STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

MARIA LOURDES BURGOS, M.D.,)
)
Petitioner,)
)
vs.)
) Case No. 04-4645MPI
AGENCY FOR HEALTH CARE)
ADMINISTRATION,)
)
Respondent.)
)

RECOMMENDED ORDER

In accordance with notice this cause came on for formal proceeding and hearing before P. Michael Ruff, duly-designated Administrative Law Judge of the Division of Administrative Hearings in Tavares, Florida, on July 19, 2005. The appearances were as follows:

APPEARANCES

For Petitioner: W. Cleveland Acree, II, Esquire
The Unger Law Group, P.L.
701 Peachtree Road
Orlando, Florida 32804

For Respondent: Jeffries H. Duvall, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Fort Knox Building III
Tallahassee, Florida 32308-5403

STATEMENT OF THE ISSUES

The issues to be resolved in this proceeding concern whether the Respondent Agency must be reimbursed by the Petition

for purported overpayments regarding Medicaid claims, as delineated in the Respondent's Final Agency Audit Report of December 12, 2003, related to the audit period of July 1, 2000 through July 31, 2002.

PRELIMINARY STATEMENT

This cause arose when the Respondent, the Agency for Health Care Administration (Agency) issued a Provisional Agency Audit report demanding that Dr. Maria Lourdes Burgos, M.D., (Petitioner) reimburse the Agency for some $51,410.93 in alleged Medicaid overpayments for certain services that the doctor had billed her patients seen between July 1, 2000 and July 31, 2002.

Sometime thereafter the Petitioner submitted additional medical record documentation which, upon review by the Agency, resulted in a lowered amount of overpayment being sought, to the amount of $43,328.57. The Petitioner was notified of this by final agency audit report dated December 12, 2003. It is this amount that the Agency in this proceeding claims as an overpayment.

A Petition was filed whereby Dr. Burgos requested a formal administrative proceeding and hearing to contest the results of the final agency audit report. The matter was thereafter referred to the Division of Administrative Hearings for formal proceeding.

The cause came before the undersigned, as noticed, for final hearing on the above date. The parties exchanged copies of the medical records which had been reviewed by the Agency for the audit purpose and other exhibits prior to hearing and stipulated to their admissibility. Additionally, official recognition is taken of Chapter 409, Florida Statutes and Florida Administrative Code Rules 59G-4.230 and 59G-1.010, which incorporated by reference, respectively, the Physicians Coverage and Limitations Handbook and the American Medical Association publication Current Procedural Terminology 2000. The issues to be resolved is thus whether medical records and testimony support the payment by the Florida Medicaid Agency of all or part of the amount of $43,238.57 for medical services, the amount currently in controversy between the parties.

Dr. Burgos presented her own testimony and did not call additional witnesses on her behalf. The Agency presented two witnesses, Dr. Larry Deeb, M.D., by deposition (see Respondent's Exhibit Nine in evidence) as a medical expert witness, and Teresa Mock an Agency employee personally involved in the Medicaid audit of the Petitioner.

Respondent's Exhibit Eight is a composite exhibit consisting of medical records of Medicaid patients treated by Dr. Burgos and worksheets prepared by the Agency on which are listed the specific services provided by her and which are the subject of

this dispute. The worksheets are derived from Medicaid billing and patients' medical records randomly selected for the audit and are attached to the medical records provided by the Petitioner pursuant to a request by the Agency. These are admitted into evidence without objection. The Petitioner submitted Exhibits One "A" and "B" through Six, all of which were admitted into evidence without objection. The Petitioner also submitted into evidence Exhibit Seven, certain health insurance claim forms, pertaining to bills that were not apparently processed by the Medicaid agency for which reimbursement remains outstanding, with no amounts as to their being yet paid to the Petitioner. The Respondent object to Exhibit Seven on the basis that it believes that the claims are now barred, since they were not submitted within the 12-month period required by the Medicaid Reimbursement Handbook, adopted in the Agency rules referenced herein. Ruling on the exhibit was deferred but the objection is now over-ruled and Exhibit Seven is admitted for reasons delineated in the Conclusions of Law below. Upon concluding the hearing the parties requested a transcript thereof and an extended briefing schedule for submission for proposed recommended orders. Proposed Recommended Orders were timely submitted and have been considered in the rendition of this Recommended Order.

FINDINGS OF FACT

1. The Agency is responsible for administering the Florida Medicaid program. The Agency is thus charged with a duty to recover overpayments to medical service providers enrolled in that program. The term "overpayment" means any amount not authorized to be paid by the Medicaid program, whether paid as a result of inaccurate reporting or improper reporting of costs, improper claims, unacceptable practices, fraud, abuse, or by mistake. See § 409.913.(1).(d), Fla. Stat.

2. The Petitioner, Maria Lourdes Burgos, M.D., is a pediatrician duly licensed in the State of Florida, practicing as an authorized Medicaid provider for purposes of the relevant portions of Chapter 409, Florida Statutes, at times pertinent hereto. During the period July 1, 2000 through July 31, 2002, (the audit period) the Petitioner had a valid Medicaid provider agreement with the Respondent Agency. During the period of the audit the Petitioner provided services to Medicaid recipients or patients and submitted claims for those services and was compensated for those services.

3. This case is a result of the Agency's attempt to recover purported overpayments from Dr. Burgos. 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. The claims are required to be true and accurate, the services are required to actually have been furnished to the recipient by the provider submitting the claim; the services are required to be medically necessary, of a comparable quality to those furnished to the general public by the provider's peers; and to have been provided in accordance with all applicable provisions of Medicaid rules, regulations, handbooks, and policies. They must be in accordance with federal, state, and local law. Additionally, the provision of medical services are required to be documented by records made contemporaneously with the provision of the services, demonstrating the medical necessity for them and the medical basis and specific need for them must be properly documented in the recipient's medical record.

4. The "audit period" involved in this proceeding is July 1, 2000 through July 31, 2002. The Medicaid program reimbursed Dr. Burgos in excess of $43,238.57 in payments pursuant to the Medicaid program during that audit period. The Final Agency Audit Report is in evidence as Respondent's Exhibit One and the calculations pertaining to the overpayment amount are included in that report as part of Respondent's Exhibit One in evidence. The Agency contends that $43,238.57 is an overpayment

and subject to recoupment because of Medicaid policy, as alleged in the Final Agency Audit Report (FAAR). Medical records reveal that some services billed, and for which payment was received, were not documented and that documentation provided supported a lower level of office visits than the one for which the Medicaid program was billed and for which payment was received by the Petitioner; and, because payments can be made only for those services listed in the provider handbook, that the Petitioner billed and received payments for services not covered by Medicaid as overpayments.

5. The Agency furnishes all authorized Medicaid providers a manual entitled The Physician Coverage and Limitations Handbook (Handbook). The Handbook contains the requirements demanded of Medicaid providers and it and the procedure code manual (CPT) manual that was in effect during the audit period is in evidence in this proceeding. The handbook has been incorporated by reference in Florida Administrative Code Rule 59G-4.230. This handbook sets forth Florida Administrative Code Rule 59G-4.230 and sets forth pertinent applicable Medicaid policies and claims processing requirements applicable to this proceeding.

6. Upon convening of the audit procedure, the Agency requested certain records from the Petitioner and the Petitioner fully complied with the relevant requirements of Chapter 409, Florida Statutes, submitting copies of all records dealing with

the recipients who where the subject of the audit. See Exhibit Eight in evidence.

7. The Petitioner, in effect, does not dispute the statistical methodology employed by the agency, but does dispute the manner in which it was applied to certain procedure codes (CPT codes) and the result of the overpayment calculations. Additionally, for every office visit that the Petitioner had with Medicaid patients, she personally made an individual judgment about the level of service that she provided and accordingly billed for that level of care and treatment provided. She was consistent in this in her billing practices as to both Medicaid and non-Medicaid patients.

8. In some instances, regarding the audited Medicaid patient/recipient records, it was demonstrated by the Petitioner that the patient presented with somewhat more complexity as to medical condition that the CPT code, postulated by the Agency as applicable, represented that thus she billed for the higher code (as for instance a "99215" instead of a "99213) or "99214"). Some of these medical judgment calls made by the Petitioner were shown to be appropriate and justified and some where shown by the Respondent's evidence, chiefly the testimony of Dr. Larry Deeb, the Respondent's expert, to be not really appropriate and that they should have been coded and therefore billed at a lower level. In any event, 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. Thus it was inappropriate for the Agency to automatically claim an overpayment due for those billings, based upon only its policy interpretation.

9. Additionally, based upon Ms. Mocks testimony, it is apparently an Agency policy or practice in conducting audits, and in recouping overpayments, that when errors are discovered in the audit or in the billing records which happen to be in favor of the practitioner (the Petitioner) that the Agency does not provide a credit applied to any alleged overpayment. It would seem that fundamental fairness dictates that both credits and overpayments be weighed against each other in calculating the ultimate amount of any overpayment, if one exists.

10. In any event, based upon Dr. Deeb's testimony and the Petitioner's testimony, with regard to the random sample of patients and their medical records submitted, reviewed and involved in this dispute, the evidence demonstrates that the Petitioner was not overpaid as to the following amounts and patients/recipients:

Recipient Number	Date of Service	CPT Billed and Paid	Disallowed/ Adjusted Amount

Recipient Number	Date of Service	CPT Billed and Paid	Disallowed/ Adjusted Amount
1	12/05/00	99215	$37.59
	09/05/01	99215	$60.95
2	03/05/01	99214	$15.11
3	09/19/00	99215	$13.01
4	04/04/01	99215	$60.95
5	09/15/00	99214	$15.11
	05/10/01	W9881	$22.70
6	01/14/02	99215	$14.52
8	11/08/01	99214	$15.11
9	05/03/01	99205	$87.24
10	05/03/01	99205	$87.24[1/]
11	04/04/02	90669	$ 0.00[2/]
	04/04/01	W9881	$37.81
	04/04/01	99214	$46.42
12	10/18/01	99214	$15.11
	01/18/02	99215	$29.63
	01/30/02	99215	$14.52
	05/20/02	99214	$15.11
13	08/14/00	99215	$13.01
14	01/31/01	99214	$15.11
	08/27/01	99214	$15.11
	05/13/02	99214	$24.58
15	10/17/00	99356	$50.94

	10/19/00	99233	$12.53
16	10/13/00	99215	$57.14
17	05/10/01	99215	$60.95
	12/11/01	W9881	$37.81
	12/11/01	99214	$46.42
20	12/22/00	99205	$17.02
22	11/19/01	99223	$42.04
	11/20/00	99239	$11.53
23	03/27/02	W1998	$ 0.00[3/]
	04/03/02	99356	$49.72
	04/22/02	99215	$ 0.00[4/]
	04/29/02	99214	$13.86
	05/10/02	99215	$ 0.00[5/]
24	08/12/01	99356	$ 0.00[6/]
	08/15/01	99239	$12.06
25	09/30/01	99223	$22.71
	10/01/01	99233	$12.66
26	12/03/01	99356	$49.25[7/]
	12/06/01	99239	$12.06
	12/14/01	99205	$18.12
	01/16/02	99215	$29.63
	01/23/02	99215	$29.63[8/]
28	10/13/01	99431	$ 0.00[9/]

Recipient Number	Date of Service	CPT Billed and Paid	Disallowed/ Adjusted Amount
	10/14/02	99233	$12.66
	10/15/01	99239	$12.06
29	02/28/02	99356	$ 5.42[10/]
	03/01/02	99233	$13.80
	03/02/02	99239	$13.66
	03/06/02	99205	$18.67
29	03/13/02	99215	$14.52

11. The Petitioner in its Proposed Recommended Order has agreed that other than the above (Proposed Recommended Order paragraph 10 patients and amounts) that the Petitioner agrees with the Agency's review and the overpayment calculations on a per office visit basis.

12. Additionally, however, as referenced above, there were additional health insurance claim forms which were, or should have been, submitted to the Agency, representing claims for payment for dates of service that clearly fall within the relevant audit period, that were never compensated by the Agency's contracted agent. The alternative is that the claim forms for some reason were not actually submitted. Unfortunately, neither the Petitioner's records and testimony nor the Agency records can clearly show whether the claim forms were actually submitted or not. It is apparently not possible to

retrieve that information from the Agency's claim filling and payment-related computer programming system, for reasons not understood by either party or the judge. There is thus no clear explanation of record concerning why these claims were not paid earlier, even though they fall within the audited period.

13. It is clear, however, that the additional claims referenced in the Petitioner's Exhibit Seven, admitted as a late exhibit herein, do relate to that audit period and represent medical services provided by the Petitioner within that audit period. Since that audit period and the claims referenced in evidence are the subject of a "proceeding" and are pending a "court or hearing decision . . ." or, alternatively and admittedly somewhat speculatively, could be subject of a "system error on claim that was originally filed within (12) months from date of service," it appears patently apparent that fundamental fairness dictates that these health insurance claim forms related to the same audit period should be considered and a determination made as to whether and how much of those claims should be reimbursed to the Petitioner for the medical services they represent. Thus, especially as to exception (2) to the twelve-month filing requirement listed in the above-reference handbook, Exhibit Seven has been admitted into evidence and the claim forms represented therein should be considered and the amounts payable to the Petitioner should be credited against the resultant

overpayment amounts calculated as a result of these Findings of Fact.

CONCLUSIONS OF LAW

14. The Division of Administrative Hearings has jurisdiction of the subject matter of and the parties to this proceeding. §§ 120.569 and 120.57(1), Fla. Stat. (2004).

15. The burden of proof to establish an alleged Medicaid overpayment by a preponderance of the evidence is that of the Agency. South Medical Services v. Agency for Health Care Administration, 633 So. 2d 440, 441 (Fla. 3rd DCA 1995); South Point Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

16. Although the Agency bears the ultimate burden of persuasion and must present a prima facie case as to each essential element of the dispute, Section 409.913(21), Florida Statutes, provides that:

> [T]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment.

Once the Agency produces into evidence the audit report supported by the Agency's work papers, the burden to rebut that report and the calculations it represents shifts to the Petitioner. See Maz Pharmaceuticals Incorporated v. Agency for Health Care Administration, DOAH Case No. 97-3791.

17. The Petitioner has contended that she is entitled to bill certain CPT codes which reflect a more severe or complex medical service or procedure that the Agency was felt was proper. In some of the cases she actually satisfied fewer of the required criteria that are set forth in the evaluation and management services guidelines in evidence. For example the doctor billed a "215" level of service code in a number of instances. The criteria for this level of billing is set forth in the CPT manual in evidence and clearly requires medical decision-making of high complexity to justify these billing levels. See Respondent's Exhibit Four in evidence. Decision-making of high complexity is defined as decisions which arise in situations in which there is a "risk of complication and/or morbidity or mortality." This level of severity was not present in many of the cases presented for consideration.

18. In fact, however, contrary to the Respondent's position, the Petitioner and the testimony of Dr. Deeb shows 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 Petitioner's testimony and Dr. Deeb's testimony demonstrate. Further, 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, that 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.

19. In this connection, although Dr. Larry Deeb performed a peer review of the sampled patient files of the Petitioner, Dr. Burgos also testified based upon her independent recollection and knowledge of those patients and a review of her medical records concerning the underlying facts and circumstances surrounding the care and treatment she provided to each of those patients on those dates of service. The Petitioner thus demonstrated by a preponderance of evidence that the alleged overpayments referenced as to the patients or recipients depicted in paragraph 10 above were adequately rebutted and those amounts depicted were not overpayments. Those amounts should be reduced from the total overpayment recoupment amount sought by the Agency.

20. Further, concerning the Medicaid provider reimbursement handbook HCFA-1500, for reasons which are not clear there has been a delay in processing the health insurance

claim forms or else they were never actually submitted as to those claim forms depicted in the Petitioner's Exhibit Seven. That exhibit has been admitted into evidence and whether or not claims were originally submitted when the 12-month claims submission time limit provided in the above-referenced handbook, it is appropriate that they be considered since they directly relate and involve patient visits, services, and care provided during the relevant audit period, which audit period is directly the subject of this proceeding and pending "court" decision. It is thus concluded that the re-submission of those claim forms, if re-submission is necessary, comes within the above-referenced exception to the handbook prohibition on submitting claims beyond the 12-month time limit. Consequently, the amount of payments due the Petitioner with regard to the claim forms contained in Petitioner's Exhibit Seven should be credited against any overpayment determined to be due from the Petitioner to the Respondent.

RECOMMENDATION

Based on the foregoing Findings of Fact, Conclusions of Law, the evidence of record, the candor and demeanor of the witnesses, and the pleadings and arguments of the parties, it is, therefore,

RECOMMENDED that the Respondent, Agency for Health Care Administration, re-calculate the amount of overpayment in a

manner consistent with the above Findings of Fact and Conclusions of Law, excluding from the amount of overpayment those amounts determined above to have not constituted overpayments. It is further

RECOMMENDED that the Respondent calculate the amount of reimbursement not provided pursuant to the recently submitted or re-submitted (but never paid) Exhibit Seven health insurance claim forms, and as for the reasons indicted in the above Findings of Fact and Conclusions of Law, and credit that additional amount of reimbursement against the overpayment calculation amount in arriving at the new overpayment due from the Petitioner to the Respondent. The Petitioner shall repay the Respondent the re-calculated monetary amount of overpayment within a reasonable period of time and by reasonable installment payments, agreed to by both parties, but shall not be obligated to pay other costs or fees related to this matter.

DONE AND ENTERED this 4th day of November, 2005, in Tallahassee, Leon County, Florida.

P. MICHAEL RUFF
Administrative Law Judge
Division of Administrative Hearings
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060
(850) 488-9675 SUNCOM 278-9675
Fax Filing (850) 921-6847
www.doah.state.fl.us

Filed with the Clerk of the
Division of Administrative Hearings
this 4th day of November, 2005.

ENDNOTES

[1/] Although the DOS was documented to be 05/08/01, it was corrected to 05/03/01.

[2/] Reimbursement for pneumococcal vaccine was not credited, and thus a credit of $10.00 is appropriate.

[3/] Although immunizations and the well-care visit were submitted, the well-care visit was never paid and no explanation was ever given, thus a credit of $68.74 is required.

[4/] The level of care warrants 99214 as opposed to the 99213 than was allowed which must be recalculated for credit.

[5/] Pursuant to meeting with Dr. Burgos and Dr. Deeb, he agreed to allow her one hour of critical care credit which should be applied at a CPT code of 99295.

[6/] Pursuant to meeting with Dr. Burgos and Dr. Deeb, he agreed to allow her one hour of critical care credit which should be applied at a CPT code of 99295.

[7] The billing entry was misdated and should have reflected a DOS of 12/04/01 for which a medical record exists, the apparent reason for denial.

[8] Petitioner is granted an upcharge to a 99214 and for the Agency must calculate the credit amount.

[9] Pursuant to Dr. Deeb's revisions, the allowable CPT code was a 99223 which should be reimbursed at $85.50, thus showing a credit of $49.12.

[10] To be consistent with Dr. Deeb's analysis of Recipient Number 26, DOS 12/03/01, reimbursement of $84.42 should have been allowed as opposed to what was submitted and then reduced.

COPIES FURNISHED:

Jeffries H. Duvall, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station No. 3
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308

W. Cleveland Acree, II, Esquire
The Under Law Group, P.L.
701 Peachtree Road
Orlando, Florida 32804

Richard Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Christa Calamas, General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3431
2727 Mahan Drive
Tallahassee, Florida 32308

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.