STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 07-2195MPI
LAZARO N. PLASENCIA, M.D.,	)	
Respondent.	)	
AGENCY FOR HEALTH CARE ADMINISTRATION,	)	
Petitioner,	)	
vs.	)	Case No. 07-2462MPI
ANA M. ELOSEGUI, M.D.,	)	
Respondent.	)	

RECOMMENDED ORDER

Pursuant to notice a formal hearing was held in this case on December 17, 2007, in Tallahassee, Florida, before J. D. Parrish, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: L. William Porter, II, Esquire
Agency for Health Care Administration
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For Respondent: Robert N. Nicholson, Esquire
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STATEMENT OF THE ISSUE

Whether the Respondents were overpaid by Medicaid for radiology and nuclear medicine services provided to Florida Medicaid patients. The Agency for Health Care Administration (AHCA, Agency or Petitioner) asserts that the Respondents, Lazaro N. Plasencia, M.D., and Ana M. Elosegui, M.D., billed Medicaid for procedures they did not perform in violation of Medicaid policy, the Florida Administrative Code, and Florida Statutes. The Respondents maintain that because of ambiguities in Medicaid policy regarding reimbursement protocols for the radiology services at issue, the Respondents mistakenly believed in good faith that under the applicable Medicaid regulations and guidelines, Medicaid would reimburse the "maximum" fee allowable under the relevant fee schedule. The Respondents acknowledge that the "professional component" of the radiology services at issue was provided by a third-party physician specialist. The Respondents further assert that they are entitled to, at the minimum, payment of the "technical component" of the medically necessary radiological services that they provided to Medicaid recipients. The Petitioner seeks reimbursement from Dr. Plasencia in the amount of $196,129.52 and $122,065.08 from Dr. Elosegui.

PRELIMINARY STATEMENT

On January 9, 2007, the Agency referred DOAH Case No. 07-2195MPI to the Division of Administrative Hearings. That case

related to the Medicaid billing attributable to the Respondent, Dr. Plasencia. The case against Dr. Elosegui, DOAH Case No. 07-0102MPI, was also opened on January 9, 2007. In Dr. Elosegui's case, however, the case was closed and jurisdiction relinquished to the Agency on or about March 15, 2007. When additional audit efforts did not resolve the issue of Medicaid over payment, Dr. Elosegui's case was reopened as DOAH Case No. 07-2462MPI on June 1, 2007. The cases were consolidated for final hearing on November 11, 2007. The Respondents are Medicaid providers and in the regular course of doing business were audited by the Agency regarding their Medicaid claims. The audit period pertinent to Dr. Plasencia is July 1, 2001 through December 31, 2005. The pertinent period for Dr. Elosegui is October 11, 2002 through December 31, 2005.

At the hearing, the Petitioner presented evidence from Ouida Mazzoccoli, a program administrator at the Agency; and Vicki Stiles, an investigator for Medicaid Program Integrity. The Petitioner's Exhibits 1 through 20 (Plasencia) and Petitioner's Exhibits 1 through 19 (Elosegui) were admitted into evidence. Petitioner's Exhibits 12-A and 12-B were also received in evidence. The Respondents presented no evidence.
The Transcript of the proceeding was filed on January 4, 2008. A Joint Motion for Enlargement of Time was granted by order entered on January 23, 2008, and the parties were granted leave until February 25, 2008, to file their proposed recommended orders.

The parties' Proposed Recommended Orders have been fully considered in the preparation of this Recommended Order. Also, pertinent stipulated facts set forth in the parties' Prehearing Stipulation are incorporated below.

FINDINGS OF FACT

1. The Petitioner is the state agency charged with the responsibility of monitoring the Medicaid Program in Florida.

2. At all times material to the allegations of DOAH Case No. 07-2195MPI, the Respondent, Dr. Plasencia, was a licensed medical doctor in good standing with the State of Florida, license #ME49315, and was also a Medicaid provider, #0448125-00.

3. Similarly, at all times material to the allegations of DOAH Case No. 07-2462MPI, the Respondent, Dr. Elosegui, was a licensed medical doctor in good standing with the State of Florida, license #ME85963, and was also a Medicaid provider, #2654636-00.

4. Drs. Elosegui and Plasencia practiced medicine together in a shared office space in Miami, Florida.

5. The Respondents were not members of a "group practice." The Respondents were individual providers who billed Medicaid separately, using their individual Medicaid provider numbers. The doctors performed services for Medicaid recipients and submitted the charges for those services to Medicaid.

6. Medicaid has a "pay and chase" policy of paying Medicaid claims as submitted by providers. Audits performed by the Agency

then, after-the-fact, reconcile the amounts paid to providers with the amounts that were payable under the Medicaid guidelines and pertinent rules. If more is paid to the provider than allowable, a recoupment against the provider is sought.

7. In these cases, the Respondents conducted (or supervised) various tests including "Radiological and Nuclear Medicine" services for Florida Medicaid patients in a shared office setting. The services at issue in these cases were billed under the CPT procedure codes of series 70000 and 90000.

8. The Petitioner has not challenged any procedure at issue as not "medically necessary."

9. Moreover, the Petitioner does not dispute that the Respondents performed or supervised the "technical component" of the universe of the radiological services at issue.

10. The "professional component" for the universe of the radiological services at issue in this proceeding was outsourced to third-party physicians. The Respondents contracted with the outside third-party physicians for the "professional component" services to read and interprete the radiological product. These third party physicians were not Medicaid providers, nor were they part of a Medicaid group provider that included the Respondents.

11. When billing for the radiological services, the Respondents billed Medicaid for both the "technical" and "professional" components using the "maximum" fee set forth in the Fee Schedule. The Respondents knew or should have known that

they had not performed a global service as they never performed or supervised the "professional" component of the services billed.

12. The Petitioner performed an audit of the radiological claims for Dr. Plasencia for the dates of service July 1, 2001 through December 31, 2005.

13. On December 1, 2006, the Petitioner issued a Final Audit Report that concluded Dr. Plasencia had been overpaid $196,129.52. Additionally, the Petitioner sought an administrative fine against Dr. Plasencia in the amount of $1,000.00.

14. Similarly, the Petitioner performed an audit of the radiological claims submitted by Dr. Elosegui for the dates of service October 11, 2002 through December 31, 2005.

15. On December 1, 2006, the Petitioner issued a Final Audit Report that concluded Dr. Elosegui had been overpaid $122,065.08. The Petitioner also sought an administrative fine against Dr. Elosegui in the amount of $1,000.00.

16. In January 2005, the Fee Schedule applicable to CPT 90000 procedure code services was revised. The Fee Schedule specified a reimbursement amount for the "technical" component of the radiological services in the CPT 90000 code set. Prior to that time, there had been no reimbursable amount for the "technical component" performed separately from the "professional component."

17. The Medicaid provider agreements executed between the parties govern the contractual relationships between these providers and the Agency. The parties do not dispute that those provider agreements, together with the pertinent laws or regulations, control the billing and reimbursement claims that remain at issue. The amounts, if any, that were overpaid were related solely to the radiological services billed under a global or inclusive manner that included the "professional" component within the amount claimed to be owed by Medicaid.

18. The provider agreements pertinent to these cases are voluntary agreements between AHCA and the Respondents.

19. The Fee Schedule adopted by the Petitioner dictates the code and reimbursement amounts authorized to be billed pursuant to the provider agreement.

20. The Respondents performed or supervised the "technical components" for the radiological services billed to Medicaid. The Respondents did not perform the "professional component."

21. For all of the 70000 series billing codes the components can be split and the "technical component" can be identified and paid separately. For these billing codes, the Respondents were given (or paid for) the "technical component" of the 70000 codes.

22. Similarly, for the 90000 billing codes, for the "technical component" portion where it was identifiable and

allowable, the Petitioner gave the Respondents credit for that amount.

23. The "technical component" for the 90000 billing codes was not identifiable or allowable prior to 2005.

24. Prior to the amendment to the Fee Schedule the 90000 billing codes were presumed to be performed in a global manner; i.e. the "professional component" and the "technical component" were done together by the Medicaid provider submitting the claim. That was not the factual case in these audits.

25. Respondents were not authorized to bill the 90000 codes in the global manner as they did not perform the "professional component" of the services rendered.

26. Any Medicaid provider whose billing is not in compliance with the Medicaid billing policies may be subject to the recoupment of Medicaid payments.

27. The Petitioner administers the Medicaid program in Florida. Pursuant to its authority AHCA conducts audits to assure compliance with the Medicaid provisions and provider agreements. These “integrity” audits are routinely performed and Medicaid providers are aware that they may be audited.

28. These “integrity” audits are to assure that the provider bill and receive payment in accordance with applicable rules and regulations. The Respondents do not dispute the Agency’s authority to perform audits such as the ones at issue.

CONCLUSIONS OF LAW

29. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of these proceedings. § 120.57(1), Fla. Stat. (2007).

30. Pursuant to Chapter 409, Florida Statutes (2007), the Petitioner is responsible for administering the Medicaid Program in Florida.

31. As the party asserting the overpayment, the Petitioner bears the burden of proof to establish the alleged overpayment by a preponderance of the evidence. See Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992).

32. Section 409.913, Florida Statutes (2007), provides, in pertinent part:

> 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:
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> * * *
>
> (d) "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.
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> * * *

> (7) When presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to supervise the provision of, and be responsible for, goods and services claimed to have been provided, to supervise and be responsible for preparation and submission of the claim, and to present a claim that is true and accurate and that is for goods and services that:
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> * * *
>
> (e) Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law.
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> * * *
>
> (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.

33. In this case the Agency seeks reimbursement of overpayments based upon the Respondents' failures to perform the "professional" component of the services billed. In this case it is concluded the Respondents were not entitled to bill for and be paid the maximum (global) fee for the radiology services as they did not perform the global service.

34. Finally, the Respondents did not submit bills for the "technical" component of any radiology service they performed.

35. Had they submitted a bill in the 90000 codes for the "technical" component, the service they performed, it would have been denied as it was not an allowable billing under the Medicaid system as a payable service.

35. For any "technical" service performed by the Respondents that was allowable and identifiable, they have been given credit.

36. The Respondents voluntarily participated in a program that dictated the manner in which all claims would be filed and allowed. Apart from the strict compliance with those dictates, the Respondents not entitled to payment for their claims. See Colonnade Medical Center, Inc. v. Agency for Health Care Administration, 847 So. 2d 540 (Fla. 4th DCA 2003).

37. The Respondents' assertions that they should be compensated for the "technical" component despite their indifference to the billing requirements is unacceptable. Had they billed correctly, recoupment of the overpayments would not be necessary as the payments would not have been made.

38. The “overpayments” in this cause result from an unacceptable practice or mistake. The unacceptable practice was the Respondents' global billing practice when they did not perform the "professional" component of the radiology service. The mistake was claiming that after-the-fact they should receive a portion of a fee that was not divisible or allowable. In complying with its mandate from the federal government, AHCA is held to a high standard and must assure that overpayments are recouped. See 42 C.F.R. § 433.312(a)(2).

39. In this case, the audit reports support and constitute evidence of the overpayments claimed. See § 409.913(22), Fla

Stat. (2007). The Respondents did not present substantial, credible evidence to rebut the overpayments claimed.

40. The Agency has met its burden of proof in this case and has established by a preponderance of the evidence that the Respondents received overpayments as claimed.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order of recoupment as set forth in the reports at issue. The final order should also impose an administrative fine against each Respondent in the amount of $1,000.00.

DONE AND ENTERED this 1st day of April, 2008, in Tallahassee, Leon County, Florida.

J. D. PARRISH
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
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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.