

NO. 45923-0-II

**COURT OF APPEALS, DIVISION II
OF THE STATE OF WASHINGTON**

HAROLD BIRCUMSHAW,

Appellant,

v.

STATE OF WASHINGTON, HEALTH CARE AUTHORITY,

Respondent.

BRIEF OF RESPONDENT

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TABLE OF CONTENTS

I. INTRODUCTION.....1

II. ISSUES PRESENTED.....3

 1. Does HCA have the authority to audit Medicaid providers and assess overpayments as a result of its findings?3

 2. Does HCA’s audit authority include the ability to enforce documentation requirements by assessing overpayments?.....3

 3. Should Dr. Bircumshaw’s factual arguments be disregarded because he does not properly assign error to findings of fact, does not otherwise clearly identify the findings of fact he is challenging, and fails to offer any argument on specific findings of fact?3

III. COUNTERSTATEMENT OF THE CASE3

IV. ARGUMENT9

 A. Standard Of Review9

 B. Unchallenged Findings Of Fact Are Verities On Appeal12

 C. HCA Has The Authority To Assess Overpayments When A Provider Fails To Maintain Adequate Documentation14

 1. HCA Has Authority To Assess Overpayments For Non-Compliance With Agency Rules, Which Include Documentation Requirements15

 2. Enforcing Documentation Requirements Is Not Contrary To Federal Law20

 D. The Unjust Enrichment Doctrine Does Not Apply When The Parties Are Operating Under An Express Contract22

E. HCA Has Not Imposed Punitive Damages And Has Not Violated Dr. Bircumshaw’s Substantive Due Process Rights	24
F. The BOA’s Decision Is Not Internally Inconsistent	25
G. There Is Substantial Evidence To Support The Final Order’s Findings Of Fact	27
1. Airway Optical Order Forms Alone Are Not Adequate Documentation Of Medicaid Services	27
2. Dr. Bircumshaw’s Arguments Also Fail Because He Has Not Applied The Standard Of Review And Has Not Provided Accurate Citations.....	33
V. CONCLUSION	37

TABLE OF AUTHORITIES

Cases

<i>ARCO Prods. Co. v. Wash. Utils. & Transp. Comm'n</i> , 125 Wn.2d 805, 888 P.2d 728 (1995).....	11, 12
<i>Armstrong v. Dep't of Fisheries</i> , 91 Wn. App. 530, 958 P.2d 1010 (1998).....	20
<i>BMW of North America, Inc. v. Gore</i> , 517 U.S. 559, 116 S. Ct. 1589 (1996).....	25
<i>Callecod v. Wash. State Patrol</i> , 84 Wn. App. 663, 929 P.2d 510 (1997).....	11
<i>City of Univ. Place v. McGuire</i> , 144 Wn2.d 640, 30 P.3d 453 (2001).....	11
<i>Connecticut Dep't of Soc. Servs. v. Leavitt</i> , 428 F.3d 138 (2d Cir. 2005)	15
<i>Farwest Steel Corp. v. Mainline Metal Works, Inc.</i> , 48 Wn. App. 719, 741 P.2d 58 (1987).....	22
<i>Frank Cy. Sheriff's Office v. Sellers</i> , 97 Wn.2d 317, 646 P.2d 113 (1982).....	10
<i>Hurlbert v. Gordon</i> , 64 Wn. App. 386, 824 P.2d 1238 (1992).....	34
<i>In re Disciplinary Proceeding Against Haskell</i> , 136 Wn.2d 300, 962 P.2d 813 (1998).....	12
<i>Lawson v. Boeing Co.</i> , 58 Wn. App. 261, 792 P.2d 545 (1990).....	34
<i>Mark Group, Inc. P.S. v. State Dep't of Emp't Sec.</i> , 148 Wn. App. 555, 200 P.3d 748 (2009).....	12

<i>Mercy Hosp. of Watertown v. New York State Dep't of Soc. Servs.</i> , 79 N.Y.2d 197, 590 N.E.2d 213 (1992).....	22
<i>Pierce Cy. Sheriff v. Civil Serv. Com'n of Pierce Cnty.</i> , 98 Wn.2d 690, 658 P.2d 648 (1983).....	11
<i>Port of Seattle v. Pollution Control Hearings Bd.</i> , 151 Wn.2d 568, 90 P.3d 659 (2004).....	10
<i>Pub. Util. Dist. 1 v. Dep't of Ecology</i> , 146 Wn.2d 778, 51 P.3d 744 (2002).....	10, 20
<i>Roller v. Dep't of Labor & Indus.</i> , 128 Wn. App. 922, 117 P.3d 385 (2005).....	13
<i>Trucano v. Dep't of Labor & Indus.</i> , 36 Wn. App. 758, 677 P.2d 770 (1984).....	12
<i>Verizon Nw., Inc. v. Washington Emp't Sec. Dep't</i> , 164 Wn.2d 909, 194 P.3d 255 (2008).....	9
<i>Wright v. Dave Johnson Ins. Inc.</i> , 167 Wn. App. 758, 275 P.3d 339 (2012).....	23

Statutes

42 U.S.C. 1396a.....	15
42 U.S.C. 1396a(5).....	21
42 U.S.C. 1396a(30).....	15
42 U.S.C. 1396a(30)(A).....	21
42 U.S.C. 1396a(37)(B).....	15, 21
RCW 34.05.....	9
RCW 34.05.570(1).....	9
RCW 34.05.570(1)(a).....	27

RCW 34.05.570(2)(c)	20
RCW 34.05.570(3).....	9, 10
RCW 34.05.570(3)(e)	11
RCW 41.05A.010(4).....	16, 24
RCW 43.20B.010(4).....	24
RCW 43.20B.010(5).....	16
RCW 74.09.200	15, 16, 22
Second Engrossed Second Substitute House Bill 1738 (Laws of 2011, 1st Spec. Sess., ch. 15)	3

Rules

RAP 10.3(g)	12
RAP 10.3(h)	12
RAP 10.4(f).....	34

Regulations

WAC 182-550-1050.....	5
WAC 182-550-1700.....	5
WAC 388-502-0010 (2003).....	4
WAC 388-502-0020 (2003).....	17, 24, 27
WAC 388-502-0020(1) (2003)	17
WAC 388-502-0020(1)(a) (2003).....	28
WAC 388-502-0020(1)(b) (2003).....	28

WAC 388-502-0100(1) (2003)	17
WAC 388-502-0230 (2003).....	16
WAC 388-502-0240(10)(b) (2003).....	16
WAC 388-502-0240(11)(a) (2003).....	16
WAC 388-502-0240(4) (2003)	16

I. INTRODUCTION

The Health Care Authority (“HCA”) is the state agency designated to administer the Medicaid program in Washington. Dr. Bircumshaw is an enrolled Medicaid provider of optometric services. As required by state and federal law, and expressly contained in both agency rules and the contract that Dr. Bircumshaw signed when he enrolled as a Medicaid provider, HCA has the authority to conduct post-payment audits and assess overpayments. That authority includes the ability to assess overpayments when a provider fails to create and maintain adequate documentation. The duty to maintain adequate documentation is a vital, threshold requirement that is necessary to protect the integrity of the Medicaid program. Without it, there can be no meaningful inquiry into whether services were actually provided, whether they were medically necessary, or whether they complied with applicable Medicaid limitations.

Dr. Bircumshaw acknowledged in his contract with HCA that “failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented.” Yet in many instances he merely maintained order forms for glasses or contacts as documentation of services.

After HCA initiated an audit and determined that he failed to maintain adequate documentation, Dr. Bircumshaw had the opportunity to provide additional documentation to HCA, participate in two informal dispute conferences with HCA, plead his case during a 9-day hearing, and ultimately to appeal to HCA's Board of Appeals ("BOA").

He now takes issue with the final BOA decision, but fails to identify the findings of fact he is challenging, offer any argument applying the appropriate standard of review, or even provide accurate citations to the 6,500 page record. His factual arguments should be disregarded. But if the Court chooses to consider them, there is ample evidence to support the BOA decision to disallow Medicaid claims supported only by order forms.

Beyond bare factual assertions, Dr. Bircumshaw claims that assessing an overpayment results in an unjust enrichment and constitutes punitive damages in violation of his substantive due process rights. These claims are unfounded because the overpayments are directly tied to claims that did not comply with applicable rules or his contract. And Dr. Bircumshaw expressly agreed to HCA's ability to assess overpayments for claims that are not supported by adequate documentation. The BOA decision should be upheld.

II. ISSUES PRESENTED

1. Does HCA have the authority to audit Medicaid providers and assess overpayments as a result of its findings?
2. Does HCA's audit authority include the ability to enforce documentation requirements by assessing overpayments?
3. Should Dr. Bircumshaw's factual arguments be disregarded because he does not properly assign error to findings of fact, does not otherwise clearly identify the findings of fact he is challenging, and fails to offer any argument on specific findings of fact?
4. Does the doctrine of unjust enrichment apply where the parties are operating pursuant to an express contract, and not a contract implied at law?
5. Does a provider overpayment constitute punitive damages or violate the provider's substantive due process rights when the overpayment is tied on a dollar-for-dollar basis to non-compliant Medicaid claims and the parties are operating under a contract that expressly permits the overpayment?
6. Is it internally inconsistent to reverse some audit findings on a technical legal basis, while upholding other findings that do not have the same legal deficiency?
7. To the extent the Court considers Dr. Bircumshaw's factual assertions, is there substantial evidence to support findings that order forms are not sufficient documentation?

III. COUNTERSTATEMENT OF THE CASE

The Health Care Authority is the single state agency designated to administer the Medicaid program in Washington.¹ Harold Bircumshaw,

¹ In 2011, the Legislature enacted a bill under which HCA replaced the Department of Social and Health Services as the "single state agency" for purposes of administering the Medicaid program. *See* Second Engrossed Second Substitute House Bill 1738 (Laws of 2011, 1st Spec. Sess., ch. 15). The dates relevant to this case stretch

O.D., provides optometric services. CP at 6136-37. To be eligible to receive Medicaid payments, a provider must submit an enrollment application and sign a core provider agreement with HCA. WAC 388-502-0010 (2003). For all dates relevant to this case, Dr. Bircumshaw was an enrolled Medicaid provider operating under a core provider agreement (“CPA”). *See* CP at 705-07.

In 2007, HCA’s Surveillance and Utilization Review Section reviewed Dr. Bircumshaw’s billing practices. CP at 708, 5116. The review was initiated as the result of a referral by HCA’s Quality Management Team based on excessive visits and improper billing. CP at 708. Further, Dr. Bircumshaw had a history of non-compliance, including a guilty plea to first degree theft from the Medicaid program in 1991. CP at 697, 699, 708. After its review, the Surveillance and Utilization Review Section concluded that Dr. Bircumshaw had abnormal billing patterns and failed to maintain appropriate documentation. CP at 710. It recommended that HCA conduct a full audit. CP at 708,

from 2003-present. To avoid confusion, this brief refers to both HCA and the Department of Social and Health Services as simply “HCA.” Further, the Medicaid program itself has had a number of names, including Medical Assistance Administration (“MAA”). The record contains citations to Medical Assistance Administration or MAA and other previous names. Again, to avoid confusion and to avoid the need to explain the last decade of Medicaid history in Washington, this brief will refer to simply “HCA” as the entity that administers Medicaid.

5116. On November 29, 2007, HCA sent Dr. Bircumshaw a letter notifying him of HCA's intent to conduct an audit.² CP at 716-17, 5126.

The scope of the audit was limited to measuring compliance with:

regulations stated in the Revised Code of Washington (RCW), Washington Administrative Code (WAC), the provider's Core Provider Agreement with [HCA], the Schedule of Maximum Allowances, Billing Instructions, and Numbered Memoranda.

CP at 761. The universe of claims examined was also clearly defined as paid claims with dates of service from June 2, 2003 through May 31, 2006. CP at 761.

The claims universe contained a total of 9,531 procedures. CP at 762. HCA did not examine each individual claim within that universe. *See* CP at 761-62. Rather, it examined a total of 373 specific procedures that were selected from the universe. CP at 762. Of these 373 procedures, 348 were randomly selected, and any overpayments associated with the procedures were extrapolated to the audit universe. CP at 762. HCA also reviewed the 25 highest paid claims in the audit universe. CP at 762. Those procedures were audited on a claim-by-claim basis and the results were not extrapolated to the universe. CP at 762.

² Dr. Bircumshaw cites several provisions related to Utilization Review ("UR"). UR is a distinct subset of audits that is conducted in the hospital setting to measure issues such as whether services were provided at the appropriate level of care (i.e., inpatient versus outpatient). *See, e.g.*, WAC 182-550-1050; WAC 182-550-1700. It is not the only type of audit and provisions concerning UR are irrelevant to this case.

In November 2008, HCA issued a draft audit report that assessed an overpayment of \$233,028.66. CP at 757. Dr. Bircumshaw exercised his right to participate in an informal dispute conference with HCA. CP at 850. The conference was held in February 2009. CP at 853. Dr. Bircumshaw provided additional documentation for some procedures. CP at 853-54. During the dispute conference, HCA agreed to give Dr. Bircumshaw another opportunity to submit additional documentation. CP 860. A second dispute conference was held in March 2009. CP at 862. Based on the documentation provided at the dispute conferences, HCA reversed some findings and the overpayment was reduced. CP at 853-54, 862.

On April 28, 2009, HCA issued the final audit report (“Audit Report”), which assessed a total overpayment of \$224,111.64. CP at 864; 867. The Audit Report assessed a monetary overpayment pursuant to four separate findings. Each procedure with an associated finding is listed on the appendices to the report. CP at 879-942. Overpayments that were extrapolated to the audit universe are listed on Appendix A to the Audit Report, and overpayments in the top 25 that were not extrapolated to the audit universe are listed on Appendix B to the Audit Report. *See* CP at 880, 936.

Finding 1 identifies procedures that were not supported by sufficient documentation, and is itself broken into sub-findings 1A through 1D. CP at 871. Finding 1A identifies 41 procedures for which the medical records do not support that the claim actually billed and paid was performed. CP at 871, 874. Finding 1B identifies 130 procedures that were not supported by any chart note to document that Dr. Bircumshaw fitted and dispensed spectacles. CP at 871, 874. Finding 1C identifies 12 instances where Dr. Bircumshaw was required to maintain a client history to substantiate a comprehensive ophthalmological exam, but failed to do so. CP at 871, 874. Finding 1D identifies 7 instances where Dr. Bircumshaw did not maintain a required lab order. CP at 871, 874.

Finding 2 identifies 78 instances in which Dr. Bircumshaw submitted a claim at a higher level of service than what was justified by his documentation. CP at 874.

Finding 3 identifies 40 instances where Dr. Bircumshaw billed for the initial fitting of spectacles in conjunction with billing for the repair and refitting of spectacles. CP at 875.

Finding 4 identifies instances of billing errors, and is broken into sub-findings 4A through 4C. CP at 875-76. Finding 4A is a catch-all finding that identifies 19 instances in which a claim was billed in error. CP at 876. Finding 4B identifies 7 instances in which Dr. Bircumshaw

billed for the same service twice. CP at 876. Finding 4C identifies 48 instances in which Dr. Bircumshaw did not comply with a required period of time between fittings. CP at 876.

Dr. Bircumshaw requested an administrative hearing to challenge the Audit Report. An adjudicative proceeding was held at the Office of Administrative Hearings over the course of nine days in January and February 2010. *See* CP at 5029, 5208, 5395, 5592, 5798, 5995, 6161, 6331. The Administrative Law Judge (“ALJ”) assigned to the case ultimately upheld the overpayment in its entirety. CP at 433.

Dr. Bircumshaw requested review by HCA’s BOA. In a Review Decision and Final Order (“Final Order”) issued on December 9, 2012, the review judge upheld the overpayment with respect to Findings 1 and 4. CP at 276. With respect to Finding 2, the review judge determined that HCA had proved Dr. Bircumshaw billed for the incorrect level of exam for the cited procedures. CP at 250-53, Findings of Fact (FF) at 76-81. With respect to Finding 3, the review judge likewise concluded that Dr. Bircumshaw did not present any evidence to overcome the findings. CP at 253-54, FF at 82-85. Ultimately, however, the review judge concluded that HCA had not given Dr. Bircumshaw adequate notice of the legal basis for assessing an overpayment pursuant to Findings 2 and 3, and reversed those findings on that basis. CP at 269-70, Conclusions of Law

(CL) at 21-24. Based on the modification, the overpayment was lowered and HCA was ordered to recalculate the overpayment.³ CP at 276. Each party filed a motion for reconsideration, and both motions were denied. CP at 63-64.

Dr. Bircumshaw filed a petition for judicial review in Pierce County Superior Court. CP at 1. On January 13, 2014, the Superior Court affirmed the Final Order in its entirety. CP at 6486, 6489-91. Dr. Bircumshaw filed a notice of appeal on February 10, 2014. CP at 6494.

IV. ARGUMENT

A. Standard Of Review

Review of agency action is governed by the Administrative Procedure Act, Title 34.05 RCW. The burden of demonstrating the invalidity of agency action is on the party asserting the invalidity. RCW 34.05.570(1). When the challenged action is an agency order, the review is limited to the findings and conclusions of the final decision-maker for the agency, not the initial decision-maker. *Verizon Nw., Inc. v. Wash. Emp't Sec. Dep't*, 164 Wn.2d 909, 915, 194 P.3d 255 (2008). A reviewing court may only invalidate the order for specific, enumerated reasons. *See* RCW 34.05.570(3). Dr. Bircumshaw only cites four of those

³ Dr. Bircumshaw fails to acknowledge that the overpayment is no longer the \$224,111.64 cited in the Audit Report.

reasons. Brief of Appellant (Br. Appellant) at 28-29. As applicable to this case:

The court shall grant relief from an agency order in an adjudicative proceeding only if it determines that:

(a) The order, or the statute or rule on which the order is based, is in violation of constitutional provisions on its face or as applied;

....

(d) The Agency has erroneously interpreted or applied the law;

(e) The order is not supported by evidence that is substantial when viewed in light of the whole record before the court, which includes the agency record for judicial review, supplemented by any additional evidence received by the court under this chapter;

....

(i) The order is arbitrary or capricious.

RCW 34.05.570(3).

Of those subsections, (a) and (d) concern errors of law and the agency's conclusions are reviewed de novo. *Frank Cy. Sheriff's Office v. Sellers*, 97 Wn.2d 317, 325, 646 P.2d 113 (1982). However, in doing so, the Court should grant substantial weight to an agency's interpretation of an ambiguous statute that the agency administers. *Pub. Util. Dist. 1 v. Dep't of Ecology*, 146 Wn.2d 778, 790, 51 P.3d 744 (2002). This is especially true when the agency has expertise in a certain subject area. *Port of Seattle v. Pollution Control Hearings Bd.*, 151 Wn.2d 568, 593-95, 90 P.3d 659 (2004).

Under subsection (e), the court reviews an agency's findings of fact under the "substantial evidence" standard. RCW 34.05.570(3)(e). A finding will be upheld if it is supported by "evidence that is substantial when viewed in light of the whole record before the court." *Id.* This standard is highly deferential to the agency fact finder. *ARCO Prods. Co. v. Wash. Utils. & Transp. Comm'n*, 125 Wn.2d 805, 812, 888 P.2d 728 (1995). The evidence is viewed in the light most favorable to the party who prevailed at the final administrative forum, and the reviewing court must accept the fact-finders determinations of credibility and the weight to be given to reasonable but competing inferences. *City of Univ. Place v. McGuire*, 144 Wn2.d 640, 652, 30 P.3d 453 (2001). If there are sufficient facts from which a reasonable person could make the same finding as the agency, the finding should be upheld, even if the Court would make a different finding based on its reading of the record. *Callegod v. Wash. State Patrol*, 84 Wn. App. 663, 676 n.9, 929 P.2d 510 (1997).

Subsection (i) contains the "arbitrary and capricious" standard. This is a very narrow standard and the party asserting it "must carry a heavy burden." *Pierce Cy. Sheriff v. Civil Serv. Com'n of Pierce Cnty.*, 98 Wn.2d 690, 695, 658 P.2d 648 (1983). It is defined as an action which is willful and unreasoning in disregard of facts and circumstances. *Id.* "Where there is room for two opinions, action is not arbitrary or

capricious when exercised honestly upon due consideration, even though one may believe the conclusion was erroneous.” *Trucano v. Dep’t of Labor & Indus.*, 36 Wn. App. 758, 762, 677 P.2d 770 (1984). A discretionary decision may not be set aside “absent a clear showing of abuse.” *ARCO*, 125 Wn.2d at 812.

B. Unchallenged Findings Of Fact Are Verities On Appeal

An appellant challenging the findings in an administrative order must specifically assign error to “each finding of fact” it is challenging. RAP 10.3(g); *see also Mark Group, Inc. P.S. v. State Dep’t of Emp’t Sec.*, 148 Wn. App. 555, 561-62, 200 P.3d 748 (2009). In addition to properly assigning error, an appellant challenging an administrative adjudicative order must also set forth a separate statement of each error the party contends was made by the agency, together with issue statements pertaining to each assignment of error. RAP 10.3(h). Unless the appellant properly assigns error or clearly discloses the challenged findings in its issue statements, the challenged findings will not be reviewed. RAP 10.3(g). It is incumbent on appellant to present argument to the court why specific findings of fact are not supported by the evidence and to cite to the record to support that argument. *In re Disciplinary Proceeding Against Haskell*, 136 Wn.2d 300, 311, 962 P.2d 813 (1998).

Unchallenged findings are verities on appeal. *See, e.g., Roller v. Dep't of Labor & Indus.*, 128 Wn. App. 922, 927, 117 P.3d 385 (2005).

Here, Dr. Bircumshaw cites to the substantial evidence standard of review and generally alleges in his statement of the case that the Airway Optical order forms are sufficient documentation. But there are 103 findings of fact and a large number of those findings either mention or implicate the Airway Optical order forms. Dr. Bircumshaw did not assign error to a single finding of fact, or identify a single finding of fact in his issue statements. His statement of the case mentions some findings, but does not clearly articulate which of those findings he is challenging. His argument cites to exactly one finding of fact. *See* Br. Appellant at 42. He does not apply the substantial evidence to a single finding of fact anywhere in his statement of the case or argument. These failures prevent HCA from identifying the specific findings at issue. For instance, there are 23 findings associated with Finding 1. Dr. Bircumshaw mentions several, but not nearly all, of those 23 findings. Two findings that he does not include in his brief, findings 66 and 67, state in no uncertain terms that Airway Optical order forms are not sufficient documentation to support any of the 130 claims in Finding 1B. At a minimum, those findings are verities and the Final Order should be upheld as to Finding 1B. Without

knowing which specific findings Dr. Bircumshaw is challenging, HCA cannot evaluate these types of dispositive arguments.

Moreover, Dr. Bircumshaw has not even identified the appropriate order that is being appealed. He assigns error on the part of the ALJ, the BOA, and the Superior Court. Br. Appellant at 1. This confusion is displayed throughout, as Dr. Bircumshaw asks the Court to reverse the Superior Court and refers to the actions of the ALJ. It is BOA's Final Order that is on review. *See, e.g.*, Br. Appellant at 1, 40 ("the Superior Court must be reversed"). Neither the Office of Administrative Hearings nor the Superior Court are part of HCA and neither of their rulings constitute an agency action.

As discussed below in Section G, this is far from Dr. Bircumshaw's only factual mistake. The appellant's failure to identify even the order being appealed, let alone the specific facts in the order that are challenged, highlights the necessity to treat all findings of fact as verities.

C. HCA Has The Authority To Assess Overpayments When A Provider Fails To Maintain Adequate Documentation

States are delegated the authority to administer Medicaid, which necessarily requires the creation of both payment and payment review policies. In Washington, HCA is the entity that fills this role and it

routinely conducts post-payment audits to measure compliance with laws, rules, or other applicable provisions. Medicaid providers are required to maintain complete charts and records to fully justify services provided. When a provider does not do so, further review is impossible and HCA may assess an overpayment.

1. HCA Has Authority To Assess Overpayments For Non-Compliance With Agency Rules, Which Include Documentation Requirements

Medicaid is a jointly funded, federal-state health insurance program that pays for health care for a specific population of Americans. *See, e.g., Connecticut Dep't of Soc. Servs. v. Leavitt*, 428 F.3d 138, 141 (2d Cir. 2005). The federal and state governments share the cost of Medicaid roughly equally, but state governments administer the program. *Id.*

42 U.S.C. § 1396a contains the minimum requirements for a state's Medicaid plan. Without meeting the requirements of that chapter, the state is ineligible for federal matching funds. One such requirement is that the state must provide a post-payment review process to ensure the proper payment of Medicaid claims. 42 U.S.C. 1396a(37)(B). It must also maintain a utilization review program. 42 U.S.C. 1396a(30). Washington law likewise authorizes HCA "to inspect and audit all records." RCW 74.09.200. HCA rules contain a detailed explanation of the audit

process, and put providers on notice that HCA “conducts audits as necessary to identify benefits or payments to which contractor/providers are not entitled.” WAC 388-502-0240(4) (2003).⁴ This audit authority is expressly written into Dr. Bircumshaw’s CPA, which requires him to comply with all applicable laws, rules, and billing instructions, states that HCA may audit him to measure compliance, and states that such an audit may result in the recovery of paid claims. CP at 705-06.

HCA clearly has authority to conduct Medicaid audits. But what may be recovered as the result of an audit? An “overpayment” is defined as “any payment or benefit to a recipient or to a vendor in excess of that to which [it] is entitled by law, rule, or contract, including amounts in dispute.” RCW 43.20B.010(5); RCW 41.05A.010(4). When an overpayment is identified, the provider is liable for the excess amounts received plus interest. RCW 74.09.220. Accordingly, HCA examines claims “for compliance with relevant federal and state laws and regulations, department billing instructions, and numbered memoranda.” WAC 388-502-0240(10)(b) (2003). When an overpayment is identified, it is recovered. WAC 388-502-0240(11)(a) (2003).

⁴ When discussing HCA’s audit process, Dr. Bircumshaw cites only WAC 388-502-0230 (2003). That provision discusses provider reviews generally, but is not the provision that specifically addresses audits.

The definition of overpayment encompasses claims that are not supported by appropriate or adequate documentation. An enrolled provider must “[k]eep legible, accurate, and complete charts and records to justify the services provided to each client.” WAC 388-502-0020(1) (2003). Dr. Bircumshaw’s CPA imposes the similar requirement to “[k]eep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted.” CP at 706. The documentation must include certain specified categories of information, and all charts must be “authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.” WAC 388-502-0020 (2003).

Payment for a claim or service is only proper when the provider bills according to applicable rules and billing instructions. WAC 388-502-0100(1) (2003). When a provider such as Dr. Bircumshaw has not satisfied his core requirements as an enrolled provider, including the duty to create and maintain adequate documentation to support each claim, the claim is not permitted and he cannot be said to have billed properly and he is not entitled to payment.

In fact, Dr. Bircumshaw agreed in his CPA to be subject to exactly the type of audit at issue in this case:

The Provider understands that *failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented*, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.

CP at 706 (emphasis added). When a provider fails to maintain complete charts and records to support a paid claim, it has received more than it is entitled to by both rule and contract and HCA may properly assess an overpayment.

This conclusion is satisfied not only by applicable laws, rules, and contract provisions, but also good public policy. Without adequate documentation, HCA is left without the opportunity to evaluate whether other rules were followed, such as whether the services were actually provided, whether they were medically necessary, whether they were provided at the correct level of care, and whether they complied with all coverage requirements. The requirement to maintain adequate documentation is not a mere technicality. Where a provider fails to maintain appropriate documentation, comprehensive review is not possible. It is a threshold requirement that permits HCA to maintain program integrity and efficiently administer the Medicaid program.

Dr. Bircumshaw claims that overpayments can only be assessed “for services not medically necessary, not properly authorized or not ‘billed’ according to [HCA] rules.” Br. Appellant at 38. As already discussed, the term “billed” is not as narrow as Dr. Bircumshaw asserts. But Dr. Bircumshaw also incorrectly assumes that, because there were no findings concerning medical necessity or that services were not actually provided, then all services at issue were provided and medically necessary. That assumption represents a fundamental misunderstanding of the audit process. HCA assessed the overpayments because the lack of documentation makes meaningful review of whether the services were actually provided or medically necessary impossible. If Dr. Bircumshaw’s argument were correct, a provider could simply elect not to maintain documentation and HCA would be left without recourse to investigate whether particular claims were provided, medically necessary, and otherwise provided in compliance with laws, rules and billing instructions. The Court should avoid an interpretation that would lead to such an absurd result.

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2. Enforcing Documentation Requirements Is Not Contrary To Federal Law

Dr. Bircumshaw suggests that assessing an overpayment for inadequate documentation is contrary to law. The precise contours of that argument are unclear.

For instance, it is unclear if Dr. Bircumshaw is challenging HCA rules or HCA's application of those rules. HCA rules and Dr. Bircumshaw's contract with HCA permit overpayments based on inadequate documentation. HCA was simply enforcing those provisions. Dr. Bircumshaw, however, has not made a rule challenge.

To the extent Dr. Bircumshaw purports to challenge an HCA rule, a rule is only properly invalidated when it "exceeds the statutory authority of the agency." RCW 34.05.570(2)(c). Agency powers are not limited to those powers expressly granted in the words of an authorizing statute, and include implied powers. *Armstrong v. Dep't of Fisheries*, 91 Wn. App. 530, 537, 958 P.2d 1010 (1998). Similarly, to the extent Dr. Bircumshaw is instead challenging HCA's application of its rules, substantial weight is given to an agency's interpretation of an ambiguous statute that the agency administers so long as the agency's interpretation does not conflict with the statute. *Pub. Util. Dist. 1*, 146 Wn.2d at 790.

Regardless of the basis for Dr. Bircumshaw's challenge, he has not identified any law that is in conflict with HCA rules or HCA's determinations in this case. Indeed, Dr. Bircumshaw only cites 42 U.S.C. 1396a(30)(A). That is a provision that directs states to maintain a utilization plan to prevent unnecessary utilization and "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan." It is a provision directed at initial payment policy.⁵ It is not the provision in federal Medicaid law that authorizes audits.

42 U.S.C. 1396a(37)(B) is the statute that requires states to provide a post-payment review process "to ensure the proper and efficient payment of claims and management of the program." When read in conjunction with 42 U.S.C. 1396a(5), which provides that the program is administered by a designated single state agency in each participating state, the result is that HCA has broad authority to conduct audits and promulgate standards as long as they are aimed at ensuring proper and efficient payment and management. *See also Mercy Hosp. of Watertown v. New York State Dep't*

⁵ In fact, the Medicaid and CHIP Payment and Access Commission report cited by Dr. Bircumshaw makes this very point. *See* Br. Appellant at 32. The report addresses "the amount of payments that states make to providers and the methods that states use to distribute payments." MACPAC Report to the Congress on Medicaid and CHIP, March 2011, at 154, 158 can be found at <http://www.macpac.gov/reports> (last visited December 16, 2014). It does not address audits.

of Soc. Servs., 79 N.Y.2d 197, 203-04, 590 N.E.2d 213 (1992) (state has “broad authority” to determine standards and procedures to employ in Medicaid audits). Similarly, the state statute broadly authorizes HCA to protect public health and welfare by conducting audits as part of “a proper regulatory and inspection program.” RCW 74.09.200.

Dr. Bircumshaw has not identified any conflict between applicable law and assessing an overpayment based on inadequate documentation. As explained above, documentation requirements are essential to ensuring proper and efficient payment and program management. Without the ability to audit compliance with documentation requirements, HCA would be unable to measure compliance with other applicable standards. It is only through uniform maintenance of complete charts and records that HCA can efficiently administer the program, ensure appropriate payment, and protect the health and welfare of Washington residents.

D. The Unjust Enrichment Doctrine Does Not Apply When The Parties Are Operating Under An Express Contract

Unjust enrichment is a measure of recovery for a party asserting a contract implied at law. *Farwest Steel Corp. v. Mainline Metal Works, Inc.*, 48 Wn. App. 719, 731, 741 P.2d 58 (1987). It applies when one party retains money or benefits that in justice and equity belong to

another. *Wright v. Dave Johnson Ins. Inc.*, 167 Wn. App. 758, 773, 275 P.3d 339 (2012).

In this case, there is no implied contract. The parties are operating under an express contract that explicitly states that, “failure to submit or failure to retain adequate documentation for services billed to [HCA] may result in recovery of payments for medical services not adequately documented.” CP at 706. Dr. Bircumshaw’s allegation that HCA will be unjustly enriched if the overpayment is upheld is therefore fundamentally flawed. *See* Br. Appellant at 44-45.

Dr. Bircumshaw’s argument is also factually flawed. He claims HCA is recovering payment for “medically necessary services . . . rendered to eligible beneficiaries.” Br. Appellant at 45. That statement assumes that, because services were not denied on the basis that they were not provided or that they were not medically necessary, the services were in fact provided and were in fact medically necessary. Such a leap in logic is unfounded. HCA assessed overpayments on the basis of inadequate documentation because, without such documentation, further inquiry is hampered. Dr. Bircumshaw’s inference that services were provided, medically necessary, and otherwise in compliance with regulations, is not supported.

E. HCA Has Not Imposed Punitive Damages And Has Not Violated Dr. Bircumshaw's Substantive Due Process Rights

Dr. Bircumshaw argues that the overpayment constitutes punitive damages. He also alleges that the overpayment violates substantive due process because it is grossly excessive. Both arguments rely on a mischaracterization of the overpayment, and necessarily fail on that basis.

There are no punitive damages in this case. The Revised Code of Washington, the Washington Administrative Code, and Dr. Bircumshaw's contract with HCA all state that Dr. Bircumshaw is not entitled to payment for services when he does not comply with applicable laws, rules, or billing instructions. *See* RCW 43.20B.010(4); RCW 41.05A.010(4); WAC 388-502-0020 (2003); CP 705-06. His CPA expressly permits HCA to recover payment for claims that are not supported by sufficient documentation. CP at 706. The overpayment is neither a punitive damages award nor a penalty. It is expressly tied, on a dollar-for-dollar basis, to claims for which Dr. Bircumshaw was not entitled to payment.

Dr. Bircumshaw claims that the overpayment violates the Due Process Clause because it is grossly excessive or arbitrary, and that it is a constitutional requirement "that a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty that a State may impose." *BMW of North America, Inc. v. Gore*,

517 U.S. 559, 574, 116 S. Ct. 1589 (1996); Br. Appellant at 46. The overpayment is directly tied to non-compliant Medicaid claims and as a matter of law cannot be considered grossly excessive or arbitrary. Moreover, the Court need look no further than Dr. Bircumshaw's CPA to see that he received fair notice of both the proscribed conduct and the corresponding possibility of HCA recovery. The CPA contains both Dr. Bircumshaw's obligation to maintain complete records and the scope of HCA's ability to recoup payments that are not supported by sufficient documentation. CP at 706.

F. The BOA's Decision Is Not Internally Inconsistent

To the extent that the Court considers Dr. Bircumshaw's factual assertions, it should reject his assertion that reversing Findings 2 and 3 "is inconsistent with the result of leaving other records intact but not reversing the decision of the administrative law judge." Br. Appellant at 41. Dr. Bircumshaw does not identify what the inconsistency is. The BOA made findings of fact that Findings 2 and 3 were substantively supported by the record. CP at 250-54, FF at 76-85. It reversed, however, on the legal basis that HCA had not placed Dr. Bircumshaw on adequate notice of the legal basis of those findings. CP at 269-70, CL at 21-24. There is nothing inconsistent about reversing audit findings based on a

legal deficiency, while upholding findings that do not suffer from that legal deficiency.

Dr. Bircumshaw also claims:

The state only reviewed 41 cases in that category. In 10 or 24.39% of the cases Airway Optical orders and other records existed. With only 75% remaining it is well below the 95% confidence level state alleges it met.

Br. Appellant at 41.

It is unclear how this argument is related to any internal inconsistency, but it is also fraught with misstatements. Although extrapolation was not challenged below, Dr. Bircumshaw's statements cause confusion and warrant correction. As applied in the audit context, "confidence interval" is a statistical term that refers to the risk that an overpayment is greater than the overpayment that would be assessed if each claim in the audit universe was examined on a claim-by-claim basis. *See, e.g.*, CP at 955-56. Removing audit findings from a random sample of claims will result in a lower extrapolated overpayment, but it will not impact the statistical validity of the extrapolation. There is no evidence that the number of claims identified under a particular sub-finding has any relationship to the statistical validity of the extrapolation.

G. There Is Substantial Evidence To Support The Final Order's Findings Of Fact

Because Dr. Bircumshaw does not provide assignments of error, issue statements, or argument pertaining to specific findings, any factual inquiry should be limited to the general issue of whether there is substantial evidence to support findings that Airway Optical order forms are not sufficient documentation. There is ample evidence to support those findings.

Moreover, an appellant challenging an administrative adjudicative order bears the burden of establishing that findings of fact are not supported by substantial evidence. RCW 34.05.570(1)(a). Dr. Bircumshaw's failure to provide argument and failure to provide accurate citations demonstrates that he has not satisfied his burden.

1. Airway Optical Order Forms Alone Are Not Adequate Documentation Of Medicaid Services

Medicaid providers are required to "[k]eep legible, accurate, and complete charts and records to justify the services provided to each client." WAC 388-502-0020 (2003). Dr. Bircumshaw's CPA likewise requires him to "[k]eep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted." CP at 706. Pertinent information that must be maintained includes:

- (i) Patient's name and date of birth;
- (ii) Dates of service;
- (iii) Name and title of person performing the service, if other than the billing practitioner;
- (iv) Chief complaint or reason for each visit;
- (v) Pertinent medical history;
- (vi) Pertinent findings on examination;
- (vii) Medications, equipment, and/or supplies prescribed or provided;
- (viii) Description of treatment (when applicable);
- (ix) Recommendations for additional treatments, procedures, or consultations;
- (x) X-rays, tests, and results;
- (xi) Dental photographs and teeth models;
- (xii) Plan of treatment and/or care, and outcome; and
- (xiii) Specific claims and payments received for services.

WAC 388-502-0020(1)(a) (2003). In addition, all chart notes must be authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains. WAC 388-502-0020(1)(b) (2003). In more general terms, medical record documentation "is required to record pertinent facts, findings, and observations about an individual's health history." CP at 1011.

The central theme to Dr. Bircumshaw's briefing is the presence of Airway Optical order forms in many client records. Airway Optical is the vendor that supplies glasses and contacts to Washington Medicaid clients. CP at 5235. It has a separate contract with HCA, and HCA pays Airway

Optical directly for the materials themselves. CP at 5235. In the instance of an order for new glasses, for instance, the optometrist is therefore reimbursed for the services of fitting and then dispensing⁶ the glasses, but not for the glasses themselves. CP at 5235.

Airway Optical order forms are exactly what it sounds like they are—order forms. Specifically, “[i]t’s an order form to order the glasses or I guess contacts And not chart documentation for the services that were performed.” CP at 6049. The multiple day hearing was filled with this type of testimony and an HCA auditor repeatedly explained that the order forms are “an order form for the glasses, but not chart note documentation a service was performed.” CP at 6049; *see also* CP at 5234; CP at 6068.

This is not an arbitrary distinction. In the context of one claim for a repair and refitting, the HCA auditor explained that there was no chart note documentation and no description of the alleged repair. CP at 5234. An order form for glasses is not sufficient to justify a repair where the

⁶ Dr. Bircumshaw asserts that HCA arbitrarily added the “dispense” requirement. *See, e.g.*, Br. Appellant at 22. This is not identified as a basis for challenging the order but nevertheless justifies a response. The Current Procedural Terminology definitions for spectacle services provide that “[f]itting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and *the final adjustment of the spectacles to the visual axes and anatomical topography.*” CP at 3901 (emphasis added). Thus, although the word “dispense” is not used the definitions clearly contemplate that there will be a final visit to adjust and dispense the glasses. There is nothing arbitrary about looking for documentation to support that this final visit occurred. Dr. Bircumshaw did, in fact, properly document that glasses were dispensed in some instances. *See, e.g.*, CP at 5353.

form does not even mention or state there is anything wrong with the glasses that are being fixed. CP at 5237. In the context of another specific claim, she explained that the Airway Optical order form did not contain a description of the treatment provided, an explanation of the chief complaint or reason for the visit, findings on examination, pertinent medical history, or recommendations for additional treatment, procedures, or consultations. CP at 6068-69. Moreover, because it was merely an order form, there was no way of knowing if it was retained in the patient's record or obtained after the fact from Airway Optical. CP at 6069. A Medicaid provider is required to create and maintain documentation and reliance on a third party would be improper.

These deficiencies are highlighted by testimony from Dr. Bircumshaw's wife. Joanne Bircumshaw was employed by Dr. Bircumshaw during the audited dates of service and was responsible for his billing. *See* CP at 6110. Ms. Bircumshaw explained why a particular Airway Optical order form was sufficient documentation to support claims for a repair, refitting, and fitting. CP at 6121-22. To do so, she made a series of inferences that she claims ultimately lead to a complete explanation of the service Dr. Bircumshaw provided. CP at 6125. She claimed that the order form shows there was a repair because "[i]t explains that Airway is only going to be sending you lenses.

And those lenses have to be put somewhere.” CP at 6122. She acknowledged that the only documentation that showed there was a repair was the fact that lenses were ordered. CP at 6123. Likewise, in explaining why the fitting was supported, she inferred that after the glasses are repaired, “you now place it on the patient’s face and make sure that it is optically correct.” CP at 6124. These types of inferences portray precisely why the order forms are insufficient documentation. Providers must maintain complete documentation to explain and justify services. Dr. Bircumshaw is, in effect, asserting that HCA must infer or assume the relevant facts for a specific claim. Such inferences or assumptions would leave HCA without recourse to conduct meaningful review.

There is also no evidence that the order forms are properly authenticated. In fact, Dr. Bircumshaw testified that he did not even know that charts need to be authenticated by the person who provided the service. CP at 6147. Dr. Bircumshaw and Ms. Bircumshaw testified that a particular order form was authenticated by a lab manager because it looked like her writing. CP at 1255, 6148.

Airway Optical order forms are not evidence of services actually performed, do not explain necessary details of why the service was

performed, and are not authenticated. They are a culminating document that shows merely that glasses or contacts were ordered.⁷

Dr. Bircumshaw makes a number of statements about what he alleges are contained in Airway Optical order forms. Those statements do not overcome the fact that they do not contain all necessary information and are not authenticated. Although Dr. Bircumshaw has attempted to make this is a complicated matter, it is not. For a particular claim for fitting and dispensing of glasses, he is essentially asserting that he had an office visit with an individual, performed a series of tests, evaluations, or measurements, reached clinical determinations, ordered glasses or contacts, and then provided the glasses to the individual. What he has provided, however, is only an unauthenticated order form indicating that the glasses or contacts were ordered. The order form may include information obtained from the visit and evaluations or tests, but it is not a substitute for actual medical documentation. Likewise, proof that something was ordered is not proof that it was dispensed.

Dr. Bircumshaw's argument must also be viewed in light of his general non-compliance with HCA rules and poor billing practices. Ms. Bircumshaw explained that she was not even aware of applicable

⁷ For similar reasons, ledgers or billing transactions are insufficient documentation. Those documents just show what was billed; they are not documentation of what was actually performed. CP at 5268.

rules and instructions. CP at 6119. She and Dr. Bircumshaw instead determined proper billing parameters by billing Airway Optical and seeing which claims were rejected. CP at 6098-99. During the course of the audit, Dr. Bircumshaw explained his haphazard documentation habits:

I am liable to place information and date anywhere on the exam form, without regard to labeling, depending on the situation at hand, the timing involved, and the personalities and cases in question. I have even jotted notes, information and data down on blank pieces of paper to record what I wanted to record.

CP at 752.

There is substantial evidence to support BOA's findings that Airway Optical order forms are not charts and are not adequate to justify and document services billed to HCA. Dr. Bircumshaw maintained both poor billing and documentation practices. Although this case is now presented as if Dr. Bircumshaw thought he was maintaining adequate documentation under applicable rules, the evidence reveals the reality that he billed and documented in disregard for the rules that he expressly agreed to comply with.

2. Dr. Bircumshaw's Arguments Also Fail Because He Has Not Applied The Standard Of Review And Has Not Provided Accurate Citations

As already discussed, Dr. Bircumshaw fails to support his general assertions concerning findings of fact with any argument applying the

standard of review to specific findings. But he also fails to provide accurate citations in his discussion of those findings.

Dr. Bircumshaw designated approximately 6,500 pages of clerk's papers. He fails, however, to properly cite to those clerk's papers. In violation of RAP 10.3(a)(5) his brief is riddled with factual statements, many which are central to his theory of the case, that contain absolutely no citation whatsoever. Where citations are provided, they are primarily to bates numbers, hearing exhibit numbers, or other creative formats. For instance, there is a citation to "ATR 4.57, page 29, Fn.11" and another to "DSHS Opening Brief, Exhibit 12, pgs. 6 and 14." Br. Appellant at 6, 14. There is no explanation of what "ATR" is and the opening brief is not an exhibit. RAP 10.4(f) requires that citations to clerk's papers should be abbreviated as "CP." Dr. Bircumshaw uses proper "CP" citations to cite to precisely two portions of the clerk's papers—the petition for review by the superior court and the notice of appeal to this Court. These rules are not a formality. *Lawson v. Boeing Co.*, 58 Wn. App. 261, 271, 792 P.2d 545 (1990). Non-compliance "places an unacceptable burden on opposing counsel and" the Court. *Id.*; *see also Hurlbert v. Gordon*, 64 Wn. App. 386, 399-401, 824 P.2d 1238 (1992) (imposing sanctions in case with 6,000 pages of clerk's papers when counsel failed to provide citations, provided citations in format that made it difficult to find the

cited documents, and provided citations that did not support the factual statements for which they were made).

Further, examination reveals that many of Dr. Bircumshaw's factual statements, whether with citation or not, are wrong. For instance, Dr. Bircumshaw claims that the Final Order reverses Findings 2 and 3 based on the presence of Airway Optical order forms. He claims the reversal was based on "information contained in Dr. Bircumshaw's patient files," "based on the fact that 'records' existed and were part of the evidence produced during the administrative hearing," or "based on the fact that documentation did exist." Br. Appellant at 17-19. These statements are wrong and unjustifiable. The BOA made findings of fact that Findings 2 and 3 were substantively supported by the record. CP at 250-54, FF at 76-85. It reversed, however, on the legal technicality that HCA had not placed Dr. Bircumshaw on adequate notice of the legal basis of those findings. CP at 269-70, CL at 21-24. Dr. Bircumshaw similarly claims that the Final Order reversed "25 of the claims because the State had simply added those claims to the projected amount." Br. Appellant at 19. To the contrary, the Final Order specifically states that extrapolation was not challenged, and that the extrapolation process was valid. CP at 272-73, CL at 29.

Elsewhere, Dr. Bircumshaw claims that, when addressing whether an overpayment is proper, even the ALJ claimed “that the real issue was whether the services were provided.” Br. Appellant at 21. The citation provided is to a portion of the hearing where the ALJ addressed whether the services in the audit universe were provided by Dr. Bircumshaw or, instead, by colleague Dr. Beasley. *See* CP at 5658-59. The statement has nothing to do with the standard for payment.

In other instances, Dr. Bircumshaw attributes statements to the wrong persons or entities. At various points, he refers to the Office of Administrative Hearings as HCA, to the ALJ as HCA’s counsel, and to the Review Judge as an auditor. For examples, he states that “the State itself refers to these forms as “medical records.”” Br. Appellant at 9. The citation is to the initial order. The Office of Administrative Hearings is not part of HCA, and the cited provisions do not state that the forms are medical records. *See* CP at 441-42. Similarly, he refers to statements in the Final Order as statements by auditors. Br. Appellant at 13. Although BOA is part of HCA, the review judge is not an auditor. He also attributes statements to HCA counsel that were actually made by the ALJ. Br. Appellant at 10 (“Counsel for the Department stated ‘nobody’s going to be asking you whether or not the services were provided.’”); *cf.* CP at 5088.

These types of errors are too numerous to fully correct. In general, however, Dr. Bircumshaw fails to provide citations for a significant number of factual assertions. When citations are provided, they are frequently inaccurate in both form and content. And he does not apply the standard of review to those faulty factual assertions. These deficiencies demonstrate that he has not satisfied the necessary burden to show that findings of fact are not supported by substantial evidence.

V. CONCLUSION

HCA has the authority to conduct post-payment audits. That authority includes the ability to assess overpayments when paid claims are not documented by complete charts and records. Audits to enforce documentation requirements are essential to HCA's mandate to protect program integrity and efficiency. The overpayments assessed in this audit are directly tied to particular claims that do not comply with HCA rules or Dr. Bircumshaw's CPA. By definition, there is no unjust enrichment and the overpayment does not constitute punitive damages. To the extent the

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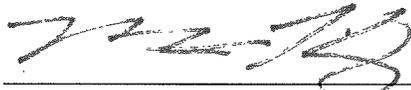
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Court reviews Dr. Bircumshaw's factual allegations, the Final Order's findings of fact are supported by ample evidence. The Final Order should be affirmed.

RESPECTFULLY SUBMITTED this 21st day of December, 2014.

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CERTIFICATE OF SERVICE

Christine Hawkins states and declares as follows:

I am a citizen of the United States of America and over the age of 18 years and I am competent to testify to the matters set forth herein. On December 22, 2014, I served a true and correct copy of this **BRIEF OF RESPONDENT** and this **CERTIFICATE OF SERVICE** on the following parties to this action, as indicated below:

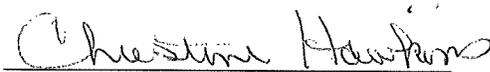
By United States Mail

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I certify under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 22nd day of December 2014, at Tumwater, Washington.



CHRISTINE HAWKINS

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WASHINGTON STATE ATTORNEY GENERAL

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