STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs.   Case No. 11-5090MPI

MARK ISENBERG, D.P.M.,

Respondent.

RECOMMENDED ORDER

Pursuant to notice, a final hearing in this cause was held by video teleconference between Tampa and Tallahassee, Florida, on January 12 and March 15 and 16, 2012, before the Division of Administrative Hearings by its designated Administrative Law Judge Linzie F. Bogan.

APPEARANCES

For Petitioner: Shena L. Grantham, Esquire
Jamie Jackson, Esquire
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308

For Respondent: Richard M. Hanchett, Esquire
Trenam, Kemker, Scharf, Barkin,
Frye, O'Neil and Mullis, P.A.
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and

Michael A. Igel, Esquire
Trenam, Kemker, Scharf, Barkin,
Frye, O'Neil and Mullis, P.A.
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STATEMENT OF THE ISSUES

Whether Respondent was overpaid for Medicaid claims submitted during the audit period January 1, 2007, through December 31, 2008, and, if so, what amount Respondent is obligated to reimburse Petitioner; and whether sanctions and costs should be assessed against Respondent.

PRELIMINARY STATEMENT

Petitioner, Agency for Health Care Administration (Petitioner/Agency/AHCA), issued a Final Audit Report (FAR) dated August 4, 2011, informing Respondent, Mark Isenberg, D.P.M. (Respondent), that an audit of claims for the period January 1, 2007, through December 31, 2008, determined that Respondent was overpaid in the amount of $105,010.14 (subsequently reduced to $102,953.97). The FAR also advised Respondent of Petitioner's intent to impose administrative sanctions and costs associated with the audit.

Respondent filed a Petition for a Formal Administrative Hearing challenging the FAR determinations. The matter was referred to the Division of Administrative Hearings (DOAH) on October 3, 2011.

The final hearing in this matter was originally scheduled for December 19 and 20, 2011, via video teleconference between Tallahassee and Tampa, Florida. A continuance was granted, and the final hearing was rescheduled for January 12 and 13, 2012. At the commencement of the hearing on January 12, 2012, a second continuance, per the request of the parties, was granted, and the final hearing was rescheduled for March 15 and 16, 2012.

At the final hearing, Petitioner presented the testimony of Robi Olmstead, Effie Green, and Dr. Peter Mason. Respondent appeared at the final hearing and testified on his own behalf. Respondent did not offer the testimony of any other witnesses during the final hearing. Petitioner's Exhibits 1 through 21 were admitted into evidence. By agreement of the parties, the record was left open following the conclusion of the presentation of evidence on March 16, 2012, so that redacted versions of certain exhibits and final cost affidavits and related documents, as appropriate, could be included in the record. Respondent's Exhibits 1 through 7 were admitted into evidence. The record closed on April 6, 2012.

A two-volume Transcript of the proceeding was filed with DOAH. A Proposed Recommended Order (PRO) was filed by Petitioner and Respondent. Each PRO was considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. This case involves a Medicaid audit of claims paid by AHCA to Respondent for dates of service from January 1, 2007, through December 31, 2008. The audit in this case evaluated 258 paid claims and of these, 255 were found to be claims that, according to Petitioner, were not submitted in compliance with Medicaid rules.[1/]

2. During the audit period, Respondent was an enrolled Medicaid waiver provider, had a valid Medicaid Provider Agreement with AHCA, and received in excess of $102,953.97 for services provided to Medicaid recipients.

3. Paragraph 3 of the Medicaid Provider Agreement states that "[t]he provider agrees to comply with local, state and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA."

4. Among other duties, Petitioner investigates and audits Medicaid providers in an effort to identify and recoup overpayments made to providers for services rendered to Medicaid recipients. Petitioner is also empowered to impose sanctions and fines against offending providers.

5. Petitioner, when it identifies overpayment, fraud, or abuse, is charged with taking affirmative steps to recoup any

overpayments and can, as appropriate, impose fines, sanctions, and corrective actions plans on the offending provider.

6. Pursuant to what is commonly referred to as the "pay-and-chase" system, Petitioner pays Medicaid providers under an honor system for services rendered to Medicaid recipients. If Petitioner determines that the provider was paid for services rendered which were not in compliance with Medicaid requirements, then Petitioner seeks reimbursement from the provider.

7. By correspondence dated March 17 and April 12, 2010, Petitioner contacted Respondent and requested records related to claims billed to Medicaid by Respondent. Respondent provided documents in response to Petitioner's requests.

8. After considering the information provided by Respondent, Petitioner, on July 16, 2010, issued a Preliminary Audit Report (PAR) and advised therein that it was believed that Petitioner had overpaid Respondent in the amount of $160,159.77. In response to the PAR, Respondent met with Petitioner's representatives and submitted additional documentation that it desired for Petitioner to consider.

9. After receipt and evaluation of the additional information submitted by Respondent, Petitioner, on August 4, 2011, issued an FAR and noted therein that Petitioner had determined that Respondent was overpaid by Medicaid in the amount of $105,010.14.[2/] In this same correspondence, Petitioner

notified Respondent that Petitioner was seeking to impose against Respondent a $3,000.00 fine and investigative, legal, and expert witness costs.

10. The FAR provided to Respondent provides, in part, as follows:

> A statistically valid random sample of 30 of your Medicaid recipient records, involving 258 paid claims, for dates of service from January 1, 2007, through December 31, 2008, was reviewed. This review determined that:
>
> 1. Lower Level (LL)--You billed and received payment for procedure codes that were not properly documented to substantiate the procedures for which you were paid. Medicaid policy defines the varying levels of care and expertise required for the procedure codes specific to your specialty of podiatry. The documentation that you provided supports a lower level than the one for which you billed and received payment. This determination was made by a peer consultant in accordance with Sections 409.913 and 409.9131, F.S. These claims have been adjusted accordingly and are indicated on the enclosed worksheets.
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> The Medicaid Podiatry Services Coverage and Limitations Handbook, Update January 2004, Chapter 2, pages 2-1 and 2-2, state:
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> **"General Service Requirements, Limitations and Exclusions**
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> * * *
>
> **Medically Necessary**
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> Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

- Be consistent with generally professional medical standards as determined by the Medicaid program, and not experimental or investigational;

- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a covered service."

Review Determination #1

Procedure codes for which you billed and were paid have been adjusted to lower levels of service and the difference between the amount you were paid and the amount allowed for the appropriate level of service is considered an overpayment.

2. **Routine Foot Care (ROUT)**--Medicaid policy states that routine foot care must be billed with a report submitted with the claim form that documents the service and contains the name and Medicaid provider number of the referring physician.

The Medicaid Podiatry Services Coverage and Limitations Handbook, Update January 2004, Chapter 2, pages 2-10, states:

"Podiatry Visit Services, Continued

Routine Foot Care

Routine foot care, procedure code 28899, can be reimbursed in addition to an office visit if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or conditions of desensitization of the legs or feet.

Routine foot care must be billed with a report submitted with the claim form that documents the service and contains the name and Medicaid provider number of the referring physician."

"Definition of Routine Foot Care

Routine foot care means the cutting or removal of corns and calluses, the trimming of nails, routine hygienic care, and other routine-type care of the foot."

Review Determination #2:

Routine foot care services that you billed and were paid by billing with procedure codes 11306 and 11307, have been denied. According to the peer reviewer, the documentation substantiates that routine foot care (procedure code 28899) was rendered. However, you billed and were paid by billing procedure codes 11306 and 11307. As Medicaid policy states, routine foot care must be billed as procedure code 28899 with a report submitted with the claim form. Our review did not reveal that reports were included in the recipients' documentation. Therefore, the amount you were paid for services that were determined by your peer as routine foot care, is considered an overpayment.

3. **Incomplete Documentation (ID)--**Medicaid policy states that medical records must state the necessity for and the extent of services provided. Medicaid payments for services that lack required documentation are considered overpayment.

The Florida Medicaid Provider General Handbook, Chapter 5, page 5-8, January 2007, states the following:

"Incomplete or Missing Records

Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payments for services or goods when the provider has incomplete records or does not provide the records.

Note: See Chapter 2 in this handbook for Medicaid record keeping and retention requirements."

4. **No Documentation (NO DOC)--**Medicaid policy specifies how medical records must be maintained. A review of your medical records revealed that some services for which you billed and received payment were not documented. Medicaid requires documentation of the services and considers payment made for services not appropriately documented as overpayment.

The Florida Medicaid Provider General Handbook, Chapter 5, page 5-4, January 2007, states the following:

"Provider Responsibility

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:

- Have actually been furnished to the recipient by the provider prior to submitting the claim;

- Are Medicaid-covered services that are medically necessary;

- Are of a quality comparable to those furnished to the general public by the provider's peers;

- Have not been billed in whole or in part to a recipient's responsible party, except for such co-payments, coinsurance, or deductibles as are authorized by AHCA;

- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accord with federal, state, and local law; and

- 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 the medical basis and specific need for them are fully documented in the recipient's medical record."

11. Respondent is a doctor of podiatric medicine and has practiced podiatry since graduating from the Ohio College of Podiatric Medicine in 1979. Respondent has been licensed to practice podiatry in Florida since 1979 and is certified by the American Board of Podiatric Surgery. In the late 1990's Respondent opened his own practice and, since that time, has

focused his professional efforts on providing podiatric services to patients residing throughout the panhandle of Florida. Respondent visits patients in their homes and also sees patients that reside in group homes and assisted living facilities.

12. Dr. Peter M. Mason (Dr. Mason) was offered and accepted as Petitioner's expert in areas regarding podiatric medical claims coding, podiatric standards of care, and podiatric medical necessity. Dr. Mason was also offered and accepted as a physician peer reviewer pursuant to section 409.9131, Florida Statutes (2011).[3/] Dr. Mason is a doctor of podiatric medicine and has practiced podiatry since graduating in 1973 from Temple University School of Podiatric Medicine (formerly Pennsylvania College of Podiatric Medicine). Dr. Mason holds certification from the American Board of Podiatric Orthopedics and Primary Podiatric Medicine and has been a Diplomate in Foot and Ankle Orthopedics since 1978. Dr. Mason is licensed by the State of Florida to practice podiatric medicine and has maintained a private practice in Largo, Florida, since 1975. Dr. Mason has been a physician advisor and peer reviewer continuously since 1990 and has conducted approximately 100 peer reviews.

CPT Codes 11306 and 11307

13. Of the 258 audited claims, 60 were identified as claims where Respondent billed either CPT Code 11306 or 11307.

14. CPT Code 11306 is used when the following service is provided: "[s]having of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; [with] lesion diameter .06 to 1.0 cm."

15. CPT Code 11307 is used when the following service is provided: "[s]having of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; [with] lesion diameter 1.1 to 2.0 cm."

16. The CPT Procedure Guidelines and Codes Manual (2007-2008) for CPT Codes 11306 and 11307 provides that "[s]having is the sharp removal by transverse incision or horizontal slicing to remove epidermal and dermal lesions without a full-thickness dermal excision [and] [t]his includes local anesthesia, chemical or electrocauterization of the wound [and] [t]he wound does not require suture closure."

17. The American Medical Association publishes a CPT Coders' Desk Reference (AMA Desk Reference). According to the AMA Desk Reference, the guidelines for CPT Codes 11306 and 11307 provide as follows:

> The physician removes a single, elevated epidermal or dermal lesion from the scalp, neck, hands, feet, or genitalia by shave excision. Local anesthesia is injected beneath the lesion. A scalpel blade is placed against the skin adjacent to the lesion and the physician uses a horizontal slicing motion to excise the lesion from its base. The wound does not require suturing

and bleeding is controlled by chemical or electrical cauterization.

18. For each of the 60 claims where Respondent used either CPT Code 11306 or 11307, Respondent diagnosed a benign neoplastic lesion. As applied to the instant case, a benign neoplastic lesion is a non-cancerous new growth on a patient's foot or feet.

19. Medicaid will reimburse for routine foot care when included within a claim for reimbursement associated with an office visit. For the same date of service, Medicaid will not, however, reimburse for routine foot care, in addition to an office visit, unless "the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or conditions of desensitization of the legs or feet." There is no evidence of record that the 60 claims in dispute involved recipients who were under the care of a physician for a metabolic disease, a condition of circulatory impairment, or a condition causing desensitization of the legs or feet.

20. Respondent, as an experienced podiatrist, is capable of independently diagnosing whether a growth on a patient's foot is either a corn or a callus.

21. According to Dr. Mason, corns and calluses are benign growths "caused by friction and pressure against an area of the foot [and] can be on the bottom of the foot, on a toe, [or] it

can be in various locations, but it is always caused by friction or pressure . . . [and] the simplest form of care that can be offered to a patient with that type of growth is to just shave the growth . . . smooth it down, [and] take off the excessive growth. That makes the patient feel better." Tr. pgs. 109-10.

22. Dr. Mason credibly opined that when a skin growth is neither a corn nor callus, the medical standard of care for determining whether the growth is benign or malignant requires that the growth, or some portion thereof, be submitted to pathology for microscopic evaluation and diagnosis. According to the medical records associated with the 60 claims where Respondent secured reimbursement using CPT Codes 11306 and 11307, none of the growths removed by Respondent were sent to pathology for microscopic evaluation and diagnosis.

23. CPT Codes 11306 and 11307 are primarily used when a physician cannot determine what a growth is by looking at it, and the physician wants to get a sample of the growth so that it can be submitted to pathology for microscopic evaluation.

24. For the 60 claims in dispute, Respondent identified each patient as possessing some combination of the following skin characteristics: tender, painful, swollen, regular, raised, inflamed, indurated, hyperkeratotic, yellow, erythematous, and hyperpigmented. Dr. Mason credibly opined that each of these

skin characteristics is associated with corns and calluses and may also be associated with other medical conditions.

25. Though Respondent, for each patient, noted the presence of the skin characteristics enumerated above, he did not include in the patient medical records specific information related to, for example, the duration, range, or intensity of the identified characteristics. For a significant majority of these recipients, the medical records prepared by Respondent merely note that the respective benign neoplastic lesions have existed for "an extended duration," that the quality of the pain associated with the condition is "tender and throbbing," and that "shoe gear worsens [the] condition."

26. Dr. Mason credibly opined that the medical records where CPT Codes 11306 and 11307 were used for treatment of benign neoplastic lesions do not affirmatively demonstrate that the benign neoplastic lesions were medical conditions other than corns or calluses. Because the benign neoplastic lesions were corns or calluses and, thus, included within the definition of "routine foot care," Respondent was not permitted to receive additional reimbursement for the shaving of the corns and calluses because as previously noted, none of the patients to which Respondent provided these services was under a physician's care for a metabolic disease, had conditions of circulatory impairment, or had desensitization of the legs or feet.

27. Included within the cluster of 60 claims where Respondent sought reimbursement using either CPT Code 11306 or 11307, are three claims for patient A.R. where Respondent claimed and secured reimbursement for the removal of corns or calluses. Unlike the other 57 claims, Respondent did not couple these claims with a separate charge for an office visit. Petitioner denied these three claims.

28. In his review of these claims, Dr. Mason opined that these claims should be denied because the "[s]having of [a] corn or callus is routine foot care, a non-covered service by Medicaid as it is routine foot care." As previously noted, included within the definition of "routine foot care" are services related to the removal of corns and calluses and the trimming of nails. When Respondent trimmed a patient's toenails and used CPT Code 99336, Petitioner allowed the charge, but reduced it to CPT Code 99334. If the trimming of nails and the removal of corns and calluses are both considered routine foot care, then consistent with how Petitioner adjusted the charges for the trimming of nails, Petitioner should not have denied these claims. While it is true that these three claims were billed using CPT Code 11306, and not 99336 or 99334, Petitioner did not deny the claims because Respondent used the wrong CPT code. It is inconsistent for reimbursement purposes to treat the removal of corns and

calluses differently from the trimming of nails, when both are considered routine foot care.

29. Additionally, Respondent provided services to patient A.R. on October 17, 2007, related to the shaving of a corn or callus. Respondent billed for this service date using CPT Code 11721. Dr. Mason's written opinion as to this claim erroneously indicates that Respondent submitted this claim using CPT Code 11306. As previously stated, it is inconsistent for reimbursement purposes to treat the removal of corns and calluses differently from the trimming of nails, when both are considered routine foot care. Petitioner erroneously determined that Respondent should not have been reimbursed for this claim.

Lower Level Billing

30. CPT Codes 99309, 99325, 99326, 99334, 99335, 99336, and 99349 are used, in part, to identify whether a patient is a "new or existing" patient and where a patient was physically located (e.g., nursing home) when evaluated by the Medicaid provider. These CPT codes are included within the phrase "office visit," as found within the section of the Podiatry Services Coverage and Limitations Handbook where billing procedures for "routine foot care" is discussed.

31. In each instance where claims submitted by Respondent were reduced to a lower level of service, the medical records created by Respondent showed that Respondent's examination of the

patients included an assessment of the patients' neurological, cardiovascular, constitutional, integumentary, and musculoskeletal systems (Systems). Dr. Mason credibly opined that Respondent's evaluation of these respective Systems was not medically necessary.

A. CPT Codes 99324, 99325, 99326

32. According to the CPT Evaluation and Management Service Guidelines and Codes Manual (2007 and 2008), CPT Codes 99324 through 99326 are service billing codes used by Medicaid providers for a "[d]omiciliary or rest home visit for the evaluation and management of a new patient. . . ."

33. For CPT Code 99324, the patient medical records maintained by the Medicaid provider must document the following three key components: a problem-focused history; a problem-focused examination; and straight-forward medical decision-making. "Usually, the presenting problem(s) are of low severity [and] [p]hysicians typically spend 20 minutes with the patient and/or family or caregiver."

34. For CPT Code 99325, the patient medical records maintained by the Medicaid provider must document the following 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

moderate severity [and] [p]hysicians typically spend 30 minutes with the patient and/or family or caregiver."

35. For CPT Code 99326, the patient medical records maintained by the Medicaid provider must document the following 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 [and] [p]hysicians typically spend 45 minutes with the patient and/or family or caregiver."

36. Respondent saw patient B.B. on June 24, 2007, for services related to the removal of corns and calluses and used CPT Code 99326 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99324 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused history and examination related to the patient's corns and calluses and that the ultimate decision to shave the patient's corns and calluses involved straight-forward medical decision-making as contemplated by CPT Code 99324.

37. Respondent saw patient D.B. on February 28, 2008, for services related to complaints about areas of skin on the patient's feet being inflamed, itchy, raw, and scaly. For the services provided, Respondent used CPT Code 99326 in support of

the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99325 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted an expanded problem-focused history and examination related to the patient's complaint and that the ultimate treatment decision was of low complexity as contemplated by CPT Code 99325.

38. Respondent saw patient D.C. on April 22, 2007, for services related to elongated toenails and used CPT Code 99326 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99324 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused history and examination related to the patient's toenails and that the ultimate decision to trim the patient's toenails involved straight-forward medical decision-making as contemplated by CPT Code 99324. Respondent also saw D.C. for elongated toenails on April 16, 2008, and again used CPT Code 99326 in support of the claim for reimbursement. Petitioner correctly denied this claim on the basis that the medical records do not establish that D.C. was a "new patient" when Respondent provided services to the patient on April 16, 2008.

39. Respondent saw patient J.D. on May 9, 2007, for services related to the removal of corns and calluses and used

CPT Code 99326 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99324 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused history and examination related to the patient's corns and calluses and that the ultimate decision to shave the patient's corns and calluses involved straight-forward medical decision-making as contemplated by CPT Code 99324.

40. Respondent saw patient R.J. on October 18, 2007, for services related to a small abrasion on the right foot and used CPT Code 99326 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99324 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused history and examination related to the patient's small abrasion and that the ultimate decision to apply antibiotic ointment to the small abrasion involved straight-forward medical decision-making as contemplated by CPT Code 99324.

41. Respondent saw patient I.W. on July 31, 2007, for services related to elongated toenails and used CPT Code 99326 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99324 to reflect a

lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused history and examination related to the patient's toenails and that the ultimate decision to trim the patient's toenails involved straight-forward medical decision-making as contemplated by CPT Code 99324.

42. Respondent saw patient M.H. on February 28, 2008, for services related to elongated toenails and used CPT Code 99325 in support of the claim for reimbursement. Dr. Mason credibly opined that the medical record for this claim reflects that the patient presented with no symptoms or abnormal findings related to the complaint of elongated nails, and, therefore, the record provides no basis for a diagnosis. For this service, Petitioner correctly denied the claim.

B. CPT Codes 99334, 99335, 99336

43. According to the CPT Evaluation and Management Service Guidelines and Codes Manual (2007 and 2008), CPT Codes 99334 through 99336 are service billing codes used by Medicaid providers for a "[d]omiciliary or rest home visit for the evaluation and management of an established patient. . . ."

44. For CPT Code 99334, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: a problem-focused interval history; a problem-focused examination; and straight-forward

medical decision-making. "Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 15 minutes with the patient and/or family or caregiver."

45. For CPT Code 99335, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: an expanded problem-focused interval 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 25 minutes with the patient and/or family or caregiver."

46. For CPT Code 99336, the patient medical records maintained by the Medicaid provider must document at least two of the three following 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 40 minutes with the patient and/or family or caregiver."

47. Respondent used CPT Code 99336 for 153 of the 258 audited claims and used CPT Code 99335 only once. Unless otherwise indicated, in those instances where Respondent used CPT Code 99336 or CPT Code 99335 for services related to the trimming of elongated toenails, Petitioner correctly changed the CPT Code to 99334 to reflect a lower level of service. Dr. Mason credibly

opined that the medical records for these claims reflect that Respondent conducted problem-focused interval histories related to the patients' elongated toenails and that the ultimate decision to trim the patients' toenails involved straight-forward medical decision-making as contemplated by CPT Code 99334.

48. Respondent used CPT Code 99336 for services related to the removal of corns and calluses. For these services, Petitioner correctly changed the CPT Code to 99334 to reflect a lower level of service. Dr. Mason credibly opined that the medical records for these claims reflect that Respondent conducted problem-focused interval histories related to the patients' corns and calluses and that the ultimate decision to shave the patients' corns and calluses involved straight-forward medical decision-making as contemplated by CPT Code 99334. For patient J.T., Dr. Mason did not express an opinion regarding date of service January 24, 2008, where Respondent filed the claim using CPT Code 99336.

49. Respondent saw patient J.H. on May 30, 2008, and used CPT Code 99336 in support of the claim for reimbursement. Dr. Mason opined in his written narrative that "[t]he record indicates a problem-focused history (elongated nails), and straight-forward decision making (trimmed toenails). The note is a duplicate of the previous note, except for change of date. Adjust to 99334." As for the patient's elongated nails, it is

factually accurate that other than the date, the entries in the medical record duplicate previous entries. However, this record also lists a second chief complaint expressed by the patient that is not duplicative of a previous complaint. There is no indication in the record that Dr. Mason considered the second complaint when reaching his opinion regarding the patient history taken by Respondent and the nature of the medical decision-making involved in treating the patient. Finally, as to patient J.H., Dr. Mason credibly opined that for date of service August 14, 2008, the CPT Code should be adjusted to 99334; and for dates of service October 16, 2008, and December 18, 2008, the CPT Code should be adjusted to 99335.

50. Respondent saw patient M.H. on May 8, 2008, for treatment related to an ingrown toenail and used CPT Code 99336 in support of the claim for reimbursement. For this service, Petitioner correctly changed the CPT Code to 99334 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused interval history related to the patient's ingrown toenail and that the ultimate decision to "slant back" the patient's ingrown toenail involved straight-forward medical decision-making as contemplated by CPT Code 99334.

51. Respondent saw patient R.J. on November 16, 2007, for follow-up treatment related to an injury to the top of the

patient's right foot. For this visit, Respondent submitted a claim for reimbursement using CPT Code 99336. For this service, Petitioner correctly changed the CPT Code to 99334 to reflect a lower level of service. Dr. Mason credibly opined that the medical record for this claim reflects that Respondent conducted a problem-focused interval history related to the patient's injury. The medical decision-making was straight-forward, as Respondent provided no specific treatment to the patient other than counseling the patient about treatment options and related matters.

52. Respondent saw patient S.L. on April 27, 2007, for elongated toenails. For this visit, Respondent submitted a claim for reimbursement using CPT Code 99336 and a diagnostic code of 701.1. For patient S.L., Respondent, in other instances where he used CPT Code 99336 for reimbursement related to trimming elongated toenails, used diagnostic code 703.8. Dr. Mason credibly opined that this claim should be denied because "[t]he diagnosis used is not consistent with the medical record."

53. Respondent saw patient J.M. on October, 17, 2007, December 19, 2007, and February 27, 2008, for treatment related to "the skin over both feet [that was] blistering, inflamed, itchy, painful, raw, reddened, scaly and swollen." Respondent, for each visit, used CPT Code 99336 in support of the claim for reimbursement. For these services, Petitioner correctly changed

the CPT Code to 99334 to reflect a lower level of service. Dr. Mason credibly opined that the medical records for these claims reflect that Respondent conducted a problem-focused interval history related to the patient's skin condition and that the ultimate decision to treat the patient's condition with antifungal spray involved straight-forward medical decision-making as contemplated by CPT Code 99334.

54. Respondent saw patient Y.P. on June 13, 2007, for treatment related to the right third toenail that was swollen, reddened, painful, ingrown, inflamed, deformed, and had a thickened nail groove. Respondent used CPT Codes 99336 and 11730 in support of the claim for reimbursement. For CPT Code 99336, Respondent used a CPT Code Modifier 25.

55. For CPT Code Modifier 25, the Podiatry Services Coverage and Limitations Handbook provides as follows:

> Use modifier 25 for a significant, separately identifiable evaluation and management service by the same podiatrist or podiatry group on the same day of the procedure or other service. A podiatrist may need to indicate that on the same day a procedure or service identified by a procedure code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.
>
> The evaluation and management service may be prompted by the symptom or condition for

> which the procedure or the service was provided. As such, different diagnoses are not required for reporting of the evaluation and management services on the same date. The circumstance is reported by adding the modifier 25 to the appropriate level of evaluation and management service.
>
> The modifier is not used to report an evaluation and management service that resulted in a decision to perform surgery.
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> A report must be submitted with the claim. This modifier requires the claim to be reviewed by a Medicaid medical consultant for justification of the evaluation and management service and appropriate pricing.

56. Petitioner reimbursed Respondent for services claimed under CPT Code 11730, but denied reimbursement for services claimed pursuant to CPT Code 99336, as modified. Dr. Mason credibly opined that the medical record for this claim failed to include the "significant, separately identifiable evaluation and management service" as required. This claim was properly denied by Petitioner.

C. CPT Codes 99307, 99308, 99309

57. According to the CPT Evaluation and Management Service Guidelines and Codes Manual (2007 and 2008), CPT Codes 99307 through 99309 are service billing codes used by Medicaid providers for "[a]ll levels of subsequent nursing facility care [that] include[s] reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status

(i.e. changes in history, physical condition, and response to management) since the last assessment by the physician."

58. For CPT Code 99307, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: a problem-focused interval history; a problem-focused examination; and straight-forward medical decision-making. "Usually, the patient is stable, recovering, or improving."

59. For CPT Code 99308, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: an expanded problem-focused interval history; an expanded problem-focused examination; and medical decision-making of low complexity. "Usually, the patient is responding inadequately to therapy or has developed a minor complication."

60. For CPT Code 99309, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. "Usually, the patient has developed a significant complication or a significant new problem."

61. Respondent used CPT Code 99309 to secure reimbursement for services provided to patients C.H. and L.T. for the trimming of elongated toenails and the shaving of corns and calluses.

Unless otherwise indicated, Petitioner, in each instance where Respondent used CPT Code 99309, correctly changed the CPT Code to 99307 to reflect a lower level of service. Dr. Mason credibly opined that the medical records for these claims reflect that Respondent conducted problem-focused interval histories related to the patients' ailment(s) and that the ultimate treatment decisions involved straight-forward medical decision-making as contemplated by CPT Code 99307. Respondent used CPT Code 99309 to secure reimbursement for services provided to patient C.H. on July 26, 2008. Petitioner properly denied this claim, because Respondent failed to provide documentation to support the same.

D. CPT Codes 99347, 99348, 99349

62. According to the CPT Evaluation and Management Service Guidelines and Codes manual (2007 and 2008), CPT codes 99347 through 99349 are service billing codes used by Medicaid providers "to report evaluation and management services provided [to an established patient] in a private residence."

63. For CPT Code 99347, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: a problem-focused interval history; a problem-focused examination; and straight-forward medical decision-making. "Usually, the presenting problem(s) are self limited or minor [and] [p]hysicians typically spend 15 minutes face-to-face with the patient and/or family."

64. For CPT Code 99348, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: an expanded problem-focused interval history; an expanded problem-focused examination; and medical decision-making of low complexity. "Usually, the presenting problem(s) are of low to moderate severity [and] [p]hysicians typically spend 25 minutes face-to-face with the patient and/or family."

65. For CPT Code 99349, the patient medical records maintained by the Medicaid provider must document at least two of the three following key components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. "Usually, the presenting problem(s) are moderate to high severity [and] [p]hysicians typically spend 40 minutes face-to-face with the patient and/or family."

66. Respondent used CPT Code 99349 to secure reimbursement for services provided to patient T.E. for trimming the patient's elongated toenails and prescribing cream for a skin rash. Unless otherwise indicated, Petitioner, in each instance where Respondent used CPT Code 99349, correctly changed the CPT Code to 99347 to reflect a lower level of service. Dr. Mason credibly opined that the medical records for these claims reflect that Respondent conducted problem-focused interval histories related to the patient's ailment(s) and that the ultimate treatment

decisions involved straight-forward medical decision-making as contemplated by CPT Code 99347. Respondent used CPT Code 99349 to secure reimbursement for services provided to patient T.E. on October 15, 2008. Petitioner properly denied this claim, because Respondent failed to provide documentation to support the same.

Costs

67. Petitioner submitted affidavits in support of its claim for costs. Petitioner retained Drs. Huffer and Mason to provide expert services in the instant matter. For the combined services of Drs. Huffer and Mason, Petitioner incurred expert witness costs totaling $4,756.25.

68. Petitioner had two investigators to perform tasks related to the instant dispute: Effie Green and Jennifer Ellingsen. Petitioner's total cost incurred for work performed by Ms. Green related to the audit and ensuing litigation is $1,025.46. Petitioner's total cost incurred for work performed by Ms. Ellingsen related to the audit and ensuing litigation is $561.17.

69. Petitioner's total costs related to the instant dispute are $6,342.88.

CONCLUSIONS OF LAW

70. The Division of Administrative Hearings has jurisdiction over the subject matter. §§ 120.569, 120.57(1) & 409.913(31), Fla. Stat. (2011).

71. As the party asserting the overpayment, Petitioner bears the burden of proof to establish the alleged overpayment by a preponderance of the evidence. See Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992); S. Medical Servs. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995) (per curiam).

72. The statutes, rules, and the Medical Provider Handbooks in effect during the period for which the services were provided govern the outcome of the dispute. Toma v. Ag. for Health Care Admin., Case No. 95-2419 (Fla. DOAH July 26, 1996; Fla. AHCA Sept. 24, 1996).

73. The Medicaid program is the federal-state medical assistance program authorized by Title XIX of the Federal Social Security Act, pursuant to which the State of Florida provides medical goods and services to eligible indigent recipients. § 409.901(15).

74. Petitioner is the State of Florida agency designated to administer the Medicaid program in the State of Florida. §§ 20.42, 409.901(2) & (14), & 409.902, Fla. Stat.

75. Among other statutory duties, Petitioner oversees the activities of Medicaid providers; conducts reviews, investigations, and audits of Medicaid providers to identify fraud, abuse, and overpayments; issues audit reports with Medicaid overpayment determinations; recovers Medicaid

overpayments; and imposes sanctions upon Medicaid providers for fraud, abuse, and overpayments. § 409.913.

76. Petitioner is authorized to seek repayment of overpayments that it may have made for goods or services reimbursed under the Medicaid program. § 409.913(10), (11)(a), (15)(j) & (30).

77. Section 409.913(7)(e) and (f) requires providers to present claims for reimbursement in accordance with all Medicaid rules, regulations, and handbooks and appropriately document goods and services supplied by them.

78. Section 409.913(20) provides that "[w]hen 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."

79. Section 409.913(21) provides that "[t]he audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment." Consistent with this language, Petitioner can establish a prima facie case by proffering a properly supported audit report, which must be received in evidence. Colonial Cut-Rate Drugs v. AHCA, Case No. 03-1547MPI (Fla. DOAH Mar. 14, 2005; Fla. AHCA May 27, 2005).

80. Section 409.913(5), provides as follows:

> A Medicaid provider is subject to having goods and services that are paid for by the Medicaid program reviewed by an appropriate

> peer-review organization designated by the agency. The written findings of the applicable peer-review organization are admissible in any court or administrative proceeding as evidence of medical necessity or the lack thereof.

81. Section 409.9131(5)(b) provides that the Agency, in making a determination of overpayment to a physician, must "refer all physician service claims for peer review when the agency's preliminary analysis indicates that an evaluation of the medical necessity, appropriateness, and quality of care needs to be undertaken to determine a potential overpayment. . . ."

82. Section 409.9131(2)(d) defines "peer review" to mean:

> [A]n evaluation of the professional practices of a Medicaid physician provider by a peer or peers in order to assess the medical necessity, appropriateness, and quality of care provided, as such care is compared to that customarily furnished by the physician's peers and to recognized health care standards, and, in cases involving determination of medical necessity, to determine whether the documentation in the physician's records is adequate.

83. Florida Administrative Code Rule 59G-4.220 (August 18, 2005) provides as follows:

> (1) This rule applies to all podiatry providers enrolled in the Medicaid program.
>
> (2) All podiatry services providers enrolled in the Medicaid program must be in compliance with the provisions of the Florida Medicaid Podiatry Services Coverage and Limitations Handbook, January 2004, updated January 2005, which is incorporated by reference, and the Florida Medicaid Provider Reimbursement

Handbook, CMS-1500, which is incorporated by reference in Rule 59G-4.001, F.A.C. Both handbooks are available from the Medicaid fiscal agent.

84. The Medicaid Podiatry Services Coverage and Limitations Handbook (January 2004), Chapter 2, pages 2-1 and 2-2, states in part as follows:

General Service Requirements, Limitations and Exclusion:

* * *

Medically Necessary

Medicaid reimburses for services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

> The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a covered service.

85. The Medicaid Podiatry Services Coverage and Limitations Handbook (January 2004), Chapter 2, pages 2 through 10, states, in part, as follows:

> **Routine Foot Care**
>
> Routine foot care, procedure code 28899, can be reimbursed in addition to an office visit if the recipient is under a physician's care for a metabolic disease, has conditions of circulatory impairment, or conditions of desensitization of the legs or feet.
>
> Routine foot care must be billed with a report submitted with the claim form that documents the service and contains the name and Medicaid provider number of the referring physician.
>
> **Definition of Routine Foot Care**
>
> Routine foot care means the cutting or removal of corns and calluses, the trimming of nails, routine hygienic care, and other routine-type care of the foot.

86. The Florida Medicaid Provider General Handbook, Chapter 5, pages 5 through 8, (January 2007), states in part as follows:

> **Incomplete or Missing Records**
>
> Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payments for services or goods when the provider has

incomplete records or does not provide the records.

87. The Florida Medicaid Provider General Handbook, Chapter 5, page 5 and 4 (Jan. 2007), states, in part, as follows:

Provider Responsibility

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:

- Have actually been furnished to the recipient by the provider prior to submitting the claim;
- Are Medicaid-covered services that are medically necessary;
- Are of a quality comparable to those furnished to the general public by the provider's peers;
- Have not been billed in whole or in part to a recipient's responsible party, except for such co-payments, coinsurance, or deductibles as are authorized by AHCA;
- Are provided in accord with applicable provisions of all Medicaid rules, regulations, handbooks, and policies and in accord with federal, state, and local law; and
- 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 the medical basis and

> specific need for them are fully documented in the recipient's medical record.

88. Petitioner met its burden of proof and established for those claims identified herein that Respondent was paid for claims that failed to comply with the laws, rules, and regulations governing Medicaid providers.[4/]

Costs, Sanctions, and Interest

A. Costs

89. Section 409.913(22)(a) allows Petitioner to recover its investigative, legal, and expert witness costs. Petitioner met its burden of proof and established costs in the amount of $6,342.88.

B. Sanctions

90. Petitioner, in the FAR provided to Respondent, informed Respondent that it was seeking imposition of a fine in the amount of $3,000.00 as a result of Respondent's non-compliance with the laws, rules, and regulations governing the Florida Medicaid program. Section 409.913(15)(e) provides that Petitioner may seek any remedy provided by law, including, but not limited to, the remedies provided in subsections (13) and (16) and section 812.035, Florida Statutes, if "[t]he provider is not in compliance with provisions of Medicaid provider publications that have been adopted by reference as rules in the Florida Administrative Code . . . ." Section 409.913(16)(c) provides

that for a violation of section 409.913(15), Petitioner shall impose "a fine of up to $5,000 for each violation."

91. Florida Administrative Code Rule 59G-9.070(10)(i) (April 26, 2006) provides that for a violation of section 409.913(15)(e), the Agency may impose against a Medicaid provider for the first violation of this statute "[a] $500 fine per provision, not to exceed $3,000 per agency action."

92. Petitioner has established by clear and convincing evidence its entitlement to impose against Respondent a fine in the amount of $3,000.00.

C. Statutory Interest

93. Section 409.913(25)(c) provides, in part, that "overpayments owed to the agency bear interest at the rate of 10 percent per year from the date of determination of the overpayment by the agency, and payment arrangements must be made at the conclusion of legal proceedings."

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that that Petitioner, Agency for Health Care Administration, issue a final order and note therein that:

1. Respondent, Mark Isenberg, D.P.M., was not overpaid for services provided to patient A.R. during the audit period;

2. Respondent was not overpaid for services provided to patient J.T. on January 24, 2008;

3. Respondent was not overpaid for services provided to patient J.H. on May 30, 2008;

4. Petitioner shall recalculate, using generally accepted statistical methods, the total overpayment determination to reflect that Respondent was not overpaid for certain services provided to patients A.R, J.T., and J.H., as set forth in the Findings of Fact;

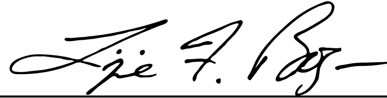
5. Respondent was overpaid for all other services identified in the FAR and that Petitioner is entitled to recoup the overpayment as determined in accordance with the preceding paragraph;

6. Petitioner is entitled to statutory interest on the overpayment;

7. Petitioner is entitled to recover from Respondent its costs in the amount $6,342.88; and

8. Petitioner is entitled to impose against Respondent an administrative fine in the amount of $3,000.00.

DONE AND ENTERED this 31st day of May, 2012, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of May, 2012.

ENDNOTES

1/ Respondent does not dispute the statistical sampling methodology used by Petitioner.

2/ Following the issuance of the FAR, Petitioner met with Respondent and his counsel on December 15, 2011, to discuss the audit review determinations. As a result of this meeting, Petitioner adjusted some of the claims at issue in the audit, thereby, reducing the claimed overpayment amount to $102,953.97.

3/ All statutory references are to Florida Statutes (2011), unless otherwise noted.

4/ Following the final hearing, Respondent, without objection, submitted an affidavit wherein he advised that as of March 30, 2012, "AHCA has withheld a total of $10,381.36 in Medicaid payments to which [Respondent] is entitled." As appropriate, and subject to review under chapter 120, Respondent may be entitled in the instant case to an offset of the referenced amount withheld.

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.