STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ORTHOPAEDIC MEDICAL GROUP OF TAMPA BAY/STUART A. GOLDSMITH, P.A.,	)	
Petitioner,	)	
vs.	)	Case No. 04-4625MPI
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Respondent.	)	

RECOMMENDED ORDER

A final hearing was held before Daniel M. Kilbride, Administrative Law Judge of the Division of Administrative Hearings, pursuant to notice on September 28, 2005, in Tallahassee, Florida.

APPEARANCES

For Petitioner: William M. Furlow, III, Esquire
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For Respondent: Grant P. Dearborn, Esquire
Agency for Health Care Administration
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STATEMENT OF THE ISSUE

Whether Petitioner is liable for overpayment of Medicaid claims for the period of January 1, 2001, through January 1,

2003, as stated in Respondent's Final Agency Audit Report dated October 26, 2004, in violation of Sections 409.907 and/or 409.913, Florida Statutes (2002), and, if so, in what amount.

PRELIMINARY STATEMENT

By Final Agency Audit Report dated October 26, 2004 ("Audit Report"), the Agency for Health Care Administration ("Respondent") notified Orthopaedic Medical Group of Tampa Bay/Stuart A. Goldsmith, P.A. ("Petitioner"), that he was liable for overpayment of Medicaid claims in the amount of $82,223.86, for the period from January 1, 2001, through January 1, 2003 ("Audit Period"). Petitioner disputed being liable for reimbursement to Respondent for overpayment of the Medicaid claims and requested a formal administrative hearing. On December 21, 2004, this matter was referred to the Division of Administrative Hearings. Upon being assigned to the undersigned Administrative Law Judge, discovery ensued. Prior to the final hearing, Petitioner submitted additional documentation to Respondent. Respondent reviewed the additional documents and reduced the proposed overpayment to $81,682.06.

At the hearing, Respondent presented the live testimony of Blanca Notman, registered nurse (R.N.); and the deposition testimony of Philip F. Averbuch, M.D., accepted as an expert witness. Petitioner presented the live testimony of Jeffrey Howard, consultant for Petitioner, as an expert witness. There

were 30 joint exhibits introduced into evidence, and Respondent offered 13 composite exhibits which were also admitted.

Official recognition was taken of the 2000 through 2002 versions of Sections 409.907 and 409.913, Florida Statutes (2002); Florida Administrative Code Rules 59G-5.010, 59G-5.020, 59G-5.110, and 59G-4.230; and Current Procedural Terminology, Fourth Edition (CPT), American Medical Association (1999). In addition, official recognition was taken of the Physician Coverage and Limitations Handbook, January 2001 edition, pp. 2-76, 2-80, and 3-1; January 2002 edition, pp 2-84, 2-88, and 3-1, and Update Log; Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-Up 221 (Medicaid Provider Reimbursement Handbook), Update Log, July 1999 edition, pp. 2-19 through 2-21, and May 2001, pp. 2-45 through 2-47; and Documentation Guidelines for Evaluation and Management Service, May 1997 edition, American Medical Association and Health Care Financing Association ("HCFA").

The parties each timely submitted Proposed Recommended Orders which have been carefully considered in the preparation of this Recommended Order.

FINDINGS OF FACT

Based upon the stipulations of the parties and the evidence presented at the hearing, the following relevant Findings of Fact are made:

1. Respondent is the state agency charged with the regulation of the Medicaid program in the State of Florida and has the authority to perform Medicaid audits and collect overpayments, pursuant to Section 409.913, Florida Statutes (2002).

2. Petitioner is a Florida-licensed physician and an authorized Medicaid provider. He was paid by Medicaid for providing services to Medicaid patients during the Audit Period of calendar years 2001 and 2002.

3. Blanca Notman, R.N., Medicaid health care analyst in Respondent's Medicaid Program Integrity Unit, conducted the audit of Petitioner's Medicaid billing during the Audit Period. Respondent's audit involved a review of services Petitioner provided during the Audit Period of 30 randomly chosen Medicaid patients. Upon completion of the audit, Respondent alleged that during the Audit Period, Petitioner violated Medicaid policy and law in that: (1) some services for which Petitioner billed and received payment were not documented; (2) the documentation/medical records Petitioner provided to Respondent support a lower level of office or hospital visit than the one for which Petitioner billed and received payment; (3) Petitioner billed for radiology services when a radiologist outside of the office/group previously billed the reading and interpretation; and (4) Petitioner's records indicate instances of double-

billing Medicaid for services by using two CPT codes when one of these codes incorporates the elements of the other.

4. With respect to each of the services reviewed, Respondent relied upon the opinion of its expert, Dr. Averbuch, as to whether or not Petitioner billed Medicaid correctly. Dr. Averbuch based his opinion on a review of documents regarding each service which were provided to him by Respondent.

5. Respondent did not establish that the records provided to Dr. Averbuch were complete, and in several instances, the records reviewed by Dr. Averbuch were incomplete. The most common difference of opinion between what was billed by Petitioner for each service and what Dr. Averbuch felt should have been billed, involved the "level of service."

6. Billing codes are five-digit numbers, the last digit denoting the degree of difficulty of the service. Generally, there are five "levels of service," with "1" being the least difficult and "5" being the most difficult.

7. There are general guidelines for establishing the "level of service" (or degree of difficulty) which are set forth in documents such as Documentation Guidelines for Evaluation and Management Services, published by the American Medical Association. However, the correct coding can only be established through expert testimony, which is based upon established and identified criteria.

8. With respect to each of the 30 patients being reviewed, Respondent prepared a worksheet listing each service provided by Petitioner for that patient during the two-year Audit Period, the code and amount billed for each of those services, and Dr. Averbuch's opinion of the code which he felt should have been billed. Dr. Averbuch testified that in his opinion, Petitioner's claims contained an inordinate number of level "4" and "5" claims and that his records did not support the level of coding billed to Respondent. Someone on Respondent's staff then filled in the purported dollar value for each adjusted code. That amount was subtracted from the amount originally billed by Petitioner, and an average error (dollar amount) for each sample claim was calculated. Respondent then applied the average error in the sample claims to all the claims during the Audit Period. A further statistical calculation was performed to arrive at a 95 percent confidence level which Respondent alleged to be the amount of overpayment it was seeking from Respondent. That amount was shown as $81,682.06.[1/]

9. Dr. Averbuch is a knowledgeable medical practitioner, who specializes in orthopedic surgery. Respondent did not establish what records he reviewed, where they came from, or that they were complete. Additionally, Dr. Averbuch's deposition testimony did not set forth much information regarding the reason he felt as he did when his opinion differed

from that of Petitioner. Also, Respondent did not establish what criteria Dr. Averbuch relied upon in arriving at his opinion.

10. Jeffrey Howard, a consultant for Petitioner, although not a physician or other health care provider, is an experienced CPT code reviewer. He testified at length about each billing code in which he disagreed with Dr. Averbuch. In his testimony, he included details about each patient and each billed service. He also testified that he relied upon the 1995 Documentation Guidelines for Evaluation and Management Services, which has been adopted by HCFA, to base his opinions. Howard did not support all of Petitioner's billings.

11. There are 40 instances in which Petitioner challenges the billing codes urged by Respondent. This is a substantial proportion of the billing codes which were in dispute.

12. There are eight billing codes, the values of which need to be established to calculate the overpayment in this case. Those codes are: 99204, 99213, 99214, 99243, 99244, 99245, 29876, and 76140.

13. In carefully reviewing each of the joint exhibits admitted in this case, the dollar amount for code 99204 was established by the worksheet on Patients 10 and 30, to be $68.74.

14. The dollar amount for code 99213 is a variable amount. In January 2001 through April 3, 2001, it is $26.29 (Patients 2, 24, and 4). The amount goes up to $31.31 (Patient 21) in June and July 2001, then returns to $26.29 in August and September for Patients 13 and 7. Once again, the amount goes up to $31.31 in October 2001 (Patient 29), before backing down to $26.47, where it remains until March 5, 2002, when it once again goes to $31.31 (Patients 2, 14, and 6). On April 23, 2002, the dollar value for code 99213 returns to $26.47, where it stays for the rest of the Audit Period, except for June 21, 2002, when it changes to $31.31 for Patient 21.

15. The dollar amount for code 99214 seems to fluctuate even more than code 99213. It is valued at anywhere from $39.03 (Patients 24, 13, and 7) to $48.27 (Patients 16, 17, 9, and 11) and at least four values in between. It changes 13 times, both up and down, during the two-year Audit Period.

16. The dollar amount for code 99243 fluctuates between $62.11 and $64.28, with the majority approved at $64.28.

17. The dollar amount of code 99244 is not reflected anywhere in the record.

18. The dollar amount for code 99245 fluctuates in an apparently random fashion between $112.18 and $122.84, with three values in between.

19. The dollar amount for code 29876 is $121.00, according to the worksheet for Patient 2.

20. The dollar amount for code 76140 is not reflected anywhere in the record.

21. Because of the seemingly random variation in the dollar amounts for codes 99213, 99214, 99243, and 99245, which were not explained and could be the result of clerical error, it is found that Petitioner shall be given credit for the highest dollar amount for each of those three codes that are reflected in the record, that is: 99213 + $31.31; 99214 + $48.27; 99243 + $64.28; and 99245 + $122.84, unless those amounts are greater than that originally billed by Petitioner, in which case he shall be given credit for the amount billed.

22. Since there is nothing in the record to establish the value of code 99244, it is found that Petitioner shall be given credit for the value of the next higher level of service (code 99245), which is valued at $122.84 or any lesser amount which was originally billed.

23. Since there is nothing in the record to establish the value of code 76140, it is found that Petitioner shall be given credit for the value of the service as he originally billed it at $42.81 [Patient 24, Date of Service [DOS] January 7, 2002, code 72148].

24. Patient 1 was a 64-year-old woman that was referred to Petitioner and presented with numbness and pain in the right hand and wrist. The patient had a stroke in 1994 on her left side and had numbness and tingling in the right upper extremity. The patient had been referred by a neurologist, Dr. Jeronimo, who had performed an electromyography and nerve conduction studies. The symptoms indicated carpal tunnel syndrome. The patient had not received treatment for this condition and was, at the time of the visit, on nine different medications. The fact of a prior cerebral vascular accident and the multitude of medications added complexity to this case. Petitioner recommended surgery, but the patient requested alternatives. The patient was placed in a splint and instructed on home therapies.

25. The greater weight of evidence demonstrates that the correct code should be 99244, and Petitioner shall receive credit for $116.12 for DOS October 15, 2002, thus reducing the total amount disallowed to $13.04.

26. Patient 2 was a 24-year-old woman who saw Petitioner for the first time in 2001. The patient had injured her knee in 1998 and was not treated by an orthopedist. The patient had pain in the right knee, and it popped and moved in a funny way. She had difficulty ambulating. Petitioner reviewed the patient's history, examined the patient, and X-rays were taken.

Petitioner's impression was a torn medial meniscus, which had been left untreated for three years. Petitioner counseled the patient about further diagnostic work, but the patient opted for surgery. Petitioner performed and billed two separate procedures, arthroscopy knee surgical synovectomy (code 29876) and arthroscopy knee surgical meniscusectomy (code 29880).

27. Dr. Averbuch testified that this was "unbundling," but Howard explained how it was not according to the National Correct Coding Edits. The greater weight of evidence demonstrates that Petitioner should receive credit for $115.18 for DOS January 4, 2001, code 99244; and $121.00 for DOS January 19, 2001, code 29876, thus reducing the total amount disallowed to $61.50.

28. Patient 3 was a 37-year-old female with chronic back pain for several years. She had been previously treated with various treatments without relief. The patient was on Social Security disability because of her condition. The patient was upset and crying during her visit to Petitioner on July 3, 2001, because of her back pain. Recently, the patient reported the pain had been getting worse. The patient did not bring any previous medical records with her. Petitioner observed that she was limited in her motion. Petitioner based his diagnosis solely upon his physical examination and discussion with the

patient. Because of the nature of her injury, this was a highly complex patient.

29. The greater weight of evidence demonstrates that the correct code should be 99244, and Petitioner should receive credit for $113.18 for DOS July 3, 2001, thus reducing the total amount disallowed to zero.

30. Patient 4 was seen by Petitioner five years prior to the visit of April 3, 2001. The patient presented with swelling and pain in the right elbow. She had recently experienced soreness and redness in the area of the right elbow. She had been seen at a diagnostic center where she had been X-rayed, but was not treated other than she was advised to take Ibuprofen. The patient had not improved. The patient had also experienced a severe sprain of her knee in the past, but was allergic to codeine. Petitioner reviewed her past medical history and gave her an examination. The bursitis appeared to be resolving. The patient was counseled to come back if she had any more swelling and that she might need an aspiration. This patient was complex due to insufficient history and past treatment. Since the patient had not been seen in over three years, she was considered a "new patient" per the CPT guidelines.

31. The greater weight of evidence demonstrates that the correct code should be 99204 for DOS April 3, 2001, and Petitioner should receive credit for $68.74 (the value of code

99204 as established by Patients 10 and 30), thus reducing the total amount disallowed to $15.48.

32. Patient 5 was a new patient, who was referred by Dr. Cosic. She was a 13-year-old female who had been having pain in her right knee for two years. She had not seen any other physician for this problem. In 1995, the patient had been struck by a vehicle and sustained some damage. Petitioner reviewed the patient's history and examined the patient. He took an X-ray, which showed a possible tumor. This is a complex case. Dr. Averbuch recognized in his deposition that this patient had been referred by another physician, yet he opined that the proper coding should not be for a referral.

33. The greater weight of evidence demonstrated that Petitioner should receive credit for $115.18 for DOS June 19, 2001, because the correct code is 99245, thus reducing the total amount disallowed to zero.

34. Patient 6 was a 17-year-old male who injured his hand when he struck a telephone pole. The majority of the pain was on the fifth metacarpal. Petitioner reviewed the patient's history and examined the patient. Tenderness was found on the border of the hand, which localized the ulna aspect, and X-rays were taken. The patient was given a short-arm cast and aluminum splint for his little finger. The age of this patient contributed to the complexity of this case.

35. The greater weight of evidence shows that the correct code should be 99244, and Petitioner should receive credit for $118.12 for DOS February 12, 2002, thus reducing the total amount disallowed to $15.11.

36. Patient 7 was a 59-year-old female with pain in her right shoulder for four months. The patient was seen by another physician, Dr. Lynch, who referred her to Petitioner. The patient had difficulty raising her arms and sleeping. She had pain all over the subacromial clavicle region of the shoulder. She denied any trauma. Unexplained pain increases the complexity of a case.

37. The greater weight of evidence demonstrates that the correct code should be 99244, and Petitioner should receive credit for $113.18 for DOS August 20, 2001, thus reducing the total amount disallowed to $12.74.

38. Patient 8 had a chief complaint of pain in the right knee. She was a 73-year-old female from Sulfur Springs (over an hour's drive away from Petitioner's office), who had been having problems for three months with her right knee. It resulted from an injury when she slipped and fell at home. The pain was on the medial side of the knee. She had seen a physician in Sebring and received an MRI. The MRI revealed a tear in the posterior medial meniscus. She was referred to Petitioner, who reviewed the history and performed an examination. His

impression was a torn medial meniscus, and the plan was for arthroscopic surgery. Although Petitioner initially agreed with the lower code, the need for surgery added to the complexity of this case.

39. The greater weight of evidence demonstrates that the correct code should be 99244, and Petitioner should receive credit for $116.12 for DOS July 1, 2002, thus reducing the total amount disallowed to $15.97.

40. Patient 9 was a 13-year-old male with pain in his right hand, who saw Petitioner on February 15, 2001. He had fallen off his bicycle and had abrasions on this right hand. The patient had been seen at another facility where he was X-rayed and received a splint. Due to pain, the patient had removed the splint. Petitioner reviewed the patient's history and examined the patient. He took X-rays, which demonstrated a fracture of the second metacarpal of the distal limb. The patient was treated with an aluminum splint. Although Petitioner initially agreed with the lower code, due to the previous treatment which did not work, this was a relatively complex case.

41. On the May 28, 2002, visit, Patient 9 had an injured left ankle, again from a bicycle accident, five days prior. The patient had difficulty walking. He had received a splint at another facility. There was tenderness over the anterior

lateral aspect of the ankle, and X-rays were taken. The complexity of this patient was influenced by the patient's Tourette's Syndrome and his Attention Deficit Disorder. The patient was changed from a splint to a hand-walker.

42. The greater weight of evidence demonstrates that the correct code for DOS February 15, 2001, should be 99244, and Petitioner should receive credit for $115.18. For DOS May 28, 2002, the correct code should be 99214, and Petitioner should be given credit for $8.27, thus reducing the total amount disallowed to $36.90.

43. Patient 10 was a referral from Dr. Madedes of Suncoast Community Center, Inc. The patient was diagnosed as a "classic gamekeepers thumb." The correct code should be 99243. Therefore, Petitioner should not be given any credit for DOS December 5, 2002.

44. Patient 11 was a referral from the Nativity Clinic. He was a 13-year-old male who had fallen off his bicycle approximately 31 days previously. He was diagnosed with a fracture and was treated without a reduction. He had been placed in a cast. Petitioner reviewed the medical history and performed an examination. Petitioner checked the patient's range of motion and took X-rays. Petitioner diagnosed a fracture of the left distal radius. He told the patient to

return in two weeks for removal of the cast. A complicating factor in this case is that the patient also had back pain.

45. The greater weight of evidence demonstrates that the correct code should be 99244, and Petitioner should receive credit for $122.84 for DOS July 21, 2002, thus reducing the total amount disallowed to $21.80.

46. Patient 12 was a 37-year-old female from Avon Park who was referred to Petitioner by another physician. She had been in an auto accident three years prior, and her shoulder was hurting and getting worse. She had seen other physicians and had MRIs. At the November 12, 2002, visit, she did not bring any medical records with her. The patient was a poor historian. At the time of her visit, she said that the pain was going into her back as well. Petitioner reviewed the history and performed an examination, which included palpation of the shoulder, which did not reveal tenderness or swelling. Petitioner also performed range of motion tests. X-rays did not show any abnormalities. Petitioner's clinical impression was "shoulder pain, etiology undetermined." The patient was sent for an MRI. An old injury, which although being treated, continues to get worse, increases the complexity of this case. With respect to the visit of November 26, 2002, the patient did not show signs of improvement, and a decision was made for surgery. This decision was not complex.

47. The greater weight of evidence demonstrates that the correct code for DOS November 12, 2002, should be 99244, and Petitioner should receive credit for $115.12. The correct code for DOS November 26, 2002, should be 99213, thus reducing the total amount disallowed to $39.51.

48. Patient 13 was a referral from Dr. Haiger and was seen by Petitioner on June 5, 2001. The patient was a 65-year-old deaf female, who presented experiencing severe pain in her left knee for almost ten years. Eight years prior she had undergone arthroscopic surgery on the knee, but it had not gotten better. The patient was in physical therapy and using canes. Petitioner reviewed the history and performed an examination. Communication between Petitioner and the patient was by writing. This was a complex patient, both because of the difficulty in communication and the fact that this was an old injury which had received much treatment, including surgery, and had not improved. On her return visit on August 7, 2001, the patient had not improved using the ordered medication. After consultation, a decision for surgery was made.

49. With respect to the visit of June 4, 2002, the patient's complaint was pain in her left shoulder for a month. The patient continues to regress, in spite of Petitioner's treatment. This is a complex patient, and her medical record is

voluminous. However, the visit of August 13, 2002, was merely routine.

50. The greater weight of evidence demonstrates that Petitioner should be given credit for $113.18 for DOS June 5, 2001, since the correct code is 99244; the correct code for DOS August 7, 2001, is 99213; the correct code for DOS June 4, 2002, is 99214; and the correct code for DOS August 13, 2002, is 99213, thus reducing the total amount disallowed to $89.21.

51. Patient 14 was a referral from Dr. Bagloo, who presented to Petitioner on January 15, 2002, with pain in her left foot. She had twisted her ankle at home a week previously and actually heard bones cracking. She was initially seen at the hospital. A computed tomography scan did not reveal a fracture. A week later on January 15, 2002, she came to see Petitioner. Her examination revealed tenderness of the dorsal aspect of the left foot. An X-ray revealed a fracture of the second-base metatarsal. The patient received a short-leg cast. The patient was seen again on February 12, 2002, and examination indicated that the patient was "healed."

52. On July 9, 2002, the patient again saw Petitioner with pain in her left foot. She had experienced a seizure a week and a half prior. The seizure and the prior injury added to the complexity of this case.

53. The greater weight of evidence demonstrates that the correct code for DOS January 15, 2002, is 99244, and Petitioner should be given credit for $118.12. The correct code for DOS February 12, 2002, is 99213, and Petitioner should receive no credit; the correct code for DOS July 9, 2002, is 99214, and Petitioner should be given credit for $48.27, thus reducing the total amount disallowed to $32.33.

54. Patient 15 was a 15-year-old male from Avon Park, with scoliosis. He had hurt himself when he fell off his boogie board and hit his chest. After reviewing the history, performing an examination, and taking X-rays, the patient was referred to a pediatric orthopedist. The age of the patient and the pre-existing condition affected the complexity of this case, although the scoliosis was previously diagnosed.

55. The greater weight of evidence supports a finding that the correct code for DOS June 11, 2002, is 99243, and Petitioner should not be given credit. Therefore, there is no reduction of the total amount disallowed.

56. Patient 16 was a referral from Dr. Libbrato. However, the patient was previously diagnosed, Petitioner billed at code 99245, and Respondent's expert opined that the code should be 99203. The billing code should account for this being a referral.

57. The greater weight of evidence supports a finding that the correct code for DOS March 25, 2002, is 99243, and Petitioner should be given credit for $64.28, thus reducing the total amount disallowed to $75.64.

58. Patient 17 was a referral from a Medicaid clinic. The patient was a 10-year-old male who had hurt his left elbow playing football a week prior. Petitioner reviewed the history and examined the patient, who was in a long-arm splint. Petitioner replaced the splint with a long-arm cast. The age of the patient and the prior inappropriate treatment added to the complexity of this case.

59. The greater weight of evidence demonstrates that for DOS May 14, 2002, the correct code is 99244, and Petitioner should be given credit for $122.84. The correct code DOS June 6, 2002, is 99213, and Petitioner should be given credit for $31.31, thus reducing the total amount disallowed to $38.76.

60. Patient 18 was a 63-year-old male who had been referred by another physician for pain in his right-hand ring finger of six months' duration. The patient claimed no trauma. The age of the patient and the unexplained injury added to the complexity of this case.

61. The greater weight of evidence demonstrates that the correct code for DOS June 18, 2002, should be 99244, and

Petitioner should be given credit for $116.12, thus reducing the total amount disallowed to zero.

62. Patient 19 presented with a fracture that appeared to be healing, but it was difficult to tell if the patient's problem was from the fracture or from osteoporosis. The patient was not responding to treatment.

63. The greater weight of evidence demonstrates that the correct code for DOS August 12, 2002, is 99214, and Petitioner should be given credit for $41.51, thus reducing the total amount disallowed to $15.04.

64. Patient 20 was an eight-year-old male who had pain in his left heel from jumping off a truck and falling. He was referred from his primary care physician. The complexity of this case was increased due to the age of the patient and the fact that prior treatment had not been effective.

65. The greater weight of evidence demonstrates that the correct code for DOS October 17, 2002, is 99244, and Petitioner should be given credit for $122.84, thus reducing the total amount disallowed to zero.

66. Patient 21 was a 10-year-old male from Plant City, who injured his right arm and shoulder in a fall from monkey bars. Petitioner's diagnosis was a fractured right humerus. The young age of this patient, plus the fact that he was a referral, added to the complexity of this case.

67. The greater weight of evidence demonstrates that the correct code for DOS May 24, 2001, is 99244, and Petitioner should be given credit for $115.18, thus reducing the total amount disallowed to $45.33.

68. Patient 22 was a nine-year-old male referred by Dr. Narvez for right leg pain. He was injured when another child fell on him. Also, the patient had broken the same leg about a year prior. A re-injury and young age added to the complexity of this case.

69. The greater weight of evidence demonstrates that the correct code for DOS January 8, 2002, is 99244, and Petitioner should be given credit for $118.12, thus reducing the total amount disallowed to zero.

70. Patient 23 was a 37-year-old male from Lake Placid, referred by Dr. Campbell. He presented with right shoulder pain. Approximately two years prior he was shot in that shoulder. The pain was in the acromioclavicular joint. The pain was felt to be a result of the injury from the gunshot wound, and surgery was recommended. The pre-existing condition increased the complexity of this case.

71. The greater weight of evidence demonstrates that the correct code for DOS January 29, 2002, is 99244, and Petitioner should be given credit for $116.12, thus reducing the total amount disallowed to $14.47.

72. Patient 24 was referred by Dr. Rivas for ongoing low back pain. The patient presented on January 16, 2001, as a 53-year-old female and stated that the pain had been getting worse in spite of treatment. It was localized in the left groin, the left posterior iliac region, the left buttock, the posterior aspect of the thigh, and the calf. The long-standing nature of the pain, without improvement from treatment, added to the complexity of this case, as well as the multiple therapies employed. The MRI reading on February 1, 2001, should be allowed. On the visit of March 1, 2001, the patient reports a new problem with pain in her knee. The visit of June 5, 2001, revealed that the patient is improved, but still in pain.

73. The greater weight of evidence demonstrates that Petitioner should be given credit for $115.18 for DOS January 16, 2001, code 99245; $42.81 for DOS February 11, 2001, code 76140; $31.31 for DOS March 1, 2001, code 99213; $31.31 for DOS June 5, 2001, code 99213, thus reducing the total amount disallowed to $28.18.

74. Patient 25 was a seven-year-old female from Lake Wales, referred by Dr. Powell for bilateral leg deformities and fallen arches. The patient also had scoliosis.

75. The greater weight of evidence demonstrates that the correct code for DOS January 27, 2001, is 99244, and Petitioner

should be given credit for $115.18, thus reducing the total amount disallowed to $32.56.

76. Patient 26 was an 18-year-old male with scoliosis, who had recently come to the United States from Cuba and was referred to Petitioner for evaluation.

77. The greater weight of evidence demonstrates that the correct code for DOS September 12, 2002, is 99243, and Petitioner should not be given credit, thus the total amount disallowed remains at $58.56.

78. Patient 27 was a 36-year-old female who was referred by Dr. Korabathing for left hip pain. She had injured it two or three weeks prior when she fell. She was initially seen in the emergency room. The discoloration persisted and the knee continued to "give out." The complexity of the case is increased because of the patient's lack of improvement.

79. The greater weight of evidence demonstrates that the correct code is 99244 for DOS April 11, 2002, and for April 23, 2002, the correct code is 99214, thus reducing the total amount disallowed to $29.87.

80. There was no challenge to the adjusted coding of Patient 28 to 99213.

81. Patient 29 was a referral from Dr. Katherinlin. He was a 13-year-old male, who injured his left foot while playing

football two or three days prior. He was initially treated at an outpatient facility. Petitioner changed the treatment plan.

82. The greater weight of evidence demonstrates that the correct code for DOS October 2, 2001, is 99244, and although he did not initially challenge the change in coding, Petitioner should be given credit for $116.12, thus reducing the total amount disallowed to $15.11.

83. Patient 30 was referred by Family Medical Center of Lakeland, Florida. The patient was a 56-year-old male with pain in the right hip and pelvis. He had been in a motorcycle accident three years prior with numerous and substantial injuries. Due to the number and substantiality of the injuries, this was a complex case.

84. The greater weight of evidence demonstrates that the correct code for DOS February 26, 2002, is 99244, and Petitioner should be given credit for $118.12, thus reducing the total amount disallowed to zero.

85. The adjustments in the preceding paragraphs drop the total overpayments for the 30 sample patients as shown in Respondent's Audit Report from $2,405.10 to $790.99. Dividing that by the total number of sample claims reviewed (133), yields a disallowance per claim of $5.94. Multiplying $5.94 by the total number of claims for the Audit Period (5,399), yields a

"point estimate of overpayment" of $32,070.06. Calculating the 95 percent confidence level can be accomplished by Respondent.

CONCLUSIONS OF LAW

86. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes (2005).

87. The burden of proof is on Respondent to establish by a preponderance of evidence that the Audit Report should be sustained. South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440 (Fla. 3d DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992).

88. The statutes, rules, and Medicaid provider handbooks, which were in effect during the period for which the services were provided, govern the outcome of the dispute.

89. Section 409.913, Florida Statutes (2002), reads in pertinent part as follows:

> Oversight of the integrity of the Medicaid program.-- The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as appropriate. . . .

* * *

(1) For the purposes of this section, the term:

* * *

(d) "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition, or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. Determinations of medical necessity must be made by a licensed physician employed by or under contract with the agency and must be based upon information available at the time the goods or services are provided.

(e) "Overpayment" includes 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.

* * *

(7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to . . . present a claim that is true and accurate and that is for goods and services that:

* * *

(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.
>
> * * *
>
> (20) When making a determination that an overpayment has occurred, the agency shall prepare and issue an audit report to the provider showing the calculation of overpayments.
>
> (21) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. . . .

90. During the Audit Period, the applicable statutes, laws, rules, and policy guidelines in effect required Petitioner to maintain all "Medicaid-related records" and information that supported any and all Medicaid invoices or claims made by Petitioner during the Audit Period. Petitioner was required, at Respondent's request, to provide Respondent with all Medicaid-related records and other information that supported all the Medicaid-related invoices or claims that Petitioner made during the Audit Period.

91. Subsection 409.907(3)(c), Florida Statutes (2002), required Petitioner to maintain "all medical and Medicaid-related records for a period of 5 years." The stated purpose behind the 5-year document-retention requirement is so that Petitioner "can satisfy all necessary inquiries by the agency."

92. Subsection 409.907(3)(e), Florida Statutes (2002), required Petitioner to allow Respondent access to "all Medicaid-related information which may be in the form of records, logs, documents, or computer files, and other information pertaining to the services or goods billed to the Medicaid program, including access to all patient records . . . ."

93. Subsection 409.913(7), Florida Statutes (2002), imposed an affirmative duty on Petitioner to comply with all the requirements as set forth in its subparagraphs (a) through (f).

94. Subsection 409.913(7)(f), Florida Statutes (2002), imposed an affirmative duty on Petitioner to make sure that any claim for goods and services are "documented by records made at the time the goods and services were provided . . . ." This subsection also imposed an affirmative duty on Petitioner to make sure that any and all the records documenting Medicaid goods and services demonstrate "the medical necessity for the goods and services rendered." This subsection further authorized Respondent to investigate, review, or analyze the records, including Medicaid-related records, that Petitioner was required to retain.

95. Section 409.913(1)(d), Florida Statutes (2002), makes Respondent the "final arbiter of medical necessity." This section states, in part, that "[d]eterminations of medical

necessity . . . must be based upon information available at the time goods or services are provided.

96. This case arises out of Respondent's attempt to recover purported overpayments made to Petitioner.

97. Subsection 409.913(7)(f), Florida Statutes (2002), declares that Medicaid goods and 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."

98. Subsection 409.913(8), Florida Statutes (2002), required Petitioner to "retain medical, professional, financial, and business records pertaining to services and goods furnished to a Medicaid recipient and billed to Medicaid for a period of 5 years after the date of furnishing such services or goods."

99. The Physician Coverage and Limitations Handbook states:

> Radiology Frequency
> Only one interpretation per radiology procedure is reimbursable.
>
> * * *
>
> Maximum fee
> To be reimbursed the maximum fee for a radiology service, the physician must provide both the technical and professional components.
>
> When a radiological study is performed in an office setting, either the physician billing the maximum fee must have performed or

directly supervised the performance and interpreted the study; or if a group practice, members of the group must perform all components of the services. . . .

Professional Component
A professional component service is the physician's interpretation and reporting of the radiological exam. . . .

100. Chapter 3 of the Physician Coverage and Limitations Handbook states:

Introduction
This chapter describes the procedure codes for services reimbursable by Medicaid that must be used by physicians providing services to eligible recipients.

Procedure and Diagnosis Code Origination
The procedure codes listed in this chapter are Health Care Financing Administration Common Procedure Coding System (HCPCS) Levels 1, 2, and 3. These are based on the Physicians Current Procedural Terminology (CPT) book.

101. The Medicaid Provider Reimbursement Handbook, states:

Requirements for Medical Records
Medical records must state the necessity for and the extent of services provided. The following requirements may vary according to the service rendered:

History; Physical assessment; Chief complaint on each visit; Diagnostic tests and results; Diagnosis; Treatment plan, including prescriptions; Medications, supplies, scheduling frequency for follow-up or other services; Progress reports, treatment rendered; The author of each (medical record) entry must be identified and must authenticate his or her entry by signature, written initials or computer

entry; Dates of service; and Referrals to other services.

Incomplete records
Providers who are not in compliance with the Medicaid documentation and record retention policies described in this chapter may be subject to administrative sanctions and recoupment of Medicaid payments. Medicaid payments for services that lack required documentation or appropriate signatures will be recouped.

102. The Medicaid Provider Reimbursement Handbook requires that "[t]he provider must retain all medical, fiscal, professional, and business records on all services provided to a Medicaid recipient."

103. The Physician Coverage and Limitations Handbook and the Medicaid Provider Reimbursement Handbook is incorporated in Florida Administrative Code Rules 59G-5.020 and 59G-4.230. The handbooks are binding when incorporated by rule.

104. By introducing the Audit Report into evidence, Respondent has presented a prima facie case as contemplated by Subsection 409.913(21), Florida Statutes (2002). Full Health Care, Inc. v. Agency for Health Care Administration, Case No. 00-4441 (DOAH June 5, 2001) (Adopted in toto October 3, 2001). However, Petitioner has presented evidence which rebuts, in part, the overpayment calculations made by Respondent.

105. The Audit Report is to be revised consistent with the findings herein, to arrive at a "point estimate of overpayment"

of $32,070.06. Since Petitioner did not take issue with the statistical method of calculating a 95 percent confidence level, that step may be performed by Respondent and included in its final order adopting this Recommended Order.

RECOMMENDATION

Based on the foregoing Findings of Facts and Conclusions of Law, it is

RECOMMENDED that Respondent, Agency for Health Care Administration, enter a final order revising its Final Agency Audit Report as directed herein.

DONE AND ENTERED this 30th day of December, 2005, in Tallahassee, Leon County, Florida.

DANIEL M. KILBRIDE
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 30th day of December, 2005.

ENDNOTE

[1/] After receipt of the Audit Report, but prior to the hearing, Petitioner was given credit for a charge that had been previously disallowed.

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.