STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 06-3494MPI
HAROLD L. MURRAY, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

This case came before Administrative Law Judge John G. Van Laningham for final hearing by video teleconference on February 14, 2007, at sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: L. William Porter, II, Esquire
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STATEMENT OF THE ISSUE

The issue for determination is whether Respondent is liable to Petitioner for the principal sum of $94,675.83, which equals the amount that the Florida Medicaid Program paid Respondent for the "professional component" of claims for radiologic services

rendered to Respondent's patients between July 1, 2001 and December 31, 2005.

PRELIMINARY STATEMENT

Petitioner Agency for Health Care Administration is the agency responsible for administering the Florida Medicaid Program. Respondent Harold L. Murray, M.D., is a doctor who has furnished goods or services to Medicaid beneficiaries.

After investigating Dr. Murray's medical practice, Petitioner issued a Final Agency Audit Report on July 19, 2006, wherein it alleged that this physician had been overpaid $94,675.83 for Medicaid claims arising from Respondent's provision of radiologic services to eligible beneficiaries. The gravamen of the Agency's complaint was that Dr. Murray had billed Medicaid (and been paid) for interpreting radiologic studies (such as X-rays and sonograms) when in fact the interpretations (called "professional component" services in Medicaid terminology) had been done by a radiologist. On September 5, 2006, Dr. Murray served an Amended Request for Formal Administrative Hearing disputing the overpayment assessment. The matter was referred to the Division of Administrative Hearings on September 15, 2006.

At the final hearing, which took place as scheduled (after one continuance) on February 14, 2007, the Agency called Vicki Anne Remick, a Medical Healthcare Program Analyst, as its sole

witness. In addition, Petitioner's Exhibits 1 and 2, and 9 through 14 were admitted into evidence.

Respondent testified on his own behalf and presented one other witness: Griselle Aguilera, Esquire. Dr. Murray did not offer any exhibits.

The two-volume final hearing transcript was filed on March 5, 2007. The parties timely filed proposed recommended orders on the established deadline (after several extensions) of May 16, 2007. These papers were carefully considered in the preparation of this Recommended Order.

Unless otherwise indicated, citations to the Florida Statutes refer to the 2006 Florida Statutes.

FINDINGS OF FACT

1. Petitioner Agency for Health Care Administration ("AHCA" or the "Agency") is the state agency responsible for administering the Florida Medicaid Program ("Medicaid").

2. Respondent Harold L. Murray, M.D. ("Murray") was, at all relevant times, a Medicaid provider authorized to receive reimbursement for covered services rendered to Medicaid beneficiaries.

3. Exercising its statutory authority to oversee the integrity of Medicaid, the Agency sent investigators to Murray's office on November 22, 2005. The purpose of this visit was to verify that claims paid by Medicaid had not exceeded authorized

amounts. To this end, the investigators inspected Murray's facilities and reviewed his medical records. What the investigators saw gave them reasons to believe that Medicaid had been overpaying Murray for radiologic services. They focused on the period from July 1, 2001 to December 31, 2005 (the "Audit Period").

4. During the Audit Period, Murray had submitted approximately 2,000 claims seeking the "maximum fee" for radiologic services, which Medicaid had paid. The maximum fee includes compensation for "professional component" services. (Medicaid uses the term "professional component" to describe the physician's services of interpreting a radiologic study and reporting his or her findings. These services are distinguished from those comprising the "technical component," which are routinely performed by technicians. These latter services include operating the radiologic equipment (e.g. an X-ray or sonographic machine) and performing the exam.) It appeared to the investigators that Murray had not, in fact, been performing the professional component.

5. Using information in its database, the Agency determined that, during the Audit Period, Murray had received Medicaid payments totaling $94,675.83 for professional component services. The Agency repeatedly requested that Murray supply additional information that might substantiate his prior claims

for fees relating to the professional component. Murray failed, refused, or was unable to comply with the Agency's requests.

6. Murray did testify at hearing, however, providing a reasonably clear picture of what had occurred. On direct examination, Murray explained that he had performed the "first preliminary" review of each radiologic examination in question before sending the study to a radiologist, whom he paid "out of [his own] pocket" to interpret the exam and make a report. According to Murray, Medicaid paid only for his (Murray's) professional component services——not the radiologist's. Murray argues that he is entitled to compensation for the professional component services that he personally performed, notwithstanding that another doctor performed the same services.

Analysis of the Facts

7. Although Murray's position might have some superficial appeal, it does not withstand scrutiny as a matter of fact, the undersigned has determined. To explain why this is so requires an analysis of Murray's testimony that entails neither legal conclusions nor findings of historical fact. The undersigned's rationale, being essentially fact-based, is explicated here in the interests of organizational coherence and readability.

8. Assume first, for the sake of argument, that Murray's "first preliminary" review constituted an authoritative interpretation of the radiologic study. Because it is

reasonable to infer (and the undersigned finds) that the radiologist's subsequent interpretation of the study was authoritative——Murray's routine practice of ordering and personally paying for the "second opinion" would have been inexplicable, and indeed irrational, if the radiologist's interpretation were of dubious value——the inevitable conclusion, assuming Murray's findings were authoritative, is that the "second opinion" was nearly always duplicative, excessive, and unnecessary.[i]

9. Murray's responses to that conclusion doubtless would be: (1) Medicaid did not pay for the second opinion, so whether it was excessive and unnecessary is irrelevant; and (2) there is no statute, rule, or Medicaid policy that forbids a provider from procuring, at his own expense, a second opinion——even an unnecessary one.

10. It is not accurate to say, however, that Medicaid did not pay for the second opinion; this, ultimately, is the fatal flaw in Murray's reasoning. To the contrary, Murray's testimony shows clearly that Medicaid did pay for some or all of the expense of the second opinion, albeit indirectly, when it paid Murray for the same work. As his own account reveals, Murray was, in effect, merely a conduit for the Medicaid money, which passed through his hands on its way to the radiologist.

11. Murray contends, of course, that the Medicaid payments for the professional component were "his," that he had earned them by performing the "first preliminary" read, and that he was free to spend his income however he chose. If our initial assumption were true, namely that Murray's preliminary interpretation were authoritative, then his claim to the Medicaid payments at issue might have merit. But, on reflection, this assumption is difficult, if not impossible, to square with the fact that Murray found it necessary always to pay another doctor to perform the very same professional component services. Indeed, having a second opinion was so important to Murray that he was willing to perform his purported preliminary read at a substantially discounted rate, at least, if not for free——or even, maybe, at a financial loss: in every instance, one of these was necessarily the net economic result of his actions.[ii]

12. If, as we have assumed, Murray were performing a valuable professional service each time he interpreted a radiologic exam, then——the question naturally arises——why would he effectively have given away his expert opinions? Murray testified that he did so for "the safety of [his] patient" and because the radiologist is "educated for that." But these "answers," far from being persuasive, actually undermine the assumption that spawns the question of motive. Indeed, Murray's

testimony confirms a reasonable inference contrary to our initial assumption, which inference is that Murray lacked sufficient confidence in his so-called "preliminary" interpretations ever to rely on them alone. This inference, which the undersigned accepts as a finding, arises from the basic undisputed fact that Murray routinely sought "second opinions" for every patient. It is ultimately determined, therefore, that whatever Murray's "first preliminary" reviews comprised, they did not constitute authoritative interpretations of the radiologic studies at hand.

13. That being the case, it is determined that Murray's preliminary opinions added little or no actual value to the subject medical transactions. Offering some sort of provisional opinion that holds only until the "real" opinion can be obtained from the radiologist is not tantamount to performing the professional component.[iii] Based on the evidence presented, it is determined that the radiologist performed the professional component of the radiologic studies at issue, not Murray.

14. As a result of improperly claiming that he had performed professional component services when in fact he had not, Murray received from Medicaid a total of $94,675.83 in payments that were not authorized to be paid. This grand total of $94,675.83 constitutes an overpayment that Murray must return to the Agency.

CONCLUSIONS OF LAW

15. The Division of Administrative Hearings has personal and subject matter jurisdiction in this proceeding pursuant to Sections 120.569 and 120.57(1), Florida Statutes.

16. The Agency is empowered to "recover overpayments . . . as appropriate." § 409.913, Fla. Stat. An "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." § 409.913(1)(e), Fla. Stat.

17. One method of recovering overpayments is through "recoupment," which is "the process by which the department [i.e. AHCA] recovers an overpayment or inappropriate payment from a Medicaid provider." Fla. Admin. Code R. 59G-1.010(245).

18. The burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence falls on the Agency. 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).[iv]

19. To be authorized for payment by Medicaid, a claim for services that a doctor has provided must comply with the terms and conditions set forth in the Physician Services Coverage and

Limitations Handbook ("Handbook"). Because the Handbook is incorporated by reference in Florida Administrative Code Rule 59G-4.230, its terms and conditions have the force and effect of administrative rules.

20. Although the pertinent provivisions of the Handbook were revised from time to time, the substantial Medicaid policy that governs this case remained the same throughout the Audit Period——and is not disputed. The principal rule behind the present dispute, as stated in the January 2001 version of the Handbook, is this:

> To be reimbursed the maximum fee for a radiology service, the physician must provide both the technical and professional components.

The same Handbook (Jan. 2001) defines the term "professional component service" as "the physician's interpretation and reporting of the radiological exam . . . ."

21. The undersigned has found that, throughout the Audit Period, Murray claimed (and was paid) maximum fees for radiologic services even though he had not performed the professional components. As further found, the amounts that Murray received for professional component services were not authorized to be paid by Medicaid; he received these sums as a result of improper claiming.

22. The undersigned accordingly finds and concludes that the total amount Murray received in payment of professional component services——$94,675.83——is an overpayment, which the Agency is entitled to recover from the provider.

23. There is one final matter to discuss. The Agency seeks to impose a fine of $1,000 against Murray. The authority to impose such a fine is given in Section 409.913(16), Florida Statutes, which provides in pertinent part as follows:

> The agency shall impose any of the following sanctions or disincentives on a provider or a person for any of the acts described in subsection (15):
>
> * * *
>
> (c) Imposition of a fine of up to $5,000 for each violation.

24. Among the acts described in subsection (15) are the following:

> (e) The provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code; with provisions of state or federal laws, rules, or regulations; with provisions of the provider agreement between the agency and the provider; or with certifications found on claim forms or on transmittal forms for electronically submitted claims that are submitted by the provider or authorized representative, as such provisions apply to the Medicaid program[.]

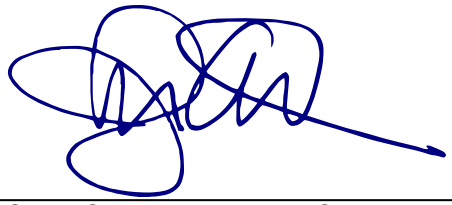
§ 409.913(15)(e), Fla. Stat.; see also Fla. Admin. Code R. 59G-9.070(7)(e).

25. Murray submitted approximately 2,000 claims for radiologic services that were not in compliance with the pertinent provisions of the Handbook. Therefore, Murray committed multiple violations, for each of which AHCA may impose a fine of up to $5,000. The fine of $1,000 that AHCA wants to impose is well within its statutory authority.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency enter a final order requiring Murray to repay the Agency the principal amount of $94,675.83, together with an administrative fine of $1,000.

DONE AND ENTERED this 10th day of July, 2007, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of July, 2007.

ENDNOTES

[i]/ The undersigned supposes (but has no evidence upon which to base a finding) that there might have been some unusual situations where a true "second opinion" would have been beneficial, even assuming Murray's interpretations were authoritative. Murray, however, always obtained a "second opinion," regardless of the novelty or complexity of the case. In the run of cases, this must have been overkill——if Murray were really performing professional component services.

[ii]/ The evidence does not reveal whether Murray paid the radiologist an amount that was greater than, less than, or equal to the Medicaid reimbursement for the professional component. There is nothing in the record, however, suggesting that the radiologist charged less than the Medicaid fee for the professional component.

[iii]/ The undersigned perceives no material difference between Murray's practice of obtaining "second opinions," on the one hand, and simply subcontracting the professional component to a radiologist, on the other. (Of course, any doctor who would use a subcontractor to interpret radiologic exams could claim, as Murray has done, that he himself performed "first preliminary" reviews, if the latter need not be authoritative to be compensable.) Plainly, however, if a doctor were permitted to subcontract his professional obligations in this way, then the statute respecting Medicaid provider agreements (§ 409.907, Fla. Stat.) would be seriously compromised, for doctors not under contract with the Agency would be able to provide services to Medicaid recipients *as subcontractors* to doctors who were under contract with the Agency. In fact, because the instant record contains no evidence concerning the identities of the radiologist or radiologists on whom Murray relied for the safety of his patients, it is possible that these radiologists (or some of them) were not Medicaid providers. In any event, acceptance of Murray's position would open the door, even if only a crack, to subcontracting.

[iv]/ Although the Agency bears the ultimate burden of persuasion and thus must present a prima facie case through the introduction of competent substantial evidence before the provider is required to respond, Section 409.913(22), Florida Statutes, provides that "[t]he audit report, supported by agency work papers, showing an overpayment to the provider constitutes evidence of the overpayment." Thus, the Agency can make a prima facie case merely by proffering a properly supported audit

report, which must be received in evidence. See Maz Pharmaceuticals, Inc. v. Agency for Health Care Administration, DOAH Case No. 97-3791, 1998 Fla. Div. Adm. Hear. LEXIS 6245, *6-*7 (Mar. 20, 1998); see also Full Health Care, Inc. v. Agency for Health Care Administration, DOAH Case No. 00-4441, 2001 WL 729127, *8-9 (Fla.Div.Admin.Hrgs. June 25, 2001)(adopted in toto, Sept. 28, 2001, AHCA Rendition No. 01-262-FOF-MDO).

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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.