STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ARNALDO R. QUINONES, M.D.,	)	
	)	
Petitioner,	)	
	)	
vs.	)	Case No. 04-1279MPI
	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
	)	
Respondent.	)	
	)	

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted on August 19 and 20, 2004, in Miami, Florida, before Administrative Law Judge Claude B. Arrington of the Division of Administrative Hearings (DOAH).

APPEARANCES

For Petitioner: Louise T. Jeroslow, Esquire
Law Offices of Louise T. Jeroslow
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Miami, Florida 33143

For Respondent: Jeffries H. Duvall, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station 3
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STATEMENT OF THE ISSUE

Whether Petitioner was overpaid by the Florida Medicaid Program and, if so, the amount of the overpayment.

PRELIMINARY STATEMENT

Respondent administers the Florida Medicaid Program. Petitioner, a licensed physician, was enrolled as a Medicaid provider with the Florida Medicaid Program during the subject Audit Period (January 1, 1996 through May 10, 1999). Following its audit, Respondent issued a Final Agency Audit Report (FAAR), which asserted that Petitioner had been overpaid by the Florida Medicaid Program in the amount of $261,336.14, and demanded repayment of that amount.

Petitioner timely requested a formal hearing to challenge Respondent's determinations as reflected by the FAAR, the matter was referred to DOAH, and this proceeding followed.

At the final hearing, Respondent presented its case first to expedite the presentation of the evidence. Respondent presented the live testimony of Pamela Langford, the deposition testimony of Dr. Joseph Shands (filed at the formal hearing), and the deposition testimony of Dr. Jeffrey P. Nadler (taken post-hearing and late-filed). Respondent offered 12 sequentially numbered exhibits, each of which was admitted into evidence. The deposition of Dr. Nadler, filed October 29, 2004, has been marked as Respondent's Exhibit 13 and admitted into evidence. Respondent's Exhibit 9 is a composite exhibit consisting of medical records for services to the 25 patients at issue, together with worksheets pertaining to the Medicaid

billings for those services. Petitioner testified on his own behalf and offered 13 sequentially marked exhibits, each of which was admitted into evidence. Official Recognition was taken of Chapter 409, Florida Statutes (1999).[1] On the joint motion of the parties, the deadline for the filing of proposed recommended orders (PROs) was extended to close of business on December 6, 2004.

A Transcript of the proceedings was filed on September 22, 2004. Each party filed a PRO, which has been duly-considered by the undersigned in the preparation of this Recommended Order.

FINDINGS OF FACT

1. At all times material to this proceeding, Respondent has been the state agency charged with responsibility for overseeing the Florida Medicaid Program, including the recovery of overpayments to Medicaid providers pursuant to Section 409.913, Florida Statutes.

2. At all times material to this proceeding, Petitioner was an authorized Medicaid provider, having been issued provider number 377290000. Petitioner had valid Medicaid Provider Agreements with the Agency for Health Care Administration (AHCA) during the Audit Period, which began on January 1, 1996, and ended on May 10, 1999.

3. Petitioner graduated from the University of Puerto Rico School of Medicine in 1987, did an internship at Tulane

University, did a residency in internal medicine at Eastern Virginia Graduate Medical School, and did a fellowship in hematology at Washington Hospital Center. He served as Chief of Hematology for Kessler Medical Center in Biloxi, Mississippi, while serving in the United States Air Force (with the rank of major). At the time of the final hearing, Petitioner was licensed to practice medicine in Florida, Virginia, Puerto Rico, and Washington, D.C. At the time of the final hearing, Petitioner was employed by the National Institutes of Health (NIH) as a Medical Officer, Health Scientist Administrator. Petitioner served as an advisor to the director of the NIH on issues related to HIV (human immunodeficiency virus) and AIDS (acquired immunodeficiency syndrome).

4. Petitioner's specialty is internal medicine with a sub-specialty in hematology. Petitioner has extensive experience treating persons suffering with HIV and AIDS dating back to 1987.

5. Pursuant to his Medicaid Provider Agreements, Petitioner agreed to: (1) retain for five years complete and accurate medical records that fully justify and disclose the extent of the services rendered and billings made under the Medicaid program; (2) bill Medicaid only for services or goods that are medically necessary; and (3) abide by the Florida Administrative Code, Florida Statutes, policies, procedures,

manuals of the Florida Medicaid Program and Federal laws and regulations.

6. Respondent audited Petitioner's Medicaid claims during the Audit Period and conducted a peer review of Petitioner's billings and medical records of 25 of Petitioner's patients as part of that audit.[2] Joseph W. Shands, M.D., conducted the peer review of the documentation provided by Petitioner for purposes of the audit conducted by AHCA. Dr. Shands first reviewed documentation provided by Petitioner in 1999. He had no further participation in the audit until he reviewed information in preparation for his deposition in this proceeding.

7. Dr. Shands graduated from medical school in 1956, trained in internal medicine, and worked as a microbiologist for approximately 15 years. He served as Chief of Infectious Diseases at the University of Florida for 23 years and also treated patients through the Alachua County Public Health Department and Shands Hospital at the University of Florida. Dr. Shands' practice was devoted almost entirely to the treatment of patients diagnosed with HIV/AIDS.

8. Dr. Shands retired from the practice of medicine in May 2002. For three years prior to his retirement, Dr. Shands practiced medicine part-time.

9. Petitioner was sent a Preliminary Agency Audit Report (PAAR) dated May 25, 1999, that found an overpayment in the

amount of $862,576.72. In response to that PAAR, Petitioner had the attorney representing him at that time respond to AHCA in writing. The letter from the attorney, dated June 2, 1999, requested a copy of AHCA's supporting materials and clarification of certain matters. AHCA did not respond.

10. AHCA issued its FAAR on January 22, 2004, asserting that Petitioner was overpaid by the Florida Medicaid Program in the total amount of $261,336.14 for services that in whole or in part were not covered by Medicaid. There was no plausible explanation why the FAAR was not issued until 2004, whereas the audit period ended in 1999. The difference between the amount of the alleged overpayment reflected by the PAAR and the amount of the alleged overpayment reflected by the FAAR is attributable to the use of different methodologies in calculating the amounts overpaid. The FAAR used the correct methodology that was not challenged by Petitioner.

11. The FAAR sets forth five categories of alleged overpayments. Each category accurately describes an overpayment based on applicable Medicaid billing criteria. The five categories are as follows:

> Medicaid policy specifies how medical records must be maintained. A review of your medical records revealed that some service for which you billed and received payment were not documented. Medicaid requires documentation of the services and considers payments made for services not

appropriately documented an overpayment. (For ease of reference, this will be referred to as Category I.)

Medicaid policy defines the varying levels of care and expertise required for the evaluation and management procedure codes for office visits. The documentation you provided supports a lower level of office visit than the one for which you billed and received payment. The difference between the amount you were paid and the correct payment for the appropriate level of service is considered an overpayment. (For ease of reference, this will be referred to as Category II.)

Medicaid policy addresses the type of pathology services covered by Medicaid. You billed and received payment for laboratory tests that were performed outside your facility by an independent laboratory. Payments made to you in these instances are considered overpayments. (For ease of reference, this will be referred to as Category III.)

Medicaid policy requires the Medicaid services be provided by or under the personal supervision of a physician. Personal supervision is defined as the physician being in the building when the services are rendered and signing and dating the medical records within twenty-four hours of service delivery. You billed and received payment for services which your medical records reflect you neither personally provided nor supervised. Payment made to you for all or a part of those services is considered an overpayment. (For ease of reference, this will be referred to as Category IV.)

Medicaid policy requires services performed be medically necessary for the diagnosis and treatment of an illness. You billed and received payments for services for which the medical records, when reviewed by a Medicaid physician consultant, indicated that the services provided did not meet the Medicaid criteria for medical

> necessity. The claims which were considered medically unnecessary were disallowed and the money you were paid for these procedures is considered an overpayment. (For ease of reference, this will be referred to as Category V.)

CATEGORY I CLAIMS

12. The disputed Category I claims can be separated into two subcategories: services performed while an employee of a corporate employer and services performed while a recipient was hospitalized. As to both subcategories Petitioner argues that he has been prejudiced by Respondent's delay in issuing the FAAR because Medicaid requires providers to retain medical records only for five years from the date of service.[3] Although Respondent was dilatory in prosecuting this matter, Petitioner's argument that Respondent should be barred (presumably on equitable grounds such as the doctrine of laches) should be rejected. Petitioner has cited no case law in support of his contention, and it is clear that any equitable relief to which Petitioner may be entitled should come from a court of competent jurisdiction, not from this forum or from an administrative agency. All billings for which there are no medical records justifying the services rendered should be denied.

CATEGORY II CLAIMS

13. The following findings as to the Category II claims are based on the testimony of the witnesses and on the

information contained in the exhibits.[4] Although nothing in the record prior to the final hearing reflects that position, Petitioner did not dispute most of the down-codings at the final hearing. Office visits, whether supported by a doctor's note or a nurse's note, for the sole purpose of administering IVIG treatment, will be discussed in the section of this Recommended Order dealing with Category V claims. The office visits, which were for the purpose of intravenous immunoglobulin (IVIG) treatment and for other reimbursable medical services, are set forth as part of the Category II disputes.

14. The following findings resolve the Category II disputes. The date listed is the date the service was rendered. The billing code following the date is the billing code that is supported by the greater weight of the evidence.

Recipient 1:[5]

01-20-98	99213

Recipient 2

09-27-96	99214
10-10-96	99213
11-13-96	99214
12-23-96	99212
02-24-97	99214
04-21-97	99213
04-28-97	99214
05-21-97	99213
06-02-97	99213
07-09-97	99213
07-23-97	99212
08-06-97	99213
08-11-97	99212

10-01-97	99213
10-10-97	99213
10-15-97	99214
10-21-97	99214
11-10-97	99213
12-08-97	99213
12-17-97	99213
12-29-97	99213
01-21-98	99213

Recipient 3

10-21-97	99213
11-04-97	99213
11-25-97	99213
12-16-97	99213
01-27-98	99214
02-26-98	99214

Recipient 4

01-03-98	99254
01-04-98	99261
01-05-98	99261

Recipient 5

09-29-97	99204

Recipient 6

11-11-97	99204
11-18-97	99213

Recipient 7

01-26-98	99204
02-23-98	99213

Recipient 8

09-26-96	99214
09-30-96	99213
10-03-96	99213
10-10-96	99212
10-25-96	99214
11-29-96	99213

12-04-96	99213
12-30-96	99213
01-22-97	99214
01-31-97	99211
02-14-97	99212
03-17-97	99214
04-04-97	99213
04-25-97	99212
05-30-97	99211
07-11-97	99213
08-08-97	99213
08-22-97	99213
09-05-97	99212
09-19-97	99214
10-31-97	99214
11-24-97	99214
12-03-97	99213
12-29-97	99213
01-09-98	99214
01-16-98	99213
01-30-98	99214
02-13-98	99214

Recipient 9

11-24-97	99203

Recipient 10

10-14-96	99205
11-04-96	99213
11-11-96	99213
11-25-96	99214
12-30-96	99213
01-27-97	99214
02-24-97	99214
03-10-97	99213
03-24-97	99212
04-07-97	99213
04-21-97	99214
05-05-97	99212
05-19-97	99213
05-21-97	Deny
06-09-97	99213
07-07-97	99212
08-04-97	99213
08-18-97	99213

09-24-97	99213[6]
10-06-97	99213
10-10-97	99214
10-27-97	99213
11-10-97	99213
11-19-97	99214
11-24-97	99213
12-08-97	99213
02-02-98	99213

Recipient 11

06-30-97	99204
11-06-97	Deny due to lack of documentation.

Recipient 12

10-14-97	99213
11-06-97	99204
11-20-97	99213
12-16-97	99213
01-06-98	99213

Recipient 13

There are no Category II billings at issue for this Recipient.

Recipient 14

There are no Category II billings at issue for this Recipient.

Recipient 15

09-16-97	99215[7]

Recipient 16

02-19-98	99212

Recipient 17

There are no Category II billings at issue for this Recipient.

Recipient 18

There are no Category II billings at issue for this Recipient.

Recipient 19

09-27-96	99212
10-01-96	99213
10-10-96	99213
10-23-96	99213
11-06-96	99213
11-20-96	99213
12-18-96	99211
12-30-96	Deny due to lack of documentation.
01-09-97	Deny due to lack of documentation.
01-22-97	99211
02-05-97	99214
03-05-97	99214
03-19-97	99211
03-24-97	99214
03-26-97	Deny due to lack of documentation.
04-02-97	99213
04-21-97	99213
05-05-97	99212
05-19-97	99213
06-02-97	99212
06-30-97	99213
07-07-97	99213
07-14-97	99213
07-28-97	99212
08-18-97	99213
08-25-97	99213
09-08-97	99213
09-15-97	99214
09-22-97	99213
10-28-97	99214
11-04-97	Deny due to lack of documentation.
11-07-97	99213
11-24-97	99213
12-29-97	99213
01-12-98	99213
01-26-98	99213

02-19-98	99214
02-23-98	99213

Recipient 20

12-04-96	99204
12-13-96	99213
01-03-97	99213
01-17-97	99213
01-27-97	99213
02-07-97	99214
02-21-97	99213
03-07-97	99214
03-21-97	99212
04-04-97	99214
04-21-97	99212
05-06-97	99213
06-04-97	99213
06-13-97	99213
06-30-97	99213
07-14-97	99213
08-04-97	99213
01-19-98	99213

Recipient 21

04-29-97	99204
05-13-97	99214
05-16-97	99213
05-23-97	99212
06-09-97	99212
06-23-97	99212
07-11-97	99211
07-25-97	99213
08-11-97	99213
09-10-97	99213
11-05-97	99214
11-19-97	99213
12-22-97	99213
01-07-98	99214
01-21-98	99213
02-04-98	99213

Recipient 22

02-16-98	99205
02-20-98	99213
02-23-98	99213

Recipient 23

06-23-97	99215
10-02-97	99213[8]

Recipient 24

There are no Category II billings at issue for this Recipient.

Recipient 25

01-24-97	99213
02-07-97	99213
02-24-97	99212
03-10-97	99213
03-24-97	99212
05-05-97	99212
05-19-97	99212
06-02-97	99212
06-16-97	99212
07-14-97	99213
07-23-97	99212
07-28-97	99213
08-18-97	99213
08-25-97	99213
09-15-97	99213
10-01-97	99213
10-13-97	99213
10-27-97	99214
12-08-97	99213
12-22-97	99213
12-29-97	99213
01-13-98	99212
01-19-98	99214
02-02-98	99212

CATEGORY III

15. As set forth in the Physician Coverage and Limitation Handbook (Respondent's Exhibit 6), Petitioner is not entitled to billings for laboratory tests that were performed outside his facility by an independent laboratory. The only billing arguably in Category III is the billing for Recipient 1 on February 19, 1998. That billing should have been approved because it was for a urinalysis by dip stick or tablet that was administered and analyzed by Petitioner. It was not analyzed by an independent laboratory.

CATEGORY IV

16. All Category IV billings pertained to Petitioner's supervision of his staff while patients were receiving treatments of IVIG. Those billings will be subsumed in the Category V billings discussion.

CATEGORY V

17. The alleged Category V overpayments relate to Petitioner's IVIG treatment of Patients 2, 8, 10, 19, 20, 21, and 25, each of whom was an adult diagnosed with AIDS. In many of these cases a nurse administered the IVIG treatment. A dispute as to whether Petitioner properly supervised the nurse while he or she administered the IVIG treatment is moot because of the findings pertaining to the IVIG treatments set forth in Paragraphs 20 and 21.

18. The Physician Coverage and Limitations Handbook requires that rendered services be medically necessary, as follows:

> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:
> the services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
> the services cannot be experimental or investigational;
> the services must reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
> the services must be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

19. The use of IVIG in adult AIDS patients is not approved by the Federal Drug Administration (FDA). The use of a drug for a purpose other than the uses approved by the FDA is referred to as an "off-label" use. The off-label use of IVIG in adult AIDS patients is not effective either from a medical standpoint or from an economic standpoint. There was a conflict in the evidence as to whether any of the Recipients at issue in this proceeding had a medical condition or conditions other than AIDS that would justify the IVIG treatment administered by Petitioner. The following finding resolves that conflict.

Utilizing applicable Medicaid billing criteria, the medical records produced by Petitioner fail to document that any of the Recipients at issue in this proceeding had a medical condition or conditions that warranted treatment with IVIG.[9]

20. All of Petitioner's billings for IVIG treatments for Recipients 2, 8, 10, 19, 20, 21, and 25 were properly denied under the rationale of the FAAR's Category V. Included in the billings that were properly denied were billings for office visits (whether documented by a doctor's note or a nurse's note) when the sole purpose of the office visit was the administration of an IVIG treatment.

CONCLUSIONS OF LAW

21. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and of the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2004).

22. An "overpayment" is defined by Section 409.913(1)(d), Florida Statutes, to include "any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." Respondent is empowered to recover overpayments. Section 409.913(10), Florida Statutes, provides part that:

> (10) The agency may require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

23. AHCA has the burden of proving an alleged Medicaid overpayment by a preponderance of the evidence. South Medical Services, Inc. v. Agency for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

24. Pertinent to this proceeding, Section 409.913(7), Florida Statutes, spells out the duties of providers who make claims under Medicaid:

> (7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:
>
> * * *
>
> (b) Are Medicaid-covered goods or services that are medically necessary.
>
> * * *
>
> (e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.

> (f) Are documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. Medicaid goods or services are excessive or not medically necessary unless both the medical basis and the specific need for them are fully and properly documented in the recipient's medical record.

25. Respondent has met its burden of proving by a preponderance of the evidence that Petitioner received overpayments from the Medicaid Program. The amount of that overpayment should be recomputed by Respondent’s staff based on the findings of fact set forth in this Recommended Order.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order adopting the Findings of Fact and Conclusions of Law set forth in this Recommended Order. It is further RECOMMENDED that the Final Order require that Petitioner repay the sum of the overpayment as determined by Respondent’s staff based on the Findings of Fact set forth in this Recommended Order.

DONE AND ENTERED this 20th day of January, 2005, in Tallahassee, Leon County, Florida.

CLAUDE B. ARRINGTON
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 20th day of January, 2005.

ENDNOTES

[1/] All references to statutes are to Florida Statutes (1999), unless otherwise indicated, and all references to rules are to the version published in Florida Administrative Code in effect as of the date of the FAAR.

[2/] The selected patients were chosen at random by computer using a program routinely employed by Respondent in conducting such audits. The medical records, to the extent they were available, were provided by Petitioner. The billings, records, and the audit worksheets constitute Respondent's composite Exhibit 9. Although the patients are identified in the medical records by name or initials, the undersigned will refer to the patients numerically consistent with the numbering set forth on the audit worksheets.

[3/] Chapter 5 of the Medicaid Provider Reimbursement Handbook provides the following record retention requirement:

> The provider must retain professional and business records on all services provided to all Medicaid recipients. All fiscal records must be retained. These records must be

kept for a period of five years from the date of service.

[4/] In particular, the medical records of the various patients have been reviewed as have the exhibits setting forth the Medicaid billing criteria, including the criteria for the billing codes for the various services of providers. Much of the dispute centered on the proper level of coding for a particular office visit or other service. Petitioner's billing codes were frequently reduced by Dr. Shands, a process referred to as down-coding, based on the criteria for the different codes, including complexity of the service and the time expended by the provider. Typically, a lower billing code for a category of services (such as office visits) will result in a lower Medicaid reimbursement. For example, a billing code of 99213 entitles the provider to a lower reimbursement than a billing code of 99214.

[5/] Due to an error, the only billing overpayments claimed for this Recipient were on the second page of the two-page worksheet. The billing overpayments the peer reviewer identified on the first page of the worksheet are not at issue in this proceeding.

[6/] The records supporting this billing were misdated.

[7/] The records supporting this billing were misdated.

[8/] The records supporting this billing were misdated.

[9/] In reaching these findings, the undersigned has carefully considered the Petitioner's testimony pertaining to each Recipient who was administered IVIG treatment, which included the reasons he believed justified the treatment, and the medical records provided by Petitioner to Respondent. The undersigned is persuaded by the testimony of Dr. Shands, who reviewed the medical records for each Recipient who had been treated with IVIG, and whose testimony is consistent with the findings made, and the failure of Petitioner to demonstrate documentation in his medical records that would justify IVIG treatment. The undersigned has also considered the literature submitted by Petitioner, but finds that the principal authority he relied upon, a 1996 study led by a German doctor named Kiehl, should not be credited because of the flawed methodology of the study.

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.