STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MEDILAB, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	CASE NO. 94-0096

RECOMMENDED ORDER

Pursuant to notice, the Division of Administrative Hearings, by its designated Hearing Officer, Joyous D. Parrish, held a formal hearing in the above-styled case on November 16-17, 1994, in Miami, Florida.

APPEARANCES

For Petitioner: Heidi E. Garwood
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For Respondent: Monte K. Rassner
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STATEMENT OF THE ISSUES

The central issue in this case is whether the provider, Medilab, was overpaid for medicaid claims as alleged in the letter dated November 3, 1993.

PRELIMINARY STATEMENT

This case began on November 3, 1993, when the Agency for Health Care Administration, Medicaid Program Integrity Office (Agency), issued a letter relying upon its audit and alleging that, Petitioner, Medilab, had been overpaid for claims that, in whole or in part, are not covered by Medicaid. More specifically, the letter alleged that a random sample of forty-three recipients representing three hundred and thirty-six claims had been audited and that, for the period October 2, 1991 through August 31, 1992, an overpayment of $19,799.00 or $58.92559433 per claim was found. Applying that amount to the total number of claims for the audit period resulted in a calculated overpayment of $217,775.90 for which the Agency sought reimbursement. Additionally, the Agency sought to impose a fine in the amount of $5,000.00. Thus the total claimed by the Agency at that time was $222,775.90.

Medilab disputed the issues of material fact and requested a formal hearing. The matter was forwarded to the Division of Administrative Hearings for formal proceedings on January 4, 1994. The case was initially scheduled for hearing for June 9-10, 1994, as Respondent's counsel was not available until May, 1994. Thereafter, on an unopposed motion the matter was continued and rescheduled for November 16-17, 1994.

The Agency's request for leave to file an amended final agency audit report was granted. As Petitioner stipulated to the validity of the statistical formulas used to calculate Medilab's overpayment, to the sample size used by the Agency to determine the overpayment, and to the methodology used to generate the random sample, no conclusion is reached as to the total amount of the alleged overpayment. The issue resolved by this order is whether the sample records demonstrate an inappropriate payment or not. Petitioner argues that it operated as a diagnostic center and conducted all testing based upon a physician order; therefore, it claims, Medilab was entitled to all payments.

At the hearing the Agency presented the testimony of the following witnesses: William K. Allen, a medical health care program analyst employed by the Agency; and Dr. John Sullenberger, chief medical consultant for the Medicaid program. Its exhibits numbered 1 through 11 were admitted into evidence. Roberto Jesus Rodriguez, president and administrator of Medilab, testified on behalf of Petitioner.

Joint exhibits numbered 1 through 6 were admitted into evidence. The parties' joint prehearing statement was filed on November 4, 1994. Pertinent facts from that document are incorporated below.

The transcript of the proceedings was filed on January 11, 1995. The parties waived the requirements of Rule 28-5.402 Florida Administrative Code; and, by stipulation, agreed to submit their proposed recommended orders within twenty days of the filing of the transcript. Specific rulings on the parties' proposed findings of fact are included in the appendix at the conclusion of this order.

FINDINGS OF FACT

1. The Agency is the state agency responsible for administering the Florida Medicaid program.

2. At all times material to this case, Medilab was a medicaid provider.

3. Medilab enrolled as a physician group provider on or about October 2, 1991. Medilab was not enrolled with the Florida Medicaid program as a diagnostic lab.

4. At all times material to this case, Medilab was owned and operated by Roberto Rodriguez and Jorge Nunez.

5. Mr. Rodriguez handled the administrative duties for Medilab while Mr. Nunez operated the diagnostic portion of the business.

6. Medilab operated several machines for diagnostic evaluations as ordered by a physician. Such machines produced documentation which was then evaluated by another physician. Dr. Carmouze did not perform the service nor interpret the diagnostic results.

7. When Medilab applied for a provider number to enroll in the Medicaid program it represented that services were to be provided by Dr. Arnoldo Carmouze. It was further represented that Dr. Carmouze would treat or supervise treatment of patients on behalf of the Medilab "group."

8. On or about January 11, 1992, Medilab received its group provider number along with a copy of the Medicaid Physician Provider Handbook. Medilab was notified that it could begin billing for services beginning October 2, 1991.

9. Subsequently, the Agency performed an audit of Medilab for the period October 2, 1991 through August 31, 1992.

10. Li-Hsiang Wu, a computer systems project analyst employed by the Agency, generated a random sample of Medicaid recipients by using a computer program to calculate the total number of Medicaid recipients for which claims were submitted during the audit period. Then Medilab's provider number and the dates of the audit were used to generate the total number of Medicaid recipients for whom claims were submitted by Medilab for the audit period.

11. Once the total number of recipients was identified, Ms. Wu generated a list of forty-three recipient numbers which were selected by the computer from the total number claimed by Medilab for the period searched.

12. Mr. Allen then requested and obtained from Medilab the medical records for the same forty-three randomly selected Medicaid recipients.

13. The medical records were first reviewed by Phyllis Stiver, the Agency's registered nurse consultant.

14. Once Ms. Stiver completed her initial review, Mr. Allen requested additional records from Medilab. Specifically, documentation for the office visit and records that established the necessity for the tests performed by Medilab were requested for each of the forty-three recipients.

15. Medilab subsequently submitted additional records to the Agency which were also reviewed by Ms. Stiver.

16. Ms. Stiver determined that based upon her review of the forty-three records, Medilab had violated Medicaid rules and policy as follows:

A. Medilab failed to have all of the medical records signed by a physician and dated; and
B. Medilab failed to document in the medical records to show that certain diagnostic tests were performed.

17. After Ms. Stiver completed her review of the records, Dr. Sullenberger reviewed each of Medilab's medical records for the forty-three patients.

18. Dr. Sullenberger determined, and it is found, that the majority of the tests performed by Medilab were not medically necessary based upon the symptoms documented for each patient, the prior patient histories established by the records, and the absence of other, less expensive testing that would normally be utilized to determine a medical condition.

19. Virtually all of the patient records reviewed recited the same medical complaints: chest pain, shortness of breath, palpitation, numbness or tingling in extremities, and dizziness.

20. Only five of the forty-three patients were over 49 years of age. The ages of the majority of the forty-three were under 50. That age group is rarely afflicted by the types of medical conditions which the Medilab equipment was used to detect.

21. The symptoms and medical histories recited in the medical records did not justify the tests performed by Medilab for the following patients (recipients identified in this record as numbers 1 through 43): 1, 2, 17, 18, 21, 22, 24, 25, 32, 34, 35, 37, 38, and 41.

22. With the exception of the electrocardiogram, the symptoms and medical histories recited in the medical records did not justify the tests performed by Medilab for the following patients (recipients identified in this record as numbers 1 through 43): 3, 4, 5, 6, 7, 9, 11, 12, 13, 15, 16, 19, 20, 23, 26, 27, 29, 30, 31, 33, 36, 39, 40, 42, and 43.

23. With regard to recipient 8, except for the electrocardiogram and the abdominal ultrasound, the tests performed by Medilab were medically unnecessary.

24. With regard to recipient 10, except for the electrocardiogram and the Doppler echocardiogram, the tests performed by Medilab were medically unnecessary.

25. With regard to recipient 14, except for the electrocardiogram and the echocardiogram, the tests performed by Medilab were medically unnecessary.

26. With regard to recipient 28, except for the mammogram, the tests performed by Medilab were medically unnecessary.

27. None of the services or testing performed by Medilab were supervised by a physician. Two physicians, Dr. Pozo and Dr. Pereira, radiologists, read the diagnostic results but were not on site to perform or supervise the tests on a daily basis.

28. Dr. Pozo did not supervise the services that were provided at Medilab.

29. Dr. Pereira, who is deceased and whose testimony was not available, did not supervise the services that were provided at Medilab. According to Mr. Nunez, Dr. Pereira had someone from his office courier the tests results and his interpretations to and from the Medilab facility. Dr. Pereira may have visited the facility on occasion but was not there during its full hours of operation.

30. Dr. Carmouze, the treating physician and representative for Medilab's physician group, did not supervise the services at Medilab. Dr. Carmouze treated over 95 percent of the total patients referred to Medilab yet Dr. Carmouze never billed the Medicaid program for the patients' office visits.

31. For the audit period, of the 493 different patients Medilab billed Medicaid for, Dr. Carmouze is the only treating physician identified by the records.

32. The Medicaid Physician's Handbook, supplied to Medilab at the time of its enrollment, specified that to be reimbursable the services performed by a

physician group provider had to be medically necessary and supervised by a physician.

33. The Medicaid Provider Agreement required Medilab to keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services rendered for five years.

34. All tests performed by Medilab were documented with a physician's order for same.

35. Medilab submitted for review all medical and fiscal records it maintained in its attempt to fully justify and disclose the extent of the services it rendered.

CONCLUSIONS OF LAW

36. The Division of Administrative Hearings has jurisdiction over the parties to, and the subject matter of, these proceedings.

37. The Agency has the burden of proof to establish whether an overpayment was made to Medilab. It has met that burden.

38. Section 409.907, Florida Statutes, provides, in pertinent part:

> The department may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with the department, who is performing services or supplying goods in accordance with federal, state, and local law . . .
>
> (1) Each provider agreement shall require the provider to comply fully with all state and federal laws pertaining to the Medicaid program . . .
>
> (2) Each provider agreement shall be a voluntary contract between the department and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient . . .
>
> (3) The provider agreement developed by the department, in addition to the requirements specified in subsections (1) and (2), shall require the provider to:
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> * * *
>
> (b) Maintain in a systematic and orderly manner all medical and Medicaid-related records as the department may require and as it determines necessary for the services or goods being provided.
>
> (c) Retain all medical and Medicaid-related records for a period of 5 years to satisfy all necessary inquiries by the department.

39. Rule 59G-1.002, Florida Administrative Code (formerly Rule 10C-7.030, Florida Administrative Code), provides, in pertinent part:

> (2) Definitions of common terms appearing in Chapter 59G, F.A.C.:
> (a) "Provider" is any group, individual or organization enrolled in or under contract pursuant to 59G-5, F.A.C., Medicaid Contracts for Prepaid Health Care Plans, with the Medicaid program and eligible to provide Medicaid compensable services.
> * * *
> (7) Services or goods billed to the Medicaid program must be necessary, Medicaid compensable and of a quality comparable [to] those furnished by the provider's peers, and the services or goods must have been actually provided to eligible Medicaid recipients by providers prior to submitting a claim. Any payment made by Medicaid for services or goods not furnished in accordance with these provisions is subject to recoupment and the Agency reserves the right in such instances to initiate other appropriate administrative or legal action.

40. At all times material to this case, "Medicaid services" or "Medicaid care" has meant medically necessary medical care or services eligible for payment by the Medicaid program. "Medically necessary" requires that the service be consistent with symptoms or be consistent with generally accepted professional medical standards. See Rule 59G-4.230, Florida Administrative Code (formerly Rule 10C-7.038, Florida Administrative Code). See also Rule 59G-1.010, Florida Administrative Code.

41. Further, such services are to be provided by or under the personal supervision of a doctor. "Personal supervision" is defined as:

> Services provided while the physician is in the building and for which the physician assumes responsibility and signs and dates the chart on the same date the service is provided. If the physician's signature cannot be obtained on the date of service due to time constraints, the signature must be obtained within 24 hours of the service.

See former Rule 10C-7.038, Florida Administrative Code.

42. Section 409.913, Florida Statutes, authorizes the Agency to impose an administrative sanction when a provider fails to comply with its provider agreement or provisions of law.

43. As the Agency has established that the claims submitted by Medilab were not "physician services," it is entitled to recover the full amounts paid for the audit period. Additionally, it is entitled to impose an administrative fine due to the failure of Medilab to comply with provisions of law.

RECOMMENDATION

Based on the foregoing, it is, hereby,

RECOMMENDED:

That the Agency for Health Care Administration, Medicaid Program Integrity Office, issue a final order charging Medilab for the full amounts paid for the audit period as the services rendered were not supervised by a physician and were, therefore, not "physician services." Additionally, the Agency should impose an administrative fine in an amount not to exceed $5,000.00.

DONE AND RECOMMENDED this 1st day of March, 1995, in Tallahassee, Leon County, Florida.

JOYOUS D. PARRISH
Hearing Officer
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Filed with the Clerk of the
Division of Administrative Hearings
this 1st day of March 1995.

APPENDIX TO RECOMMENDED ORDER, CASE NO. 94-0096

Rulings on the proposed findings of fact submitted by the Petitioner:

1. Paragraphs 1, 2, 4, 6, and 12 are accepted.
2. Paragraph 3 is rejected as not supported by the weight of credible evidence.
3. Paragraph 5 is rejected as irrelevant.
4. Paragraph 7 is accepted as to the general statement but is rejected as to the amount claimed.
5. Paragraph 8 is rejected as a mischaracterization of testimony; it is accepted Dr. Sullenberger, on further reflection and in an effort to be consistent, gave Medilab the benefit of doubt and modified disallowed items.
6. Paragraph 9 is rejected as irrelevant.
7. Paragraph 10 is rejected as irrelevant.
8. Paragraph 11 is rejected as contrary to weight of credible evidence.
9. Paragraph 13 is rejected as irrelevant or argument.
10. Paragraph 14 is rejected as irrelevant. That Dr. Carmouze never charged for the alleged office visits that generated the referral for tests was the relevant fact.
11. Paragraph 15 is accurate but is irrelevant in light of the stipulation.

Rulings on the proposed findings of fact submitted by the Respondent:

1. Paragraphs 1 through 36, 39, 41, 43, 46, 48, 49, 50, 52, and 53 are accepted.
2. Paragraphs 37, 38, 40, 42, and 47 are rejected as argument.
3. Paragraph 44 is rejected as hearsay not supported by direct evidence.
4. Paragraph 45 is rejected as not supported by the weight of credible evidence.
5. With regard to paragraph 51, the first sentence is accepted; the remainder rejected as not supported by the weight of credible evidence.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions to this Recommended Order. All agencies allow each party at least 10 days in which to submit written exceptions. Some agencies allow a larger period within which to submit written exceptions. You should contact the agency that will issue the final order in this case concerning agency rules on the deadline for filing exceptions to this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the final order in this case.