**STATE OF FLORIDA**
**AGENCY FOR HEALTH CARE ADMINISTRATION**

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2009 NOV 12 A 11:23

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v.

HAMID BAGLOO, M.D.,

Respondent.
_____/

DOAH CASE NO. 08-4921MPI
AUDIT NO. C.I. 07-4891-000
RENDITION NO.: AHCA-09-1121 -FOF-MDO

## CORRECTED FINAL ORDER

This case was referred to the Division of Administrative Hearings (DOAH) where the assigned Administrative Law Judge (ALJ), R. Bruce McKibben, issued a Recommended Order after conducting a formal hearing. At issue in this proceeding is whether Respondent was overpaid Medicaid funds for services provided to his patients, and, if so, whether the alleged overpayment was properly calculated. The Recommended Order dated September 10, 2009, is attached to this Final Order and incorporated herein by reference, except where noted infra.

## RULING ON EXCEPTIONS

The Petitioner filed exceptions to the Recommended Order.

In determining how to rule upon the Petitioner's exceptions and whether to adopt the ALJ's Recommended Order in whole or in part, the Agency for Health Care Administration ("Agency" or "AHCA") must follow Section 120.57(1)(*l*), Florida Statutes, which provides in pertinent part:

> The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state

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> with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

Fla. Stat. § 120.57(1)(*l*). In accordance with these legal standards, the Agency makes the following rulings on the Petitioner's exceptions:

In its first exception, Petitioner argues that, in Paragraph 12 of the Recommended Order, the ALJ gave Respondent credit for several Medicaid claims that were not supported by the Respondent's documentation, as required by law. However, Respondent's testimony does support the ALJ's findings. See, generally, Transcript, Volume II. Because the ALJ's findings were based on competent, substantial evidence, the Agency is not at liberty to reject or modify them. Therefore, Petitioner's first exception must be denied.

In its second exception, Petitioner argues that, in Paragraph 14 of the Recommended Order, Respondent's testimony was not supported by the documentation in his medical records and, therefore, should not be given great weight. The ALJ's findings regarding Respondent's testimony involve a weighing of evidence. The Agency cannot re-weigh the evidence to reach findings that differ from those of the ALJ.

> If, as is often the case, the evidence presented supports two inconsistent findings, it is the hearing officer's role to decide the issue one way or the other. The agency may not reject the hearing officer's finding unless there is no competent, substantial evidence from which the finding may reasonably be inferred. The agency is not authorized to weigh the evidence presented, judge credibility of witnesses, or otherwise interpret the evidence to fit its desired ultimate conclusion.

Heifetz v. Department of Bus. Regulation, 475 So.2d 1277, 1281 (Fla. 1985). Therefore, Petitioner's second exception must be denied.

In its third exception, Petitioner argues that the ALJ erred in making the finding of fact in Paragraph 16 of the Recommended Order because Petitioner's expert did refute Respondent's testimony. The ALJ made his finding by weighing the evidence presented in this case, and the Agency cannot re-weigh that evidence in order to reject the ALJ's finding. See § 120.57(1)(*l*), Fla. Stat.; Heifetz. Therefore, Petitioner's third exception must be denied.

Petitioner's next three exceptions to the Recommended Order share a common theme: the ALJ erred in overturning several of the Agency's downward adjustments based on Respondent's testimony, where the medical records did not contain documentation supporting the Current Procedural Terminology ("CPT") codes Respondent used in submitting his Medicaid claims to the Agency for payment.

AHCA is the single state agency responsible for administering Florida's Medicaid program and for ensuring state compliance with federal Medicaid laws and rules. § 409.902, Fla. Stat. AHCA is responsible for reimbursing health care providers for goods and services rendered to Medicaid recipients. § 409.908, Fla. Stat.; see FLA. ADMIN. CODE R. 59G-5.110. AHCA is also responsible for ensuring the integrity of the Medicaid program and for ascertaining that health care providers comply with all governing statutory law, rules, and provider handbooks. See § 409.913, Fla. Stat.

A Medicaid provider who submits a claim to the Agency for payment

> 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:

(a) Have actually been furnished to the recipient by the provider prior to submitting the claim.

(b) Are Medicaid-covered goods or services that are medically necessary.

(c) Are of a quality comparable to those furnished to the general public by the provider's peers.

(d) Have not been billed in whole or in part to a recipient or a recipient's responsible party, except for such copayments, coinsurance, or deductibles as are authorized by the agency.

(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.

(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.**

(Emphasis added). Once a provider submits a Medicaid claim for payment, The Agency must decide whether it will be paid.

Generally, goods or services billed to the Medicaid program must have been "provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accordance with federal, state, and local law" and have been "documented in records made at the time the goods or services were provided, demonstrating the medical necessity . . ." § 409.913(7)(e), (f), Fla. Stat.; Florida Medicaid Provider General Handbook (May 2001 and October 2003) at 5-4 ("Provider General Handbook"). See FLA. ADMIN. CODE R. 59G-5.020(1) (requiring compliance with the Provider General Handbook). AHCA will pay Medicaid claims for covered physician services, but only if the services are "medically necessary" and provided "in accordance with state and federal law." § 409.905(9), Fla. Stat; see FLA. ADMIN. CODE R.

59G-4.230. If the goods or services are not presented in the manner described above (i.e. they are not medically necessary and furnished in accordance with the law), AHCA may deny payment or require repayment. § 409.913(7), Fla. Stat.

The term "'[o]verpayment' includes any amount that is not authorized to be paid by the Medicaid program whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake." § 409.13(1)(e), Fla. Stat.; FLA. ADMIN. CODE R. 59G-9.070(2)(p); see Provider General Handbook at 5-3. AHCA is required by statute to review or audit Medicaid claims to determine possible fraud, abuse, overpayment or neglect within the Medicaid program. § 409.913 (2), Fla. Stat.; see also Provider General Handbook at 5-1. When AHCA discovers during a retrospective audit of a provider's Medicaid claims that the provider has been overpaid for goods or services, AHCA is entitled to seek repayment. § 409.913(2), (7), (20), (21), Fla. Stat. (2002, 2004, 2005, 2006); Colonnade Med. Ctr., Inc. v. AHCA, 847 So. 2d 540, 541 (Fla. 4th DCA 2003) (interpreting Section 409.913(14) and concluding "the plain meaning of the statute dictates that it is within the AHCA's power to demand repayment.").

Section 409.913(7)(f), Florida Statutes, requires a provider to submit for payment only those Medicaid claims that "[a]re documented by records made at the time the goods or services were provided, demonstrating the medical necessity for the goods or services rendered. 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." Thus, AHCA may require repayment for goods and services that were not properly documented. § 409.913(7), Fla. Stat.

In this case, Petitioner's expert testified at great length that Respondent's records, in several instances, did not support the level of service (or CPT code) for which Respondent had billed Medicaid. See, e.g., Transcript, Volume I at Pages 27, 29, 33-36, 38, 40-41, 44-45, 47-49, 52-53, 55, 60-62, 64, 65, 67, 70, 73-74, 75, 76, 78-79, 80-83, and 84-85. That testimony (along with the audit report, supported by agency work papers, showing an overpayment had been made to Respondent) constituted evidence of the overpayment. See §409.913(18), Fla. Stat.

Respondent was given the opportunity to rebut the Agency's evidence and testified at length about the services he claimed to have provided to the Medicaid recipients at issue. See, generally, Transcript, Volume II. However, Respondent's testimony was not supported by the documentation in Respondent's medical records. See, generally, Petitioner's Exhibit 15. Indeed, for all of the service dates enumerated in Paragraph 12 of the Recommended Order where the ALJ found in favor of Respondent, Respondent failed to demonstrate that his documentation justified the level of service for which he had billed Medicaid. Respondent's testimony, by itself, is not a documentation by records made at the time the goods or services were provided for purposes of section 409.913(7)(f), Florida Statutes.

The conclusions of law in Paragraphs 22, 25 and 26 of the Recommended Order are not just evidentiary determinations by the ALJ; they are policy issues that fall within AHCA's discretion. "Matters that are susceptible of ordinary methods of proof, such as determining the credibility of witnesses or the weight to accord evidence, are factual matters to be determined by the hearing officer. On the other hand, matters infused with overriding policy considerations are left to agency discretion." Baptist Hosp., Inc. v. Dep't of HRS, 500 So. 2d 620, 623 (Fla. 1st DCA 1986). If, as the ALJ concluded, a provider was allowed to rebut the Agency's evidence of overpayment by oral testimony at hearing without documentation by records made at the time the

goods or services he has billed Medicaid for were provided, the provisions of the statutes, rules and Handbook governing recordkeeping requirements would be rendered meaningless.

Based on the reasoning set forth above, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraphs 22, 25 and 26 of the Recommended Order, and that it can substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency grants Petitioner's exceptions to the conclusions of law in Paragraphs 22, 25 and 26 of the Recommended Order, and makes the following modifications to the Recommended Order:

> 22. However, pursuant to Subsection 120.57(1)(j), Florida Statutes (2009), Petitioner must prove its case by a preponderance of the evidence. See also South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440 (Fla. 3rd DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992). It is then incumbent upon the provider to rebut, impeach, or otherwise undermine AHCA's evidence. Disney Medical Equipment, Inc., d/b/a Disney Pharmacy Discount, Case No. 05-2277, WL979582, *6 (DOAH April 11, 2006). Respondent testified as to what he did for each patient but did not provide sufficient documentation by records made at the time the goods or services were provided to rebut the Agency's evidence of an overpayment.
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> 25. The testimony of Dr. Sloan as to incorrect CPT codes for the 40 patients was based entirely upon a "desk review" of the patient records, including comments and notations made therein by Respondent and his staff. Respondent's testimony as to specific circumstances relating to individual patients that somewhat refutes what Dr. Sloan found from his review is not entitled to greater weight than Dr. Sloan's testimony because it is Respondent's documentation, not his testimony, that determines what level of service was provided to a patient. See § 409.913(7)(f), Fla. Stat.
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> 26. AHCA met its initial burden of establishing an overpayment based on incorrect codes assigned to individual patients for their office visits with Respondent. With regards to the instances where the Agency down-coded Respondent's claims, Respondent failed to provide documentation justifying the code he assigned.

In its seventh exception, Petitioner argued that the ALJ's conclusions of law in Paragraphs 27 and 28 of the Recommended Order reflected "an incorrect interpretation and application of section 409.913(16), Florida Statutes, regarding Petitioner's right to sanction and assess fines." Paragraph 27 of the Recommended Order is a recitation of section 409.913(16), Florida Statutes, and thus the Agency could not substitute a conclusion of law as or more reasonable than that of the ALJ for that paragraph.

In Paragraph 28 of the Recommended Order, the ALJ concluded that "[s]ubmitting an erroneous request for a prior authorization is one of the based for which a penalty may be assessed by AHCA. However, that particular violation must be done 'knowingly' in order to justify a fine." The ALJ's conclusion that the violation must be done knowingly in order for a fine to be imposed is erroneous and inconsistent with prior Agency precedent. See, e.g., AHCA v. Harold R. Murray, M.D., 06-3494MPI (Final Order rendered on June 11, 2007); AHCA v. Womesh C. Sahedo, M.D., 07-1487MPI (Final Order rendered on December 21, 2007); and AHCA v. Jamarel Enterprises, Inc. d/b/a Camaguey Pharmacy, 07-1511MPI (Final Order rendered on February 14, 2008). In all of those cases, the ALJ recommended the imposition of fines for violations without finding that the Respondent knowingly committed those violations. Those final orders are consistent with the Agency's interpretation of section 409.913(16), Florida Statutes, which is entitled to deference. Therefore, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 28 of the Recommended Order since it is the single state agency responsible for administering the Medicaid program in the state of Florida, and that it can substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency grants Petitioner's seventh exception to the extent that it modifies Paragraph 28 of the Recommended Order to state the following:

> 28. Because the Agency proved that Respondent was overpaid for services rendered due to insufficient documentation for several CPT codes that were billed, the Agency is also entitled to sanction the Respondent for a failing to comply with the provisions of the Medicaid provider handbook and the laws and rules that govern the Medicaid program. The $3,000 fine imposed by the Agency is well within its statutory authority.

In its final exception, the exception to Paragraph 29 of the Recommended Order, Petitioner argued that, based on its other exceptions, no adjustment or recalculation of the overpayment is warranted in this case. Based upon the ruling on Petitioner's exceptions to Paragraphs 22, 25 and 26 of the Recommended Order, the Agency grants Petitioner's exception and rejects Paragraph 29 of the Recommended Order in its entirety.

## FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

## 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:**

Respondent is required to repay $82,836.07 in Medicaid overpayments, plus statutory interest, to the Agency for paid claims covering the period from January 1, 2002 to August 31, 2006. Additionally, the Agency imposes a $3,000 fine on the Respondent. Respondent shall make full payment of the overpayment and fine to the Agency for Health Care Administration within 30 days of the rendition of this Final Order. Respondent 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 10 day of November, 2009, in Tallahassee, Florida.

THOMAS W. ARNOLD, 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 12th day of November 2009.

RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
(850) 922-5873

COPIES FURNISHED TO:

Honorable R. Bruce McKibben
Administrative Law Judge
Division of Administrative Hearing
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1230 Apalachee Parkway
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> with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. . . .

Fla. Stat. § 120.57(1)(*l*). In accordance with these legal standards, the Agency makes the following rulings on the Petitioner's exceptions:

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A Medicaid provider who submits a claim to the Agency for payment

> 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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(Emphasis added). Once a provider submits a Medicaid claim for payment, The Agency must decide whether it will be paid.

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In its seventh exception, Petitioner argued that the ALJ's conclusions of law in Paragraphs 27 and 28 of the Recommended Order reflected "an incorrect interpretation and application of section 409.913(16), Florida Statutes, regarding Petitioner's right to sanction and assess fines." Paragraph 27 of the Recommended Order is a recitation of section 409.913(16), Florida Statutes, and thus the Agency could not substitute a conclusion of law as or more reasonable than that of the ALJ for that paragraph.

In Paragraph 28 of the Recommended Order, the ALJ concluded that "[s]ubmitting an erroneous request for a prior authorization is one of the based for which a penalty may be assessed by AHCA. However, that particular violation must be done 'knowingly' in order to justify a fine." The ALJ's conclusion that the violation must be done knowingly in order for a fine to be imposed is erroneous and inconsistent with prior Agency precedent. See, e.g., AHCA v. Harold R. Murray, M.D., 06-3494MPI (Final Order rendered on June 11, 2007); AHCA v. Womesh C. Sahedo, M.D., 07-1487MPI (Final Order rendered on December 21, 2007); and AHCA v. Jamarel Enterprises, Inc. d/b/a Camaguey Pharmacy, 07-1511MPI (Final Order rendered on February 14, 2008). In all of those cases, the ALJ recommended the imposition of fines for violations without finding that the Respondent knowingly committed those violations. Those final orders are consistent with the Agency's interpretation of section 409.913(16), Florida Statutes, which is entitled to deference. Therefore, the Agency finds that it has substantive jurisdiction over the conclusions of law in Paragraph 28 of the Recommended Order since it is the single state agency responsible for administering the Medicaid program in the state of Florida, and that it can substitute conclusions of law that are as or more reasonable than those of the ALJ. Therefore, the Agency grants Petitioner's seventh exception to the extent that it modifies Paragraph 28 of the Recommended Order to state the following:

> 28. Because the Agency proved that Respondent was overpaid for services rendered due to insufficient documentation for several CPT codes that were billed, the Agency is also entitled to sanction the Respondent for a failing to comply with the provisions of the Medicaid provider handbook and the laws and rules that govern the Medicaid program. The $3,000 fine imposed by the Agency is well within its statutory authority.

In its final exception, the exception to Paragraph 29 of the Recommended Order, Petitioner argued that, based on its other exceptions, no adjustment or recalculation of the overpayment is warranted in this case. Based upon the ruling on Petitioner's exceptions to Paragraphs 22, 25 and 26 of the Recommended Order, the Agency grants Petitioner's exception and rejects Paragraph 29 of the Recommended Order in its entirety.

## FINDINGS OF FACT

The Agency adopts the findings of fact set forth in the Recommended Order.

## 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:**

Respondent is required to repay $83,836.07 in Medicaid overpayments, plus statutory interest, to the Agency for paid claims covering the period from January 1, 2002 to August 31, 2006. Additionally, the Agency imposes a $3,000 fine on the Respondent. Respondent shall make full payment of the overpayment and fine to the Agency for Health Care Administration within 30 days of the rendition of this Final Order. Respondent 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 26th day of October, 2009, in Tallahassee, Florida.

HOLLY BENSON, 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 28th day of October, 2009.

RICHARD J. SHOOP, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308
(850) 922-5873

COPIES FURNISHED TO:

Honorable R. Bruce McKibben
Administrative Law Judge
Division of Administrative Hearing
The DeSoto Building
1230 Apalachee Parkway
Tallahassee, Florida 32399-3060

Tracie L. Wilks, Esquire
Assistant General Counsel
Agency for Health Care Administration
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521 East Central Avenue
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Tallahassee, Florida 32308

Henry Evans
Finance & Accounting

STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

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Agency for Health Care Administration

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| AGENCY FOR HEALTH CARE ADMINISTRATION, | ) | |
| Petitioner, | ) | |
| vs. | ) | Case No. 08-4921MPI |
| HAMID BAGLOO, M.D., | ) | |
| Respondent. | ) | |

## RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on July 28 and 29, 2009, in Tallahassee, Florida, before Administrative Law Judge R. Bruce McKibben of the Division of Administrative Hearings.

## APPEARANCES

For Petitioner: Tracie L. Wilks, Esquire
Agency for Health Care Administration
Fort Knox Building III, Mail Station 3
2727 Mahan Drive
Tallahassee, Florida 32308

For Respondent: Hamid Bagloo, M.D., pro se
521 East Central Avenue
Winter Haven, Florida 33880

## STATEMENT OF THE ISSUE

The issue in this case is whether Respondent was overpaid Medicaid funds for services provided to his patients, and, if so, whether the alleged overpayment was properly calculated.

## PRELIMINARY STATEMENT

By letter dated October 18, 2006, Petitioner, Agency for Health Care Administration ("AHCA" or the "Agency"), notified Respondent of a pending audit review concerning records relating to certain of Respondent's patients. This letter was followed by correspondence dated October 30, 2008,[1] requesting certain documents from Respondent. The documents were timely submitted to AHCA, and on March 27, 2007, AHCA issued its Preliminary Audit Report. On April 26, 2007, Respondent, through his counsel at the time,[2] provided additional documents and information contesting the audit findings. A Final Audit Report was issued by AHCA on July 15, 2007, setting forth the amount of the alleged overpayment ($82,836.07) and setting a fine of $3,000. Respondent timely filed a challenge to the audit findings. His Amended Petition for Formal Administrative Hearing was forwarded to the Division of Administrative Hearings ("DOAH") by the Agency on October 2, 2008.

At the final hearing, the Agency called three witnesses: Dr. Gregory K. Sloan, a practicing family physician in Chipley, Florida, acting as a consultant to AHCA; Tracy B. McDonnell, a program analyst for the Bureau of Medicaid Program Integrity (the "Bureau"); and Greg Riley, a reviewer for the Bureau. AHCA's Exhibits 1 through 15 (including 40 subparts to Exhibit 15) were admitted into evidence without objection.

Respondent testified on his own behalf, but did not call any other witnesses. Respondent did not offer any additional documentary evidence.[3]

Official recognition was requested (and granted without opposition) as to the following items:

- Sections 409.905 through 409.908, 409.913, 409.9131, and 414.41, Florida Statutes (versions 2001 through 2006);
- Florida Administrative Code Rule 59G-1.010 (as amended 6-24-98 and 4-16-06);
- Florida Administrative Code Rule 59G-4.230 (as amended 8-5-01, 2-20-03, 8-5-03, 8-3-04, 8-18-05 and 8-31-05);
- Florida Administrative Code Rule 59G-5.010 (as amended 7-10-00, 5-7-03 and 7-7-05);
- Florida Administrative Code Rule 59G-110 (as amended 5-9-99);
- Florida Administrative Code Rule 59G-5.020 (as amended 8-6-01, 10-8-03 and 1-19-05);
- Florida Administrative Code Rule 59G-9.070 (as amended 4-19-05 and 4-26-06);
- Florida Medicaid Provider General Handbook;
- Florida Medicaid Physicians Coverage and Limitations Handbook;
- Medicaid Provider Reimbursement Handbook, HCFA-1500 and Child Health Check-up 221;

- Child Health Check-up Coverage and Limitations Handbook;
- Current Procedural Terminology (CPT) Evaluation and Management (E/M) Service Guidelines and Codes (versions 2002 through 2006); and
- Relevant Medicaid Fee Schedules.

The parties advised that a transcript of the final hearing would be ordered. They were given ten days from the filing of the transcript at DOAH to submit proposed findings of fact and conclusions of law. Respondent indicated that he would not be filing anything subsequent to the final hearing. The Transcript was filed at DOAH on August 18, 2009. The Agency timely filed its post-hearing Findings of Fact and Conclusions of Law.

## FINDINGS OF FACT

1. AHCA is the state agency responsible for, inter alia, administering the Medicaid program in the State of Florida. The Bureau, a division of AHCA located in Tallahassee, Florida, is responsible for monitoring payments to Medicaid providers, and, when necessary, collecting return of any overpayments made to the providers.

2. Medicaid providers enter into a contract with AHCA agreeing to bill patients no more than the usual and customary charges for services provided. Charges are established, in part, in accordance with procedure codes from the Current Procedural Terminology (CPT) guidelines. The CPT codes describe

the kind of office visit which occurs during treatment to individual patients. A monetary charge is then assigned to the CPT code so that Medicaid will know how much to pay for the visit in question.

3. The provider submits its claim for payments each month to AHCA, setting forth the number of visits within each CPT procedure code. The Bureau then determines the amount of Medicaid payment earned by the provider pursuant to the claimed services. The payment is then made by AHCA to the provider.

4. The Bureau periodically performs audits of the claims submitted by providers. If a discrepancy or overpayment is discovered during the audit process, the Bureau notifies the provider by way of a demand letter. The Bureau then requests records and documents from the provider concerning the patients and charges in question. Upon review of the provider's records, the Bureau issues a Preliminary Audit Report setting forth its findings. The provider may agree (and repay the overpayment amount) or challenge the audit findings.

5. In the present case, Respondent challenged the audit findings. As a result of that challenge, AHCA requested and Respondent provided additional documentation concerning Respondent's provision of services to certain patients. The Bureau then issued a Final Audit Report, again stating the amount of the overpayment and imposing a fine. The overpayment

amount in this case is $82,836.07 and a fine of $3,000 was imposed.

6. The overpayment discovered by AHCA relates to 40 individual patients who Respondent treated during the period January 1, 2002, through August 31, 2006. Each will be more fully discussed below. For some of the patients, there was only one charge in dispute; for others there are numerous charges.

7. There are a small number of CPT procedure codes relevant to Respondent's patients at issue in this proceeding. A discussion of them is necessary to the analysis of the individual cases. Definitions and descriptions of the various codes are found in the Evaluation and Management Services Guidelines manual issued by the American Medical Association (AMA). The codes at issue are:

- 99201--Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A problem focused history; a problem focused examination; and Straightforward medical decision making.

  Usually, the presenting problems are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

- 99202--Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making.

  Usually, the presenting problems are of low to moderate severity. Physicians typically spend 20

minutes face-to-face with the patient and/or family.

- 99203--Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A detailed history; A detailed examination; and Medical decision making of low complexity.

  Usually the presenting problems are of moderate severity. Physicians usually spend 30 minutes face-to-face with the patient and/or family.

- 99204--Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity.

  Usually the presenting problems are of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

- 99205--Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

  Usually, the presenting problems are of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

- 99211--Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

  Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

- 99212--Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A problem focused history; A problem focused examination; and Straightforward medical decision making.

  Usually the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.

- 99213--Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity.

  Usually, the presenting problem(s) are of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

- 99214--Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity.

  Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

- 99215--Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity.

  Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

- 99382--Initial comprehensive preventive medicine evaluation and management . . . for a child age 1 through 4 years.

- 99384--An initial comprehensive preventive medicine evaluation and management . . . of a new patient, aged 12 through 17 years.

- 99385--An initial comprehensive preventive medicine evaluation and management . . . of a new patient, aged 18 to 39 years.

- 99392--A periodic comprehensive preventive medicine evaluation and management . . . for a child age 1 to 4 years.

- 99393--A periodic comprehensive preventive medicine evaluation and management . . . of a child age 5 through 11 years.

- 99395--A periodic comprehensive preventive medicine evaluation and management . . . of an existing patient, aged 18 through 39 years.

- 99396--A periodic comprehensive preventive medicine evaluation and management . . . of an existing patient, aged 40 through 64 years.

- W9881--A checkup and screening for a child.[4]

8. The exact correlation between the CPT procedure codes and specific dollar amounts was not provided at final hearing, but there was a dollar amount assigned (by AHCA) to each of the services provided by Respondent to his patients. The Medicaid Fee Schedules (of which official recognition were taken) do provide a maximum fee for each code, but there was no testimony as to how each fee was assigned in this case, i.e., whether it was the maximum fee or not.

9. AHCA used the services of a hired consultant (Dr. Sloan) to review Respondent's patient records concerning the assignment of CPT procedure codes for services rendered. Dr. Sloan is an experienced physician with a family practice in Chipley, Florida (a city in the Florida panhandle). Dr. Sloan had never, prior to the instant action, performed a review of another physician's records for the purpose of ascertaining the proper procedure code. This was his first foray into this process.

10. Dr. Sloan reviewed Respondent's patient records and determined that all 40 patient records at issue had at least one erroneous procedure code, resulting in the reduction of allowable charges for those procedures. After Dr. Sloan's review was completed, another medical professional (Greg Riley, a registered nurse) reviewed the charts and made some adjustments to the monetary charges. Riley had reviewed the records initially just to make sure the records were complete. His subsequent review, after Dr. Sloan, was to determine the correct charges based on Dr. Sloan's adjustments of the procedure codes.

11. For the purposes of reviewing the following paragraph, the patients were each assigned a number (1 through 40) and will be referenced by their assigned number herein with a parenthetical number, e.g., (1) (2) (3), etc. Some patients had

more than one visit at issue. For those patients, the visit will be referred to by a written number, e.g., One, Two, Three, etc. A review of each patient and each office visit will be discussed in the following Findings of Fact. The original code and monetary charge will be stated, followed by Dr. Sloan's revised code and Riley's reduction in monetary charge. A statement of Respondent's position concerning the charge will come next, followed by a conclusion as to the proper charge based on all the evidence presented.

12. The evidence at final hearing as to each resident was presented by way of three groups of documentation. First, there is an AHCA form listing all claims in the Medicaid sample, showing the CPT code for each patient and each patient visit. Second, there is the Respondent's office chart from each patient visit. Third, there is a written response from Respondent's former counsel as to each patient visit. This evidence, along with the testimony of witnesses, shows:

(1) One: Coded 99205 with a charge of $85.41--Dr. Sloan reduced the code to 99203, due to lack of a comprehensive history; charge was reduced to $48.68. Respondent showed that, according to annotations in the chart, the patient presented with multiple problems and a comprehensive examination was conducted. 99205 is supported.

Two: Coded 99214 for $39.46--claim denied in full, as visit was a follow up only; no face-to-face time with doctor. Respondent's records show he did meet with patient, but did not exercise complex medical decision-making. The evidence supports a reduction to 99211, with the appropriate charge for that code.

(2) One: Coded 99205 for $85.41--reduced to 99202 due to lack of documentation. Respondent did not prove entitlement to a higher code. 99202 is appropriate.

Two: Coded 99215 for $58.28--reduced to 99212 for $21.84, because visit was not deemed "extensive" by Dr. Sloan. Respondent did not prove elements of 99215. 99212 is appropriate.

Three: Coded 99395 for $51.85--denied in full due to lack of documentation and no management issues during the visit. Respondent's records indicate comprehensive exam, and he testified to long face-to-face visit with resident. 99395 is supported.

(3) One: Coded 99204 for $66.74--reduced to 99203 for $48.37, because the examination was deficient. Respondent's records show that comprehensive examination done, history taken, and moderate complexity medical decisions made. 99204 is supported.

Two: Coded 99215 for $58.94--reduced to 99213 for $26.47, due to lack of complex history or exam. The records show some level of medical decision-making that could support a higher code. 99214 would be appropriate.

(4) One: Coded 99204 for $66.74--reduced to 99203 for $48.37, due to lack of complex history. Respondent did not prove otherwise. 99203 is appropriate.

Three: Coded 99214 for $39.51--reduced to 99213 for $26.61 for lack of documentation. Respondent did not prove otherwise. 99212 is appropriate.

Four: Coded 99213 for $24.47--reduced to 99212 for $21.84 (a difference of $2.63) for lack of complexity. Respondent did not prove otherwise. 99212 is appropriate.

(5) One: Coded 99204 for $68.74--reduced to 99203 for $48.66, due to lack of complexity. Respondent explained his notations in the patient chart and proved the complex nature of the patient's medical problems. 99204 is supported.

Four: Coded 99214 for $39.64--reduced to 99212 for $21.84, because the examination lacked detail. Respondent's records and testimony established that a

detailed examination was performed. 99214 is supported.

(6) One: Coded 99204 for $66.74--reduced to 99202 for $32.44, because of lack of complexity, i.e., upper respiratory infection. Respondent did not prove that a higher code was justified. 99202 is appropriate.

(7) One: Coded 99205 for $6.74--denied in full, because the exam lacked a review of services (ROS) component. Respondent's records showed otherwise. 99205 is supported.

Three: Coded 99214 for $39.49--reduced to 99212 for $21.84 due to lack of exam and/or exam was "problem focused."[5] Respondent indicated patient had undergone complete physical three days prior. Visit at issue was for a specific problem. 99212 is appropriate.

Four: Coded 99213 for $24.47--reduced to 99212 for $21.84, because no exam shown; visit was problem focused. Respondent's records indicate only a brief visit. 99212 is appropriate.

Five: Coded 99213 for $24.4--reduced to 99211 for $12.48, due to visit being solely to refill medication. Respondent states, erroneously, that the 99211 code means that only a nurse saw the patient. In actuality, the code says that the physician does

not have to see the patient, but may do so. 99211 is appropriate.

Six: Coded 99214 for $39.49--reduced to 99212 for $21.84, because the visit was only problem focused. The examination performed by Respondent appears to be just that, for an oral problem. 99212 is appropriate.

Seven: Coded 99213 for $24.47--denied in full, because of absence of history taken and examination record. Doctor appeared to only provide results of prior test. Respondent did not prove otherwise. Denial is appropriate.

(8) One: Coded 99204 for $68.74--denied in full by Dr. Sloan, but upgraded to 99203 for $50.64, by the RN. No comprehensive history or exam was proven by Respondent. 99203 is appropriate.

(9) One: Coded 99384 for $71.54--reduced to 99213 for $32.56 due to insufficient documentation. Respondent showed that the patient came in for a school checkup. 99384 is supported.

(10) One: Coded 99204 for $68.74--reduced to 99202 for $34.01, because the visit was only problem focused. But Respondent showed that although patient showed with only one problem (toothache), other problems

were identified during the visit. 99204 is supported.

(11) One: Coded 99204 for $68.74--reduced to 99202 for $32.71, because visit was only problem focused, i.e., skin irritation. Respondent showed that patient was also in a high risk pregnancy and additional services were provided. 99204 is supported.

Two: Coded 99395 for $71.54--denied in full by Dr. Sloan for failure to do more than an abdominal exam and take vital signs. Respondent did show that an annual evaluation was done, but the records do not appear to indicate a full examination. 99212 would be warranted.

(12) One: Coded 99214 for $41.51--reduced to 99213 for $32.56, because the visit was problem focused. Respondent did spend some time with patient, but did not show elements of higher code. 99213 is appropriate.

(13) One: Coded 99204 for $68.74--reduced to 99202 for $34.01, because visit was problem focused for an ingrown toenail. Respondent showed that the patient actually had multiple issues and Respondent did a fairly comprehensive history and examination. 99204 is supported.

(14) One: Coded 99204 for $68.74--reduced to $32.71, because visit was problem focused for an upper respiratory infection. Respondent showed that a comprehensive history and examination were done in order to more adequately address the new patient's needs. 99204 is supported.

Two: Coded 99395 for $68.84; denied in full, because of full examination done just one week prior. Respondent showed that the annual evaluation done on this date had a different focus than the prior visit and was justified and necessary. 99395 is supported.

(15) One: Coded 99215 for $58.29--reduced to 99212 for $21.84, because the visit was only to refill a prescription. A one-item exam plus vitals was performed. Respondent did not establish need for higher code. 99212 is appropriate.

Two: Coded 99214 for $39.46--reduced to 99213 for $26.61, because the visit was only to address dermatitis. Respondent showed the existence of multiple problems and extensive time spent with patient. 99214 is supported.

Three: Coded 99214 for $41.46--reduced to 99212 for $21.84, because visit was problem focused for an

insect bite. Respondent did not prove higher code was needed. 99212 is appropriate.

Four: Coded 99214 for $39.46--reduced to 99213 for $23.61, because visit was problem focused for vaginitis. Respondent did not prove otherwise. 99213 is appropriate.

Five: Coded 99396 for $53.72--initially denied in full by Dr. Sloan, then reduced to 99211 by the RN. Respondent showed that a legitimate annual evaluation of patient was done. 99396 is supported.

Six: Coded 99215 for $60.29--reduced to 99213 for $26.61, because Dr. Sloan deemed the examination inadequate; Respondent failed to do a ROS. Respondent showed that he spent a lot of time with the patient, but not that there was any degree of medical decision-making at a high complexity level involved. 99214 would be appropriate.

Seven: Coded 99214 for $41.46--reduced to 99213 for $26.21, because visit was for an expanded problem-focused reason (ear infection). Respondent did not prove otherwise. 99213 is appropriate.

(16) One: Coded 99215 for $58.88--reduced to 99212 for $21.84, due to lack of examination documentation and that visit was problem focused. Respondent showed

that additional issues were presented and discussed. 99215 is supported.

Four: Coded 99214 for $41.49--reduced to 99212 for $21.84 for same reasons as prior visit. Respondent did not provide evidence of further issues. 99212 is appropriate.

(17) One: Coded 99214 for $41.51--reduced to 99213 for $27.67, due to lack of examination details. Respondent could not support higher code. 99213 is appropriate.

(18) One: Coded 99204 for $66.73--reduced to 99203 for $48.25, due to inadequate ROS and low complexity of the patient. Respondent could not support higher code. 99203 is appropriate.

(19) One: Coded 99204 for $68.74--reduced to 99202 for $34.01, because visit was for an expanded problem focus reason with straightforward medical decision-making. Respondent did not establish reason for higher code. 99202 is appropriate.

(20) One: Coded 99204 for $66.74--reduced to 99202 for $32.37, because it was a problem focused visit for an upper respiratory infection (URI). Respondent found patient to be in a high risk pregnancy and

examination escalated due to that fact. 99204 is supported.

(21) One: Coded 99204 for $66.74--reduced to 99202 for $37.37, because visit was problem focused for URI. Respondent did not support higher code. 99202 is appropriate.

(22) One: Claim was allowed.

(23) Two: Coded 99214 for $41.51--reduced to 99213 for $32.56, because the visit was problem-focused for a URI. Respondent could not prove higher code was necessary. 99213 is appropriate.

Three: Coded 99213 for $26.47--reduced to 99212 for $26.45 (two cent difference). Respondent acquiesced. 99212 is appropriate.

Four: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem-focused for an allergic reaction. Respondent noted that patient had allergic rhinitis and perhaps pneumonia. 99214 is supported.

Five: Coded 99213 for $26.47--reduced to 99212 for $26.45 (two cent difference). Respondent acquiesced. 99212 is appropriate.

Six: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused for URI.

Respondent did not prove need for higher code. 99213 is appropriate.

Eight: Coded 99393 for $71.54--denied in full, due to fact that prior visit should have covered examination. Respondent showed that the annual evaluation or physical focused on different aspects of patient's wellbeing than regular office visits. 99393 is supported.

Ten: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused for gastrointestinal problem. Respondent did not sufficiently justify the higher code. 99213 is appropriate.

Twelve: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

Thirteen: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

Fourteen: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused.

Respondent did not prove otherwise. 99213 is appropriate.

Sixteen: Coded 99214 for $41.51--reduced to 99213 for $27.67, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

(24) One: Coded 99205 for $85.11--reduced to 99203 for $48.69, because of lack of documentation. The evidence and documentation presented by Respondent was sufficient to validate higher code. 99205 is supported.

(25) Two: Coded 99214 for $41.51--reduced to 99212 for $26.45, because visit was problem focused. Respondent did not support a higher code. 99212 is appropriate.

Three: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

(26) One: Claim was allowed.

(27) One: Coded 99205 for $87.41--reduced to 99202 for $34.01, due to inadequate documentation. Respondent showed sufficient documentation to warrant code. 99205 is supported.

Three: Coded 99215 for $60.95--reduced to 99213 for $27.67, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

Four: Coded 99212 for $21.84--reduced to 99211 for $12.97, because visit was for a lab draw only. Respondent did not prove otherwise. 99211 is appropriate.

Five: Coded 99214 for $41.51--reduced to 99212 for $27.71, because visit was problem focused. Respondent failed to show all elements of higher code. 99212 is appropriate.

Six: Coded 99214 for $41.51--reduced to 99213 for $27.67, because visit was problem focused. Respondent failed to show all elements of higher code. 99213 is appropriate.

(28) One: Coded 99214 for $41.49--reduced to 99213 for $32.56, because visit was problem focused. Respondent showed that patient had several complex problems. 99214 is supported.

(29) One: Coded 99204 for $68.74--reduced to 99202 for $33.66, because visit was problem focused for a URI. Respondent did not prove otherwise. 99202 is appropriate.

(30) One: Coded 99214 for $41.51--reduced to 99212 for $26.45, because no examination done on a problem focused visit. Respondent showed that more extensive examination was done, that patient had disappeared for two years and doctor needed to catch up on their history, and diagnoses were complex. 99214 is supported.

Two: Coded W9881 for $68.74--reduced to 99211 for $12.48, because visit was for minor checkup. Respondent showed that visit was a legitimate checkup for the child. W9881 is supported.

Three: Coded 99212 for $21.84--reduced to 99211 for $12.97, because visit was just for refills and vital signs taken. Respondent did not show otherwise. 99211 is appropriate.

Four: 99214 for $41.51--reduced to 99213 for $32.56, because visit was only for expanded problem focus. Respondent did not prove elements of higher code. 99213 is appropriate.

(31) One: Coded 99204 for $68.74--reduced to 99202 for $33.74, because visit was problem focused. Respondent showed the patient had multiple problems that required treatment. 99204 is supported.

Three: Coded 99214 for $41.51--reduced to 99213 for $32.56, because visit was problem focused for URI. Respondent showed the elements of the higher code. 99214 is supported.

Four: Coded 99392 for $71.54--reduced to 99212 for $26.45, because it was deemed a simple office visit. Respondent proved that the visit was indeed an annual evaluation. 99392 is supported.

Five: Coded 99214 for $41.51--reduced to 69210 (a procedure code having to do with cerumen impaction removal, i.e., removing wax from the patient's ear) for $25.31. Respondent proved the difficulty of that procedure for a child and that by doing so he saved the family a much higher medical charge had they gone to a specialist. 99214 is supported.

(32) One: Claim was allowed.

(33) One: Coded 99204 for $66.74--reduced to 99202 for $33.66, because visit was problem focused for a depressive disorder. Respondent did not prove otherwise. 99202 is appropriate.

(34) One: Coded 99215 for $60.35--denied, in full, because of lack of evidence that face-to-face examination occurred. Respondent showed sufficient

evidence that such an examination did occur. 99215 is supported.

(35) One: Coded 99382 for $71.54--initially denied, in full, but then reduced to 99202 for $34.01 by the RN. Respondent showed that a full screening for a new patient was done. 99382 is supported.

(36) One: Coded 99204 for $66.74--reduced to 99202 for $33.74, because visit was problem focused for hypertension. Respondent indicated he spent considerable time with the patient, but did not meet the requirements for a higher code. 99202 is appropriate.

Two and Three: The dates and designations for these two visits are confused in the record. One visit is coded 99396 for $55.16, the other is 99215 for $58.35. The first was allowed, the second denied. Respondent did not prove the elements of the two higher codes. 99396 is appropriate. 99215 is denied.

Four: Coded 99212 for $19.84--reduced to 99211 for $12.48, because the visit was simply a blood pressure check. Respondent did not prove otherwise. 99211 is appropriate.

Five: Coded 99214 for $39.46--reduced to 99212 for $21.84, because visit was problem focused, and there was no examination. Respondent did not prove otherwise. 99212 is appropriate.

Six: Coded 99396 for $54.75--denied, in full, because of lack of documentation. Respondent showed the existence of a legitimate annual exam. 99396 is supported.

Seven: Coded 99214 for $39.46--reduced to 99213 for $26.61, because visit was an expanded problem focused relating to hypertension. Respondent did not prove otherwise. 99213 is appropriate.

Eight: Coded 99214 for $39.46--reduced to 99212 for $21.84, because visit was problem focused with only vitals taken. Respondent showed the visit was more extensive than that, but not to the level of 99214. 99213 would be supported.

(37) One: Coded 99204 for $66.74--reduced to 99202 for $32.37, because visit was problem focused. Respondent showed that patient had many special needs and additional services were required. 99204 is supported.

Two: Coded 99214 for $39.51--amount was adjusted to $34.75, due to fact that wrong code was used.

Respondent provided sufficient evidence to support his code. 99214 is supported.

Four: Coded 99214 for $39.51--denied, in full, because lack of documentation and belief that visit was simply a pre-op visit. Respondent did not support the higher procedure code, but did support a code of 99202.

Six: Coded 99214 for $41.49--reduced to 99213 for $26.61, because visit was problem focused to remove foreign object from patient's ear. Respondent satisfied elements of the higher procedure code. 99214 is supported.

Seven: Coded 99212 for $19.84--denied, in full, because of lack of documentation. Respondent's testimony and documents show that services were performed. 99212 is supported.

Nine: Coded 99213 for $24.47--denied, in full, because visit seemed to be only an interpretation on a test. Respondent did not prove otherwise. Claim is denied.

Ten: Coded 99214 for $41.46--reduced to 99213 for $26.61, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

Eleven: Coded 99395 for $51.83--denied in full, because the issues had been covered during the patient's prior visit. Respondent showed that the visit was an annual periodic visit and was legitimate. 99395 is supported.

Twelve: Coded 99213 for $24.47--denied, in full, because of lack of documentation and visit was only for lab work. Respondent did not prove otherwise. Claim is denied.

(38) One: Coded W9881 for $68.74--reduced to 99212 for $26.45, because visit was only a skin evaluation. Respondent showed that the patient was brought in by a state agency for a physical. W9881 is supported.

(39) One: Coded 99204 for $66.74--reduced to 99201 for $31.20, because visit was problem focused on obesity. Respondent spent time with the patient, but did not prove the elements of the higher code. 99202 would be appropriate.

Two: Coded 99212 for $19.84--denied, in full, because there is no evidence of a visit. Respondent did not prove otherwise. The claim is denied.

Three: Coded 99396 for $54.75--denied, in full, because of lack of medical necessity. Respondent did not prove otherwise. Claim is denied.

Four: Coded 99214 for $39.46--reduced to 99211 for $12.48, because no exam was conducted. Respondent did not prove otherwise. 99211 is appropriate.

Five: Coded 99212 for $19.84--denied, in full, because the visit was for a lab draw only. Respondent did not prove otherwise. 99211 is appropriate.

Six: Coded 99214 for $39.46--reduced to 99211 for $12.48, because visit was only for lab work review. Respondent proved that more services were provided. 99214 is supported.

Seven: Coded 99212 for $19.84--denied, in full, because of absence of face-to-face meeting. Respondent showed documentation that such a meeting occurred. 99212 is supported.

Eight: Coded 99213 for $24.47--denied, in full, because no face-to-face meeting occurred. Respondent did not prove otherwise. Claim is denied.

(40) One: Coded 99204 for $68.74--reduced to 99202 for $32.71, because visit was problem focused for HIV patient. Respondent did not prove otherwise. 99202 is appropriate.

Two: Coded 99385 for $49.83--denied, in full, because of lack of medical necessity. Respondent

showed need for annual medical evaluation. 99385 is supported.

Three: Coded 99214 for $39.46--reduced to 99213 for $26.61, because visit was problem focused. Respondent did not prove otherwise. 99213 is appropriate.

Four: Coded 99214 for $39.46--reduced to 99212 for $21.84, because visit was problem focused. Respondent showed that more than a simple visit occurred. 99213 would be appropriate.

13. Dr. Sloan, although undeniably a qualified family medicine practitioner in his own right, operates his business in a geographic area far removed from Respondent. Dr. Sloan's office is located in Chipley. Respondent's office is in central Florida, in Winter Haven. No evidence was presented to indicate how the diversity of those two areas would affect Dr. Sloan's ability to accurately address Respondent's coding. Thus, it is presumed for purposes of this proceeding that Dr. Sloan was competent to perform the review of records.

14. Nonetheless, Respondent is uniquely positioned to evaluate the patients who came to his office. Respondent is the only witness who testified at final hearing who knows exactly what kind of treatment each such patient received. His descriptions of the office visits and interpretation of the

patient charts are, therefore, given great weight. Further, Respondent's testimony was very credible as to his description of his patients and their various ailments.

15. The assignment of charges to each code was not discussed sufficiently at final hearing for the undersigned to make any specific findings as to the proper Medicaid charges for the revised codes. That is the purview of AHCA. The fee schedule introduced into evidence contains only the maximum fee for each CPT code; it does not provide guidance in setting a fee less than the maximum.

16. No evidence was presented to refute Respondent's description of his services to the 40 patients at issue; nor did Dr. Sloan address Respondent's explanation and interpretation of the patient charts.

17. The Agency used the technique of "cluster sampling" to determine the amount of overpayment to Respondent. This technique, which has been upheld in Agency for Health Care Administration v. Custom Mobility, 995 So. 2d 984 (Fla. 1st DCA 2008), rev. den., Custom Mobility, Inc. v. Agency for Health Care Administration (Fla. Feb. 2, 2009), was correctly applied in the instant case.

18. It was the cluster sampling of Respondent's 40 patients that resulted in the calculation of overpayment by AHCA.

## CONCLUSIONS OF LAW

19. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes (2009).

20. The burden of proof in this case is on Petitioner, as it is the party asserting the affirmative of the issue. Department of Banking and Finance, Division of Securities and Investor Protection v. Osbourne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996); see also Young v. Department of Community Affairs, 625 So. 2d 831 (Fla. 1993).

21. The Agency made a prima facie case as to the overpayments to Respondent by submitting into evidence its audit report.

22. However, pursuant to Subsection 120.57(1)(j), Florida Statutes (2009), Petitioner must prove its case by a preponderance of the evidence. See also South Medical Services, Inc. v. Agency for Health Care Administration, 653 So. 2d 440 (Fla. 3rd DCA 1995); Southpointe Pharmacy v. Department of Health and Rehabilitative Services, 596 So. 2d 106 (Fla. 1st DCA 1992). It is then incumbent upon the provider to rebut, impeach, or otherwise undermine AHCA's evidence. Disney Medical Equipment, Inc., d/b/a Disney Pharmacy Discount, Case No. 05-2277, WL979582, *6 (DOAH April 11, 2006). Respondent, as

set forth above, provided sufficient evidence to rebut or impeach the Agency's evidence as to some of the patient visits.

23. The Agency is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act. The medical assistance program is designated as the "Medicaid Program" in Section 409.902, Florida Statutes (2009).

24. The Agency has the sole responsibility for overseeing and administering the Medicaid Program for the State of Florida pursuant to Section 409.913, Florida Statutes (2009).

25. The testimony of Dr. Sloan as to incorrect CPT codes for the 40 patients was based entirely upon a "desk review" of the patient records, including comments and notations made therein by Respondent and his staff. To the extent that Respondent testified as to specific circumstances relating to individual patients that somewhat refute what Dr. Sloan perceived from his review, Respondent's perception is given greater weight.

26. AHCA met its initial burden of establishing questions concerning the codes assigned to individual patients for their office visits with Respondent. However, the questions raised by AHCA for each patient did not firmly establish, by a preponderance of the evidence, that Respondent had miscoded the visits. Rather, the questions raised a possibility that

Respondent had used the wrong codes. Respondent then provided competent and substantial evidence as to each code, in some cases justifying the code he assigned and in some cases not (as set forth in paragraph 11, above). It is of no particular import that the evidence presented by Respondent was in some instances (e.g., patient charts) exactly the same evidence relied upon by AHCA.

27. AHCA also proposes to fine Respondent $3,000 in accordance with its authority under Subsection 409.913(16), Florida Statutes, which states:

> 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. Each day that an ongoing violation continues, such as refusing to furnish Medicaid-related records or refusing access to records, is considered, for the purposes of this section, to be a separate violation. Each instance of improper billing of a Medicaid recipient; each instance of including an unallowable cost on a hospital or nursing home Medicaid cost report after the provider or authorized representative has been advised in an audit exit conference or previous audit report of the cost unallowability; each instance of furnishing a Medicaid recipient goods or professional services that are inappropriate or of inferior quality as determined by competent peer judgment; each instance of knowingly submitting a materially false or erroneous Medicaid provider enrollment application, request for prior authorization for Medicaid services, drug exception request, or cost

> report; each instance of inappropriate prescribing of drugs for a Medicaid recipient as determined by competent peer judgment; and each false or erroneous Medicaid claim leading to an overpayment to a provider is considered, for the purposes of this section, to be a separate violation.

28. Submitting an erroneous request for a prior authorization is one of the bases for which a penalty may be assessed by AHCA. However, that particular violation must be done "knowingly" in order to justify a fine. There is no evidence in the record that Respondent knowingly submitted an erroneous request. He presented evidence that he believed his requests included the proper CPT codes and that each charge was entirely justified. There is, therefore, no basis for imposing a fine against Respondent in this matter.

29. However, Respondent's CPT codes were not always correct or consistent with the definitions created by the AMA. To the extent some codes were erroneous, adjustment of the charge is appropriate. Upon completion of the adjustments, a new sum total of overpayments should be calculated.

## RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that a final order be entered by Petitioner, Agency for Health Care Administration, setting forth the following:

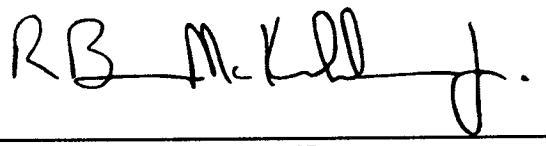
1. That each CPT code substantiated by Respondent, Hamid Bagloo, M.D., be deemed proper and that the amount paid for those office visits be allowed;

2. That the codes validated by Respondent pursuant to his testimony at final hearing in this matter be assigned a monetary charge consistent with the Medicaid Fee Schedule;

3. That the sum total of AHCA's overpayment to Respondent be reduced in an amount commensurate with the findings herein; and

4. That the fine imposed against Respondent be stricken.

DONE AND ENTERED this 10th day of September, 2009, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 10th day of September, 2009.

ENDNOTES

[1/] The letter is dated October 30, 2008, but that date is completely out of sequence with the events. It is likely the actual date of that letter was October 30, 2006, but that discrepancy was not discussed at final hearing. Respondent does

not dispute that he received the letter, so the discrepancy is not material to the ultimate findings herein.

[2/] Respondent was represented by counsel in the initial stages of this case. However, a disagreement between Respondent and counsel ended in counsel withdrawing from representation. The records introduced by AHCA at final hearing include information submitted by Respondent's former counsel, including numerous copies of a medical journal article about billing. The article was not deemed relevant, was not relied upon by Respondent in his case-in-chief, and will not be used as a basis for any finding in this Recommended Order.

[3/] Respondent's patient charts and office notes were already part of the Agency's exhibits.

[4/] The AMA materials introduced at final hearing do not provide a definition of W9881, but this is the definition provided by Respondent.

[5/] "Problem focused" visits are those in which the patient presents with a specific problem to be addressed, e.g., sore throat, broken arm, cough, etc. In a problem focused visit, the physician is not doing an overall examination, but is focusing on the issue at hand.

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.