STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF MEDICINE,	)	
Petitioner,	)	
vs.	)	Case Nos. 01-4548PL
	)	01-4549PL
JOEL K. SHUGAR, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Notice was provided and a formal hearing was held on March 12 through 14, 2002, in Tallahassee, Florida, and conducted by Harry L. Hooper, Administrative Law Judge, with the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Diane K. Kiesling, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Room 3226, Mail Stop 39
Tallahassee, Florida 32308

For Respondent: Gary A. Shipman, Esquire
Brian Newman, Esquire
Pennington, Moore, Wilkinson,
Bell & Dunbar, P.A.
Post Office Box 10095
Tallahassee, Florida 32302-2095

STATEMENT OF THE ISSUE

Whether Respondent's medical license should be disciplined because he filed false insurance claims.

PRELIMINARY STATEMENT

An Administrative Complaint was filed before the Board of Medicine in the case of Dr. Joel K. Shugar (Dr. Shugar) on April 20, 2001, which was assigned to the Division of Administrative Hearings (DOAH) Case Number 01-4549PL. A second Administrative Complaint was filed on September 26, 2001, which was assigned DOAH Case Number 01-4548PL. In both cases Respondent demanded a formal hearing before DOAH, and on November 27, 2001, the agency referral was filed with DOAH. In response to the DOAH's Initial Order, the parties, among other things, requested that the cases be consolidated. By Order filed December 5, 2001, the cases were consolidated under DOAH Case Number 01-4548PL.

The cases were set for March 11 though 14, 2002. Due to the necessity to address certain discovery issues, the case did not proceed to a final hearing until March 12, 2002.

The Administrative Complaints in this case, as originally filed, charged violations of Section 458.331(1)(h) and (n), Florida Statutes. Petitioner withdrew all charges under Section 458.331(1)(n), Florida Statutes, during the final hearing. Petitioner also withdrew the request contained in the consolidated complaint that a sanction involving suspension or revocation of license be recommended.

Petitioner called Ms. V.A.A.; Jean Acevedo; Diana Calderone, M.D. (by videotaped deposition); and Thomas Breza, M.D. (by videotaped deposition). Petitioner offered and had admitted Exhibits 1-6, 8-10, 11 (as it relates to specific admissions 6, 46, 65, 77, 82, 83, and 84 only), 12-14, 15, 15A, and 16.

Dr. Shugar presented the testimony of Margie Vaught; Mitchell King, M.D.; Sheila Hilson; and Broward Taff. Dr. Shugar also testified. Dr. Shugar offered and had admitted Exhibits 5, 9, 10, 12, 13, 15, 16, 19, and 20.

A Transcript was filed May 6, 2002. The parties jointly requested that proposed recommended orders be due on May 29, 2002. This was approved by an Order entered May 13, 2002. Both parties filed Proposed Recommended Orders on or prior to that date and they were considered in the preparation of this Recommended Order.

Because of confidentiality issues, references to patients are accomplished through the use of initials rather than names.

References to statutes are to Florida Statutes (1995), unless otherwise noted.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of medicine pursuant to Section 20.43 and Chapters 456 and 458, Florida Statutes.

2. Pursuant to Section 20.43(3)(g) Petitioner has contracted with the Agency for Health Care Administration to provide consumer complaint, investigative, and prosecutorial services required by the Division of Medical Quality Assurance, councils or boards, as appropriate, including the issuance of emergency orders of suspension or restriction.

3. Dr. Shugar is a physician holding Florida license ME 0053263, which was issued to him by Petitioner.

4. Dr. Shugar, during all times pertinent, practiced medicine in Perry, Florida. Dr. Shugar began practicing in Perry in 1991. Although Respondent is currently known to be primarily an ophthalmologist during all times pertinent, he was engaged in the general practice of medicine.

Patient B.O.

5. B.O., a 49-year-old female, became a patient of Dr. Shugar in February 1995. On June 8, 1996, Patient B.O. was seen by Dr. Shugar. He observed a lesion on her nose. Patient B.O. and Dr. Shugar were concerned that the lesion might be malignant.

6. On or about July 27, 1996, Patient B.O. presented to Dr. Shugar for the purpose of having the lesion removed. Using local anesthesia, Dr. Shugar surgically removed the lesion and some surrounding tissue. This material was sent to a pathologist in Tallahassee, Florida, who upon examination,

opined that the growth was a benign nevus rather than a carcinoma.

7. On August 5, 1996, the sutures were removed and Patient B.O.'s medical records indicated that the area was, "well healed." Patient B.O. had no complaints with regard to the outcome of the surgery.

8. When Patient B.O. subsequently received a bill in the amount of $2,225, she was shocked at the amount. She called Respondent's office and her insurance company. She personally paid only $100.

9. Sheila Hilson was the person who assigned Physicians' Current Procedural Terminology (CPT) codes for Dr. Shugar. CPT codes are numbers assigned to actions taken during patient evaluation and management and to procedures performed. CPT codes are widely used by government agencies and insurance companies.

10. CPT codes translate into dollar amounts used for billing patients and provide the basis for reimbursement by insurers and governmental agencies. A CPT code for a simple procedure will translate into a certain number of dollars. A CPT code for a more complex procedure will translate into a larger number of dollars.

11. Dr. Shugar utilized a superbill, which is a list of CPT codes provided in the written word and in a bar code. The

superbill contained only the most common ailments. In the usual case, Dr. Shugar, subsequent to treating a patient, would circle the appropriate CPT code on the superbill. The superbill with the circled item would then be forwarded to his administrative office and the appropriate charge would be billed to the patient or third party payer in accordance with Dr. Shugar's direction.

12. If the superbill did not contain an item for a particular procedure, Dr. Shugar would make a note on a patient and evaluation management form and his clerical staff would divine the correct CPT code from his note.

13. Dr. Shugar did not regularly supervise the billing process. He would only become involved when a problem was encountered.

14. As noted above, Dr. Shugar, during times pertinent, had a general or family type practice which meant that he treated a wide variety of ailments. Because of this, it was impossible for his superbill to reflect all of the work that he accomplished.

15. The procedure performed on Patient B.O. was not reflected on the superbill. This being so, Ms. Hilson reviewed Respondent's notes on the patient management and evaluation record and determined a CPT code. This was her usual practice when the procedure was not listed on the superbill.

16. Ms. Hilson, when reviewing the patient evaluation and management form, noted that Respondent had performed work on Patient B.O.'s nose and observed the word "plasty." She began her code determination exercise by turning to the section under "nose" and thereafter went to the section under "repair." Following this trail resulted in the conclusion that the procedure was a rhinoplasty.

17. As will be noted hereinafter, determining correct CPT codes is fraught with difficulty and often experts on CPT codes will disagree as to the proper code to be assigned when presented with identical descriptions of a procedure. That having been said, Ms. Hilson's determination, nevertheless, was far off the mark.

18. A rhinoplasty, CPT Code 30400, is what is colloquially called a "nose job." A rhinoplasty is a substantially more involved procedure than the excision of a lesion. Moreover, it is usually, but not always, considered a cosmetic procedure of a type not usually reimbursed by insurance.

19. Ms. Hilson also filed for this procedure under CPT Code 13152, "Repair, complex, scalp, arms, and/or legs; . . . 2.6 cm to 7.5 cm."

20. It was this error that resulted in Patient B.O.'s being shocked when she received her bill. The bill, in the form of a claim, was also sent to B.O.'s medical insurance carrier.

21. Patient B.O.'s insurance carrier responded to the claim with a letter dated August 27, 1996, which was date stamped by Respondent's office on September 5, 1996. This letter requested documentation as follows: (1) Degree of functional impairment; (2) date of injury; (3) X-ray report of the injury; (4) pre-operative photographs; and (5) patient's history and physical examination report. Neither the coding of the procedure nor the word rhinoplasty was mentioned in the letter.

22. On September 10, 1996, Ms. Hilson discussed the matter with Dr. Shugar for the first time. Dr. Shugar answered the carrier's letter on September 23, 1996. Neither the coding of the procedure nor the word rhinoplasty was mentioned in this letter. The response was factually correct.

23. The claim, despite the additional information supplied by Dr. Shugar, was denied by the carrier. In the ensuing months Ms. Hilson and the carrier exchanged letters. Eventually Dr. Shugar discovered that Ms. Hilson had filed a claim for a rhinoplasty.

24. Subsequently, on September 8, 1997, the claim was re-filed under CPT Codes 11441 and 13150-51. This was incorrect also and resulted in codes which caused Dr. Shugar to be inadequately reimbursed for the procedure performed.

25. Subsequent to this filing, Patient B.O.'s insurance carrier paid $600 to Dr. Shugar. This amount, along with the $100 paid to him by Patient B.O., resulted in Respondent's receiving a total of $700 for treating the lesion on Patient B.O.'s nose.

Patient V.A.A.

26. V.A.A. became a patient of Dr. Shugar in 1995. On February 14, 1996, Patient V.A.A. presented to Dr. Shugar with a lesion on her cheek and a crusted place on her nose. Both areas caused concern for malignancy which Dr. Shugar desired to rule out. Dr. Shugar made a referral to a Dr. Grate in Tallahassee, Florida, an ear, nose, and throat physician, because of Respondent's concern that the area on her nose was a basal cell carcinoma.

27. On March 23, 1996, Dr. Shugar removed the lesion on Patient V.A.A.'s cheek. Dr. Shugar noted that the lesion was 1.1 centimeters in diameter. He documented in V.A.A.'s medical record that he "excised under loupe mag., 3.0 cm length, complex closure."

28. A pathology report was generated by Ketchum Wood and Burgert Pathology Associates which diagnosed an absence of malignancy. On April 4, 1996, it was noted that the incision was "well healed."

29. Ms. Hilson reviewed the Patient Evaluation and Management Record and filed a claim with Patient V.A.A.'s insurance carrier for the cheek surgery using CPT Codes 11403 and 13131. CPT Code 11403 addresses, "Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; . . . lesion diameter 2.1 to 3.0." CPT Code 13131 addresses, "Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 1.1 cm to 2.5 cm."

30. Ms. Hilson's use of CPT Code 11403 was improper because that code does not address procedures involving the cheek and because the lesion, as noted in the Patient Evaluation and Management Record, was 1.1 centimeters. It was the length of the closure which was three centimeters.

31. Upon consideration of all the available evidence, it appears that Ms. Hilson simply made a coding error because of a transposition of the length of the lesion and the length of the closure. Because of the coding error, Dr. Shugar obtained less compensation than he was entitled to.

32. When Patient V.A.A. came to Dr. Shugar on April 4, 1996, for follow-up on her cheek incision, Dr. Shugar was concerned because Patient V.A.A. had not visited Dr. Grate as she had been advised. Patient V.A.A. had decided to forgo treatment by Dr. Grate because her medical insurance would not pay for treatment by him.

33. Dr. Shugar had previously made a differential diagnosis on the suspicious area on V.A.A.'s nose of basal cell and squamous cell carcinoma. The passage of time since February 14, 1996, when he first observed the area, and a closer examination of the area, enabled Dr. Shugar to make a diagnosis of basal cell carcinoma during the April 4, 1996, visit.

34. After considering the desires of Patient V.A.A. and the treatment regimens available in the local area, Respondent decided on that date to prescribe Efudex. Efudex is a chemical, which when applied to a growth on the skin, will destroy the growth and, for that matter, skin not having a growth upon it. Dr. Shugar referred to this procedure as, "Chemical treatment of malignancy."

35. This was billed by Ms. Hilson under CPT Code 17283. This code is under the general heading of, "Destruction, Malignant Lesions, Any Method," and specifically, "Destruction, malignant lesion, any method, face, ears, eyelids, nose, lips, mucous membrane,: . . . lesion diameter 2.1 to 3.0 cm."

36. Patient V.A.A. obtained the Efudex and applied it to the lesion herself, having been instructed by Dr. Shugar as to its proper use.

37. On April 25, 1996, Dr. Shugar saw Patient V.A.A. and instructed Patient V.A.A. to discontinue the use of the Efudex.

On May 29, 1996, V.A.A.'s last visit with him, Dr. Shugar noted that the carcinoma on her nose was "well-treated."

38. After receiving the superbill for the April 4, 1996, treatment provided to Patient V.A.A., Ms. Hilson selected CPT Code 17283. She selected this code based upon Dr. Shugar's note that he had used "chemical treatment." This selection was not discussed with Dr. Shugar.

39. When Patient V.A.A. received her explanation of benefits she believed it to be in error because it indicated a surgical procedure had been performed on April 4, 1996. She contacted Dr. Shugar's office on September 5, 1996, and pointed out that she did not have a surgical procedure on April 4, 1996. Dr. Shugar called her and explained that the chemical treatment, according to the CPT manual, was the same as a surgical procedure.

40. In the 1996 CPT Code Manual, the narrative description for CPT Code 17283 states, "Destruction, malignant lesion, any method, . . . nose." Destruction is further defined to include chemical treatment.

41. The CPT Code Manual language is amended from year to year to resolve ambiguities and confusion over code selection. In 1999, the CPT Code Manual was amended to clarify that initiation of treatment with Efudex should no longer be billed

under the series of codes for chemical treatment of benign lesions. Dr. Shugar was correct in his use of the 1996 manual.

42. Patient V.A.A. was insured under a cancer policy issued by American Family Life Assurance Company. In October of 1996, Patient V.A.A. was provided a claims form by her insurance representative. She called Dr. Shugar to inquire again about the nature of the procedure he provided.

43. Patient V.A.A.'s insurance representative suggested that she complete it and send it to the insurance company. She either faxed or personally delivered it to Dr. Shugar's office.

44. Subsequently, she received the claims form from Dr. Shugar's office. The claims form has what appears to be Dr. Shugar's initials on it. Dr. Shugar denied that he initialed the form. Broward Taff, who was accepted as a handwriting expert, testified that the initials on the claim form were inconsistent with the more than one hundred known signatures and initials provided by Dr. Shugar.

45. The claim to the insurance company would have resulted in a payment directly to Patient V.A.A. The record contains no evidence that Dr. Shugar was aware that the claim form was submitted to his office or that he participated in its completion.

Petitioner's experts

46. Jean Acevedo conducts coding and billing compliance audits for health care practices. She is a licensed health care risk manager and a certified professional coder. She was accepted as an expert in the area of CPT coding.

47. In conducting an audit she reviews between ten and 15 patients per provider. Physicians make mistakes when determining CPT codes upon which billing amounts are determined. She is of the opinion that a physician who is in a general practice treating a wide variety of maladies is apt to make more billing errors than a physician who is a specialist.

48. When performing a compliance audit on providers who have been previously determined to have submitted false bills, Ms. Acevedo will audit between 20 to 50 patient charts. She considers a provider to be in compliance so long as the errors do not exceed five percent of the total dollar amount of the charges billed.

49. The testimony of Ms. Acevedo was credible.

50. Thomas Breza, M.D., is a dermatologist. He was accepted as an expert witness in the area of CPT coding.

51. He never performs services which are not on his superbill. It is his opinion that physicians are responsible for every billing error which results in an incorrect claim being filed. He believes he would be committing fraud if he

allowed an incorrect bill to leave his office. However, Dr. Breza admitted that he has mailed incorrect bills from his office.

52. Dr. Breza's testimony indicated that his personal definition of fraud is different from the legal definition of fraud. His opinion, with regard to the requirements of accuracy, are based on his experience as a specialist and failed to take into account the variety of diagnoses and procedures experienced in a general practice.

53. Diana Calderone, M.D., was accepted as an expert witness in the area of CPT coding.

54. Like Dr. Breza, Dr. Calderone takes a Draconian approach when addressing coding errors. While opining that coding and resultant billing errors were unacceptable, she conceded that total accuracy is unrealistic and acknowledged that she had made mistakes in this area.

55. Dr. Calderone, is also a dermatologists with little or no experience with the coding problems inherent in a general practice.

56. Margie Vaught is an independent health care consultant. She is a certified professional coder, and sits as a board member of the National Advisory Board of the American Academy of Professional Coders. She performs compliance audits

for health care practices. She was accepted as an expert witness in the area of CPT coding.

57. She reviews between ten to 30 patient charts per practitioner when doing a compliance audit. She has never made an audit that did not reveal coding errors.

58. Ms. Vaught reviewed all of the information provided in this case regarding the bills prepared by Dr. Shugar. It is her opinion that there is insufficient information for one to determine whether there is any pattern to Dr. Shugar's billing procedures.

59. Ms. Vaught noted that the HCFA Form 1500 was a form developed for billing in the case of federal medical programs. A HCFA Form 1500 will be accepted by federally funded programs with the signature of a physician's agent rather that the actual signature of the physician. She explained that many private carriers use the HCFA Form 1500 for billing purposes and some of them require no signature.

60. Ms. Vaught's testimony was credible.

61. Mitchell King, M.D., is a board-certified family practice physician. He is an assistant professor and director of the Department of Family Medicine at Northwestern University Medical School in Chicago. Dr. King was accepted as an expert in the area of CPT coding.

62. Dr. King has published three studies related to CPT coding by family practice physicians. One of the studies demonstrated that 38 percent of family practice physicians delegate all or a portion of CPT coding to a staff member. Another found that physicians selected the wrong code 48 percent of the time. Another found that certified coders disagreed as to the appropriate code 43 percent of the time.

63. Dr. King agreed with Ms. Acevedo to the effect that a family practice physician would have more coding errors because of the broad nature of the services rendered. He believes that the CPT code manual is difficult to use.

64. Dr. King's testimony was accepted as credible.

CONCLUSIONS OF LAW

65. The DOAH has jurisdiction over the parties and the subject matter in accordance with Sections 120.57(1) and 456.073(5), Florida Statutes (2000).

66. The party seeking to prove the affirmative of an issue has the burden of proof. Florida Department of Transportation v. J.W.C. Company, Inc., 396 So. 2d 778 (Fla. 1st DCA 1981); and Balino v. Department of Health and Rehabilitative Services, 348 So. 2d 349 (Fla. 1st DCA 1977). Therefore, the burden of proof is on Petitioner.

67. Because this case is penal in nature, the material allegations set forth in the Administrative Complaint must be

proven by clear and convincing evidence. Department of Banking and Finance v. Osborne Stern and Company, 670 So. 2d 932 (Fla. 1966).

68. Even though Section 458.331(3), Florida Statutes, seems to provide a standard of proof of "by the greater weight of the evidence," in a case not involving a suspension or revocation of a license, the standard provided by the statute is trumped by the holding in Osborne Stern. Although the language of Osborne Stern does not expressly state that it is grounded in constitutional considerations, the court's discussion of the taking of a property interest leads to that conclusion.

69. Section 458.331(1)(h), Florida Statutes, provides as follows:

> 458.331 Grounds for disciplinary action; action by the board and department.--
>
> (1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (h) Making or filing a report which the licensee knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the capacity as a licensed physician.

70. Petitioner alleged that Dr. Shugar violated Section 458.331(1)(h), Florida Statutes, by "making or filing a report which the licensee knows to be false." This parrots the language found in the first sentence of the statute.

71. The word false has pejorative connotations which do not fit the facts found in this case. Clearly, there is evidence of record that incorrect reports emanated from Dr. Shugar's office. It is equally clear that Dr. Shugar has a duty to ensure that CPT codes and resulting bills are correct. The failure to ensure that they are correct has civil, as opposed to penal, consequences. In other words, if he files incorrect bills, he may be liable to repay any overpayments made to him as a result.

72. The record in this case is devoid of any evidence that Dr. Shugar signed the claims in question or that he knew that the submissions were false. Accordingly, he did not violate the provisions of Section 458.331(1)(h), Florida Statutes.

RECOMMENDATION

Based upon the Findings of Fact and Conclusions of Law,

RECOMMENDED:

That a final order be entered which dismisses the allegations of the complaints.

DONE AND ENTERED this 11th day of June, 2002, in Tallahassee, Leon County, Florida.

____

HARRY L. HOOPER
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 11th day of June, 2002.

COPIES FURNISHED:

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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.