STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 07-0675MPI
CONSTANCE BENCE,	)	
Respondent.	)	

RECOMMENDED ORDER

A final hearing was held before Daniel M. Kilbride, Administrative Law Judge (ALJ) of the Division of Administrative Hearings (DOAH) on July 19, 2007, in Tampa, Florida.

APPEARANCES

For Petitioner: L. William Porter II, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Building 3
Tallahassee, Florida 32308-5403

For Respondent: Constance Bence, pro se
734 137th Street, Northeast
Bradenton, Florida 34212

STATEMENT OF THE ISSUE

Whether Respondent is liable for overpayment of Medicaid claims, for the period of January 1, 2004, through January 1, 2006, as stated in Petitioner's Final Audit Report (FAR), dated July 19, 2006, due to Respondent's failure to properly document

for services billed and collected, in violation of Section 409.913, Florida Statutes (2006),[1] and, if so, in what amount.

PRELIMINARY STATEMENT

By FAR, dated July 19, 2006, the Agency for Health Care Administration (Petitioner) notified Constance Bence (Respondent) that she was liable for overpayment of Medicaid claims in the amount of $12,500.70 for the audit period. Petitioner was also seeking to impose a fine of $1,500.00. Respondent disputed being liable for reimbursement to Petitioner for overpayment and requested a formal administrative hearing.

A Petition for Formal Administrative Hearing was filed on February 9, 2007. Following discovery, a final hearing in this matter was held on July 19, 2007.

At the final hearing, the Petitioner offered two witnesses: James Edgar, M.D., and Gary Mosier, Registered Nurse Consultant, and Medical Healthcare Program Analyst for AHCA in the Bureau of Medicaid Program Integrity. Petitioner offered 26 exhibits, which were admitted into evidence. The exhibits included 2004 through 2006 versions of Sections 409.905, 409.906, 409.907, 409.908, 409.913, 409.9131 and 414.41, Florida Statutes; Florida Administrative Code Chapters 59G-4 and 59G-5; and Advanced Registered Nurse Practitioner Services Coverage and Limitations Handbook, January 2004 edition, p. 2-45; Physician Services Coverage and Limitations Handbook, January 2007 update,

p. 2-106; Current Procedural Terminology (CPT), American Medical Association (2004) pps 332-335; CPT (2005), pps 347-349; CPT (2006), pps 364-366.

Respondent testified in her own behalf and entered no exhibits into evidence. A Transcript of the hearing was prepared and filed on August 1, 2007.

Following the closing of evidence and before the filing of proposed recommended orders were due, Respondent asked for this matter to be placed in abeyance, due to her personal medical issues. Petitioner did not object and the case was placed in abeyance. The case continued to remain in abeyance until early 2009, when Respondent had recovered sufficiently to proceed. She then requested an extension of time to file her proposed findings of fact and conclusions of law. The request was granted. Both parties timely filed their proposed findings of fact and conclusions of law, which have been carefully considered in the preparation of this Recommended Order. In the preparation of this Recommended Order, the ALJ thoroughly reviewed the complete file, Transcript and exhibits in this matter.

FINDINGS OF FACT

1. Petitioner is the single state agency under federal law, charged with administration of the Medicaid Program in

Florida, and is charged with recovering overpayments to providers.

2. Petitioner's Bureau of Medicaid Integrity (MPI) has the primary responsibility to audit medical service providers who participate in the Medicaid program. MPI is a Bureau under the AHCA Inspector General.

3. MPI conducts audits to review provider's compliance with applicable statutes, rules, and policies regarding billing Medicaid for services rendered.

4. An MPI audit is separate and distinct from an annual or other licensure survey or inspection conducted by Petitioner. The MPI audit is a compliance audit not a licensure one.

5. MPI is mandated to review for provider fraud and abuse to ensure that the recipients are receiving the service for which Medicaid is paying.

6. Respondent is a Florida licensed Advanced Registered Nurse Practitioner (ARNP) and provided medical services, including psychological counseling to Medicaid recipients, pursuant to a contract with Petitioner under her Provider number 302123800.

7. Respondent participated in the Medicaid program at least from July 1, 2001, and continuously through December 31, 2005 (end of the Audit Period). Petitioner was paid for the services rendered.

8. The audit period for Respondent was determined to be from January 1, 2004, through December 31, 2005. Claims for services were reviewed for a standard two-year audit period, and were audited for coding, records and visits.

9. Thirty recipients were picked as a sample of recipients to examine during the two-year audit period. The selection was random and computer generated.

10. Respondent was notified that Petitioner was conducting an audit. Respondent provided the charts on the 30 recipients to be examined and each of their claims during the audit period, which comprised all of her medical records.

11. Gary Mosier is a Registered Nurse (RN), and holds a master's degree in health care administration. Mosier is employed by the AHCA Inspector General, MPI, and is a nurse consultant and investigator. He was lead analyst and investigator in this matter.

12. James Edgar, M.D., a psychiatrist with 35 years of experience, was retained by Petitioner as a peer review expert to review the charts and give a coding opinion.

13. Billing codes are five-digit numbers. There are general guidelines for establishing the 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.

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

15. In each instance where the Billing Code 90807, Individual Psychotherapy, Insight Orientation, appeared on Respondents charts for all 30 patients, Dr. Edgar down-coded the charts to Code 90862, medical management. He did not disallow payment, he adjusted each of them. His opinion was that, without the time spent with the patient being delineated on the medical chart, then the visit must be down-coded, or it could be denied completely. Dr. Edgar's testimony was credible and persuasive.

16. A Preliminary Audit Report (PAR) was sent to Respondent on September 12, 2006. The PAR informed Respondent of an alleged overpayment and explained her options prior to the completion of a FAR. It also put Respondent on notice of possible sanctions for lack of response to Petitioner.

17. AHCA pays for mental health counseling when the face-to-face time spent with the recipient is documented. The medical records resulting from these services are required by

law to be maintained for five years following the dates of service. These records must be made available when requested by Petitioner.

18. Respondent was requested to produce office appointment sheets or calendars in order to document her face-to-face time with patients.

19. Respondent sent non-contemporaneous time listings, rather than chart materials or office materials to verify and document time spent. There existed no charted or office records of the time spent with patients. Although Respondent testified that these time listings were implied because of the code that she submitted to Petitioner, this testimony is not persuasive in proving a material fact in dispute.

20. The FAR was sent to Respondent on November 7, 2006, with the spreadsheet attachment. As with the PAR, it informed Respondent of the issues involved with the audit and the overpayment calculations and sought to levy a sanction, if one applied.

21. There was no documentation in the charts of the time expended in the patient encounter, as required under the law. Although Petitioner agreed that the use of the Code 90807 implied that there was one hour of face-to-face contact with a patient, CPT policy requires both medication management and therapy, not just medication management. There was no time of

service, time spent, and no start or stop times noted in the medical records. These notations are specifically required under Medicaid policy. A record must reflect the time spent face-to-face with a patient.

22. The final overpayment calculation and final audit reports document that the overpayment to be recouped, and which Petitioner seeks, is $12,500.70, with an added sanction of $1,500.00.

23. The preponderance of evidence has shown that Respondent was overpaid in the amount of $12,500.70, and that Petitioner is authorized to impose a penalty of $1,500.00.

CONCLUSIONS OF LAW

24. DOAH has jurisdiction over the parties and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes. As such, this matter is a de novo proceeding, and not merely a review of (proposed) agency action. Florida Department of Transportation v. J.W.C. Company, 396 So. 2d 778, 786-787 (Fla. 1st DCA 1981).

25. Petitioner is charged with the administration of the Medicaid program in Florida. § 409.902 Fla. Stat. As one of its duties, Petitioner must recover “overpayments . . . as appropriate,” the term “overpayment” being statutorily defined to mean “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.

26. Since Petitioner is the party asserting the affirmative, Petitioner has the burden of establishing an alleged Medicaid overpayment by a preponderance of the evidence. § 120.57(1)(j), Fla. Stat. South Medical Services, Inc. v. Agency for Health Care Administration, 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); Fla. DOT v. J.W.C. Company, supra. See also Haines v. Department of Children and Families, 983 So. 2d 602, 606-608, (Fla. 5th DCA 2008).

27. The statutes, rules, Florida Medicaid Physician Services Coverage and Limitations Handbook, and Florida Medicaid Provider General Handbook in effect during the period for which the services were provided govern the outcome of the dispute. See Toma v. Agency for Health Care Administration, Case No. 95-2419 (DOAH 1996) (as incorporated in Toma v. Agency for Health Care Administration, 18 FALR 4735 (DOAH 1996)).

28. Section 409.913, Florida Statutes, 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:

* * *

(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.

The agency may deny payment or require repayment for goods or services that are not presented as required in this subsection.

* * *

> (21) 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.
>
> (22) The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. . . .

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

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

31. Subsection 409.907(3)(e), Florida Statutes, required Respondent to allow Petitioner 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. . . .”

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

33. Subsection 409.913(7)(f), Florida Statutes, imposed an affirmative duty on Respondent to made 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 Respondent to make sure that any and all records documenting Medicaid goods and services demonstrate the “medical necessity for the goods and services rendered.” This subsection further authorized Petitioner to investigate, review, or analyze the records, including Medicaid-related records, that Respondent was required to retain.

34. The audit process that led to the claim for overpayment was properly initiated by Petitioner in accordance with Subsections 409.913(2), (20) and (21), Florida Statutes.

35. A provider participating in the Medicaid program has an affirmative duty to supervise and be responsible for the preparation and submission of accurate claims for payment from the program. It is the provider’s duty to ensure that all claims “[a]re provided in accord with applicable provisions of

all Medicaid rules, regulations, handbooks, and policies." § 409.913(7)(e), Fla. Stat.

36. The Florida Administrative Code, as promulgated and amended over the times material to this audit, specifically made it a matter of law that the Florida Medicaid Physician Services Coverage and Limitations Handbook and Florida Medicaid Provider General Handbook are part of the Code governing all medical service providers. Fla. Admin. Code R. 59G-4.001.

37. Petitioner alleges improper and insufficient record-keeping by a Medicaid mental health counseling provider. Where records are insufficient to document the treatment billed, the claims cannot be paid. Proper documentation of mental health counseling visits, by law, must include a record of the time spent with the patient, face-to-face.

38. To be reimbursed for psychiatric counseling services, Respondent, an ARNP, must keep a full medical record that includes the time spent with the patient, pursuant to the Florida Physician Services Coverage Handbook, January 2001.

39. Respondent did not keep her records according to Medicaid policy. She did not keep time records of patient interactions in the patient chart as required by law.

40. Medicaid providers must comply with all laws and rules that pertain to the Medicaid Program and retain all medical and

Medicaid-related records for five years. These provisions are a matter of both law and contract. § 409.907, Fla. Stat.

41. Respondent, during the audit period, submitted claims and was paid for mental health counseling visits, where there was no indication of time spent face-to-face with the patient.

42. The requirement to have the medical record set forth the time spent with the patient is set forth in the ARNP Services & Coverage Handbook. This is also required by CPT 2004, 2005 and 2006. Medicaid handbooks are incorporated by reference in Florida Administrative Code Rule 59G-4.010.

43. Respondent failed to conform to the requirements, as her records did not contain time components. The case analyst, Gary Mosier, asked her to submit any contemporaneous time records she might have, such as office appointment calendars or patient sign-in/out sheets. With such contemporaneous data, Petitioner could have verified and extrapolated the time spent with patients. Respondent did not have them or supply them from archives. Records of time with patients, billed to Medicaid, are Medicaid-related records. All the audited conduct was within this time frame. Respondent did not have the records; instead, Respondent submitted a recently handwritten, non-contemporaneous listing of how long she spent with the patients, which she authored, by her own admissions, after the audit was underway. This was insufficient under the statues and rules.

44. Dr. Edgar, the expert peer reviewer, testified that these lists were not medical chart materials. They were not patient encounter time records. They did not indicate the amount of time spent with the patient in therapy, recorded at the time of the encounter, in the medical chart. The medical chart data was insufficient under the law, policies or common practice in the community.

45. The records upon which Respondent based her billings to Medicaid are deficient under law. The laws governing the Medicaid programs required a finding that Respondent was overpaid and that recoupment is an available remedy.

RECOMMENDATION

Based upon the above Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Agency for Health Care Administration enter a final order instructing Respondent to repay the sum of $12,500.70, and imposing a fine if appropriate.

DONE AND ENTERED this 2nd day of March, 2010, in Tallahassee, Leon County, Florida.

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

Filed with the Clerk of the
Division of Administrative Hearings
this 2nd day of March, 2010.

ENDNOTE

[1/] All references to Florida Statutes are to Florida Statutes (2006), unless otherwise indicated.

COPIES FURNISHED:

Constance Bence
2588 West Socrum Loop Road
Lakeland, Florida 32810

L. William Porter, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Station 3
Tallahassee, Florida 32308

Thomas W. Arnold, Secretary
Agency for Health Care Administration
Fort Knox Building, Suite 3116
2727 Mahan Drive
Tallahassee, Florida 32308-5403

Justin Senior, General Counsel
Agency for Health Care Administration
Fort Knox Building, Suite 3431
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308-5403

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.