STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

2006 MAY 25 A 8:14

MARIA LOURDES BURGOS, M.D.,

Petitioner,

vs.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.
_____/

DOAH CASE NO. 04-4645MPI
AUDIT NO. C.I. 98-0229-008
RENDITION NO.

PMR
CLOS

FILED
2006 MAY 25 PM 4:31
DIVISION OF ADMINISTRATIVE HEARINGS

FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), P. Michael Ruff, conducted a formal administrative hearing. At issue in this proceeding is whether the Petitioner must reimburse the Respondent for purported overpayments as specified in the Respondent's Final Agency Audit Report of December 12, 2003, which covered the audit period of July 1, 2000 through July 31, 2002. The Recommended Order dated November 4, 2005, is incorporated herein by reference, except where noted infra.

RULING ON EXCEPTIONS

Respondent filed exceptions to which the Petitioner filed a response. The Petitioner did not file any exceptions.

In its first exception, the Respondent took exception to the ALJ's findings of fact and conclusions of law concerning the interpretation of the section of the Physician Coverage and Limitations Handbook ("Handbook")[1] that involved billing for both "Well Child Check-Up" visits and "sick office visits" for the same patient encounter. In Paragraph 8 of the

[1] which was incorporated by reference in Rule 59G-4.230, Florida Administrative Code.

Recommended Order, the ALJ found that "based upon the testimony of Dr. Larry Deeb, as well as the Petitioner's testimony, the submission of both a 'well-child' checkup billing and a 'sick office visit' billing was appropriate and consistent with good medical practice under the circumstances demonstrated by the Petitioner's testimony and her records." In Paragraph 18 of the Recommended Order, the ALJ found that "the double-billing alleged for a well-child checkup and a sick child visit on the same date of service for two recipients was clearly appropriate under the circumstances proven...." As the record evidence demonstrated, the Handbook clearly stated that a physician cannot bill Medicaid for both a well-child check-up and a sick office visit for the same recipient on the same date of service. See, e.g., Transcript, Pages 47-48; and Respondent's Exhibit 9 at Pages 11, 25-26 and 53. The ALJ correctly found in Paragraph 3 of the Recommended Order that

> In choosing to become a Medicaid provider, a physician such as Dr. Burgos must assume the responsibilities enumerated in Section 409.913(7), Florida Statutes (2004), which provided generally that such a provider had an affirmative duty to supervise the provision of such services and be responsible for the preparation and submission of claims.

Further on in Paragraph 3 of the Recommended Order, the ALJ enumerated that one of Petitioner's responsibilities as a Medicaid provider was to provide services "in accordance with all applicable provisions of Medicaid rules, regulations, handbooks, and policies." Double-billing Medicaid for both a well-child check-up and a sick office visit was not in accordance with the Handbook. See, e.g., Transcript, Pages 47-48; and Respondent's Exhibit 9 at Pages 11, 25-26 and 53. The Agency is entitled to considerable deference in interpreting its own rules and such interpretations will be upheld unless clearly erroneous. See Suddath Van Lines, Inc. v. State, Department of Environmental Protection, 668 So.2d 209 (Fla. 1st DCA 1996). In spite of

both the Petitioner's and Dr. Deeb's testimony to the contrary, the Agency concludes that the correct interpretation of the Handbook prohibits double-billing for both a well-child check-up and a sick office visit on the same date of service, regardless of the circumstances. Thus, the findings of fact in Paragraphs 8 and 10 of the Recommended Order were based on an erroneous interpretation of the Handbook. Therefore, the Respondent's first exception is granted, and the third sentence of Paragraph 8 of the Recommended Order is changed to state:

> In any event, regardless of the testimony of Dr. Larry Deeb, as well as the Petitioner's testimony, the submission of both a 'well-child' checkup billing and a 'sick office visit' billing is contrary to the Physician Coverage and Limitations Handbook, incorporated by reference in Rule 59G-4.230, Florida Administrative Code; and not allowable under the circumstances demonstrated by the Petitioner's testimony and her records.

Further, the following claims in which the Petitioner double-billed Medicaid for both a well-child check-up and a sick office visit shall be deleted from Paragraph 10 of the Recommended Order:

Recipient Number	Date of Service	CPT Billed and Paid	Disallowed/ Adjusted Amount
1	09/05/01	99215	$60.95
	12/05/00	99215	$37.59
4	04/04/01	99215	$60.95
9	05/03/01	99205	$87.24
11	04/04/01	99214	$46.42
14	05/13/02	99214	$24.58
16	10/13/00	99215	$57.14
17	05/10/01	99215	$60.95
	12/11/01	99214	$46.42

Additionally, the conclusions of law in Paragraph 18 of the Recommended Order are modified to state:

> 18. However, contrary to the Petitioner and the testimony of Dr. Deeb, the double-billing alleged for a well-child checkup and a sick-child visit on the same date of service was clearly prohibited by the Physician Coverage and Limitations Handbook,

> incorporated by reference in Rule 59G-4.230, Florida Administrative Code, even under the circumstances given. With regard to the amounts and patient/recipients numbered and depicted in the above paragraph 10 in the Findings of Fact, the Petitioner demonstrated through her testimony, as well as to some extent through that of Dr. Deeb, those reported amounts of overpayment were really not overpayments. Thus their sum total should be deducted from the overpayment amount referenced above being sought by the Agency. Therefore, the Agency did not prove by a preponderance of the evidence that the Petitioner received an overpayment for the specific Medicaid claims addressed in paragraph 10 above analyzed during the audit.

In its second exception, the Respondent took exception to portions of Paragraph 10 of the Recommended Order wherein the ALJ found that Petitioner was not overpaid for certain dates of service based on the code that the Petitioner billed, in spite of the Agency's contrary determination. However, the ALJ's findings in Paragraph 10 regarding these claims were based on competent substantial evidence. See Transcript, Pages 73-90, 100-109, 110-112, 113-114, 116, 117, 118-119, 120-122, 123-130, 132-139, 155-156, 164-166, and 167-184; and Respondent's Exhibit 8. Thus, the Agency cannot reject them. See § 120.57(1)(*l*), Fla. Stat.; Heifetz v. Department of Bus. Regulation, 475 So.2d 1277, 1281 (Fla. 1985) (holding that an agency "may not reject the hearing officer's finding [of fact] unless there is no competent, substantial evidence from which the finding could reasonably be inferred"). Therefore, the Respondent's second exception is denied.

In its third exception, the Respondent took exception to the findings of fact in Paragraphs 12 and 13 of the Recommended Order, and the conclusions of law in Paragraph 20 of the Recommended Order, wherein the ALJ found and concluded that the Agency should reimburse the Petitioner for claims that may or may not have been submitted to the Agency for payment during the time period encompassed by the audit. The ALJ's findings and conclusions on this

issue are in direct contradiction to established Agency precedent. In the case of Utopia Home Care, Inc. v. Agency for Health Care Administration, 26 FALR 2947 (AHCA 2004) (per curiam aff'd on appeal, 903 So.2d 196 (Fla. 1st DCA 2005)), the ALJ stated that "Petitioner has the burden of proving by a preponderance of the evidence that it is entitled to the payments which it seeks." Id. at 2953. The Utopia case, like the case at hand, dealt with the issue of a Medicaid provider who claimed it had timely submitted claims for payment that were never paid by the Agency. It is obvious in this case that the Petitioner did not prove by a preponderance of the evidence that it had submitted the claims at issue in Paragraphs 12, 13 and 20 to the Agency for payment. The ALJ even conceded this fact by stating that "[u]nfortunately, neither the Petitioner's records and testimony nor the Agency records can clearly show whether the claims forms were actually submitted or not." The Agency finds that there is no competent substantial evidence to support the findings of fact in Paragraph 13 of the Recommended Order. The Agency further finds that it has substantive jurisdiction over the conclusions of law in Paragraph 20 of the Recommended Order due to the fact that they involve an interpretation of the Handbook and that, based on the prior precedent in the Utopia case, it could substitute conclusions of law as or more reasonable than those of the ALJ. Therefore, the Respondent's third exception is granted, Paragraph 13 of the Recommended Order is stricken in its entirety, and Paragraph 20 of the Recommended Order is changed to state:

> 20. Further, concerning the Medicaid provider reimbursement handbook HCFA-1500, the Petitioner failed to prove by a preponderance of the evidence that she should be entitled to receive payment for the claim forms depicted in the Petitioner's Exhibit Seven. See Utopia Home Care, Inc. v. Agency for Health Care Administration, 26 FALR 2947 (AHCA 2004) (per curiam aff'd on appeal, 903 So.2d 196 (Fla. 1st DCA 2005)). Consequently, there are no payments due the Petitioner with regard to the claim forms contained in Petitioner's Exhibit Seven that

could be credited against any overpayment determined to be due from the Petitioner to the Respondent.

FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order, except where noted supra.

CONCLUSIONS OF LAW

The Agency adopts the conclusions of law set forth in the Recommended Order, except where noted supra.

IT IS THEREFORE ADJUDGED THAT:

Petitioner is required to repay $28,257.80 in Medicaid overpayments to the Agency for paid claims covering the period from July 1, 2000 through July 31, 2002. Petitioner shall make full payment of the monies, totaling $28,257.80, to the Agency for Health Care Administration within 30 days of the rendition of this Final Order. Petitioner shall pay by check payable to the Agency for Health Care Administration and mailed to the Agency for Health Care Administration, Office of Finance and Accounting, 2727 Mahan Drive, Fort Knox Building 2, Mail Stop 14, Tallahassee, Florida 32308.

DONE and ORDERED this 24 day of May, 2006, in Tallahassee, Florida.

Alan Levine

ALAN LEVINE, Secretary
AGENCY FOR HEALTH CARE ADMINISTRATION

NOTICE OF RIGHT TO JUDICIAL REVIEW

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO JUDICIAL REVIEW, WHICH SHALL BE INSTITUTED BY FILING THE ORIGINAL NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A COPY ALONG WITH THE FILING FEE PRESCRIBED BY LAW WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF THE RENDITION OF THE ORDER TO BE REVIEWED.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Final Order has been furnished by U.S. or interoffice mail to the persons named below on this 25th day of May, 2006.

RICHARD J. SHOOP, Agency Clerk
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COPIES FURNISHED TO:

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