 from the upper jaw of a 17-year-old. Both experts agreed that grafting was medically necessary. Dr. Crosby used CPC code 21210. Because there was no harvesting of bone, CDT Code 7953 is the appropriate code for the kind of graft used here. AHCA properly adjusted the payment for these procedures.

Recipient 27, Claims 8 and 12

58. These claims involve the removal of upper and lower left wisdom teeth of a 16-year-old. Dr. Hardeman testified that these procedures were not medically necessary, but did not explain why. However, because there was no harvesting of bone,

CDT Code 7953 is the appropriate code for the kind of graft used here, rather than CPC code 21210 and 21215 used by Dr. Crosby. AHCA properly adjusted the payment for these procedures.

Recipient 34, Claim 12

59. This claim involves the lower jaw bone graft in a 12-year-old after removal of tooth 29. Grafting was not appropriate due to the age of the patient. Further, because there was no harvesting of bone, CDT Code 7953 is the appropriate code for the kind of graft used here, rather than CPC code 21215 used by Dr. Crosby. AHCA properly adjusted the payment for this procedure.

CONCLUSIONS OF LAW

60. DOAH has jurisdiction over the subject matter of this proceeding. §§ 120.569 and 120.57(1), Fla. Stat.; § 409.913(31), Fla. Stat.

61. AHCA bears the burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence. Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

62. AHCA is authorized to seek repayment of overpayments it may have made for goods or services reimbursed under the Medicaid program. §§ 409.913(1), 409.913(11), 409.913(15)(j), and 409.913(30), Fla. Stat.

63. 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." This means that AHCA can make a prima facie case by proffering a properly supported audit report, which must be received in evidence. Absent credible evidence to the contrary, the audit report and agency papers establish the total overpayment.

64. AHCA established a prima facie case, and proved by a preponderance of the evidence, that Dr. Crosby should not have been paid for the claims based on the Findings listed in the FAR. Consequently, AHCA is entitled to reimbursement for the improper claims.

65. Section 409.913(7)(f) requires providers to make sure that claims for services are documented by records created contemporaneously with the provision of the service. The medical records must fully and properly document the medical basis and specific need for the service.

66. To be eligible for coverage by Medicaid, a service must be "medically necessary," defined in section 409.913(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.

67. As discussed in the Finding of Facts, AHCA met its burden of proof for all claims. AHCA proved that it paid Dr. Crosby for claims that failed to comply with the laws, rules, and regulations governing Medicaid providers.

68. Florida Administrative Code Rule 59G-9.070(7) addresses a provider's failure to comply with Medicaid laws and authorizes AHCA to impose an administrative fine. It states in pertinent part:

> 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[.]

69. The rule provides for imposition of a $1,000.00 fine per claim for a first offense. The violations found in this Order and those conceded by Dr. Crosby, totaled 49. The undersigned finds no factual basis for an enhancement of the fine amount. The appropriate fine is $49,000.00.

70. The authority under rule 59G-9.070 to impose sanctions on providers is clear. The meaning of the phrases "will impose" and "shall be imposed" are unambiguous and directory. Carmack

v. State, 31 So. 3d 798, 800 (Fla. 1st DCA 2009)(holding that the terms of a law or regulation should be given their plain meaning).

71. To impose a punitive administrative fine, AHCA must establish the factual grounds for doing so by clear and convincing evidence. Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854, 857 (Fla. 2015). AHCA presented clear and convincing evidence that Respondent failed to comply with state and federal law, rules, regulations, and policies of the Medicaid program for the violations found in this Order.

72. AHCA seeks, and is entitled to, reimbursement of costs that it expended the investigation of Dr. Crosby and the litigation of the audit findings. This includes services rendered by the investigators involved in the audit and the expert consulted to assist the agency. § 409.913(23), Fla. Stat. The amount expended pre-hearing was $1,125.05. Additional costs have been incurred in preparing for and attending the final hearing.

## 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: requiring Respondent to repay claims in the amount of $841,666.43; imposing a sanction of $49,000.00; and requiring Dr. Crosby to repay AHCA's

investigative, legal and expert witness costs. If the parties do not stipulate to the amount of costs, the final order should permit Dr. Crosby to request a hearing to contest the amount of costs.

DONE AND ENTERED this 18th day of April, 2019, in Tallahassee, Leon County, Florida.

MARY LI CREASY
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of April, 2019.

ENDNOTES

[1/] Although Dr. Crosby disagreed with her own expert as to all claims for Patient 5, she also admitted that she had no records to document the basis for the claims, just the procedure codes which she entered. The undersigned finds the testimony of the two experts more credible than that of Dr. Crosby and that these claims were properly denied by AHCA.

[2/] Dr. Marx also testified at hearing that the teeth involved in this claim were significantly impacted. Code D7953 refers to preservation of the ridge. Due to the level of impaction, there was no ridge to preserve and this was a defect in the bone, according to Dr. Marx. He reasoned that code 21215 was appropriate. This was a significant deviation from his deposition testimony during which he agreed code D7953 was appropriate. Dr. Marx offered no explanation for his change in

testimony. Therefore, his opinion offered at final hearing was discredited.

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## NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.