STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 13-0795MPI

ALFRED IVAN MURCIANO, M.D.,

Respondent.
_____/

RECOMMENDED ORDER

This case came before Administrative Law Judge Todd P. Resavage for final hearing by video teleconference on January 21, 2014, at sites in Tallahassee and Miami, Florida.

APPEARANCES

For Petitioner: Jeffries H. Duvall, Esquire
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For Respondent: William J. Sanchez, Esquire
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STATEMENT OF THE ISSUES

The issues for determination are whether Respondent must reimburse Petitioner an amount up to $1,051,992.99, which sum Respondent received from the Florida Medicaid Program in payment

of claims arising from his treatment of pediatric patients between September 1, 2008, and August 31, 2010; and whether Petitioner is entitled to sanctions in the amount of $210,398.60, and costs of $3,349.86.

PRELIMINARY STATEMENT

Petitioner, Agency for Health Care Administration, is the agency responsible for administering the Florida Medicaid Program. Respondent, Alfred Ivan Murciano, M.D., is a Medicaid provider.

After completing a review of Respondent's claims for Medicaid reimbursement for dates of service during the period of September 1, 2008, through August 31, 2010 ("the audit period"), Petitioner issued a Final Agency Audit Report ("FAR") on January 8, 2013, wherein it alleged that Respondent had been overpaid $1,051,992.99 for services that in whole or in part were not covered by Medicaid. The FAR further provided that Petitioner was seeking sanctions in the amount of $210,398.60, and costs of $3,349.86.

The FAR advised Respondent that he had the right to request a formal or informal hearing pursuant to section 120.569, Florida Statutes. Respondent timely requested a formal hearing on the matter. On March 5, 2013, Petitioner referred the matter to the Division of Administrative Hearings ("DOAH") where it was assigned to the undersigned.

The final hearing was initially scheduled for June 3, 2013. On May 23, 2013, the parties filed a Joint Motion for Continuance, which was granted, and the final hearing was ultimately rescheduled for January 21, 2014.

On January 14, 2014, the parties filed unilateral prehearing statements. The parties commonly stipulated that, during the audit period, Respondent operated as an authorized Medicaid provider and had been issued Medicaid provider number 0632431-00. Additionally, the parties stipulated that, during the audit period, Respondent had a valid Medicaid provider agreement.

Both parties were represented by counsel at the hearing, which went forward as planned. The final hearing Transcript was filed on February 19, 2014. The identity of the witnesses and exhibits and the rulings regarding each are as set forth in the Transcript.

On March 18, 2014, Respondent filed an Unopposed Motion for Extension of Time to File Proposed Recommended Orders. Said motion was granted and the parties were ordered to submit proposed recommended orders on or before April 24, 2014. The parties timely filed proposed recommended orders, which were considered in preparing this Recommended Order. Unless otherwise indicated, all rule and statutory references are to the versions in effect at the time of the audit period.

FINDINGS OF FACT

1. Petitioner is the state agency responsible for, inter alia, administering the Florida Medicaid Program.

2. Respondent is, and at all times relevant was, a physician licensed to practice medicine in Florida. Respondent was certified by the American Board of Pediatrics in General Pediatrics in 1989. Additionally, Respondent was certified by the American Board of Pediatrics in Pediatric Infectious Diseases in 2005. Respondent's practice is solely hospital-based and exclusive to pediatric infectious disease. Respondent evaluates, and provides care and treatment to, patients in Level III Neonatal Intensive Care Units ("NICU") and Pediatric Intensive Care Units ("PICU") in Miami-Dade, Broward, and Palm Beach County, Florida hospitals.[1/]

3. Respondent has never been the subject of any disciplinary proceedings.

4. Exercising its statutory authority to oversee the integrity of the Medicaid program, Petitioner identified Respondent as a Medicaid provider who had submitted a high volume of claims for inpatient recipients. Accordingly, Petitioner conducted a review or audit to verify the claims paid by Medicaid during the audit period.

5. On or about September 14, 2011, Petitioner issued a request for records letter to Respondent. Said correspondence

notified Respondent that Petitioner was in the process of completing a review of claims Respondent billed to Medicaid during the audit period to determine whether the claims were billed and paid in accordance with Medicaid policy. The request identified 30 of Respondent's patients and requested copies of the patients' Medicaid-related records, including all hospital records. The requested records were to be submitted within 21 days.

6. Respondent provided records responsive to the September 14, 2011, request for records.[2/]

7. Upon receipt, Petitioner organized the submitted records and provided the same to a reviewing nurse, Blanca Nottman. The reviewing nurse preliminarily inspected the same to determine if any policy violations were apparent and noted any findings.

8. Ms. Nottman, in turn, provided the records and notations to Petitioner's "peer coordinator." The peer coordinator maintains a list of all the peers that have a contract with Petitioner. A peer "means a Florida licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice." § 409.9131(2)(c), Fla. Stat.

9. The peer coordinator then forwarded all records and documents provided by Respondent to Richard Keith O'Hern, M.D.,

to conduct a peer review of Respondent's claims. Section 409.9131(2)(d), defines a peer review as follows:

> an 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.

10. Dr. O'Hern was certified, in 1979, by the American Board of Pediatrics in General Pediatrics. Dr. O'Hern completed a one-year infectious disease fellowship during his training at the University of Florida in 1977-78. Dr. O'Hern retired from a private general pediatric practice in December 2012. During his thirty-seven year career, he provided care and treatment to approximately 80,000 babies, of which approximately 16,000 were sick with infectious disease issues.[3/]

11. During his career, Dr. O'Hern was on three hospital medical staffs, and estimated that his practice involved working in the hospital setting approximately 10-20 percent of the time, with the balance in his office.

12. Dr. O'Hern was never certified by the American Board of Pediatrics in pediatric infectious diseases and would not, at the time of the review, have been eligible to become certified in pediatric infectious diseases. Additionally, Respondent provided

unrefuted testimony that Dr. O'Hern would not be permitted to treat Respondent's patients at Level III NICUs and PICUs.

13. Dr. O'Hern received copies of the medical records submitted by Respondent as well as "copies of the worksheets that Medicaid uses to determine the appropriateness of medical reimbursement." For each of the thirty patients, whose encounters were under review for the audit period, Dr. O'Hern reviewed the patient's noted complaint; whether the patient was a new or existing patient; whether the patient was inpatient or outpatient; the medical history, physical exam, and assessment of the patient; and the amount of time spent with the patient. Dr. O'Hern would then, based upon the above information, "determine the level of coding that leads to reimbursement."

14. Upon completion of his review, Dr. O'Hern notated his findings and returned the same to the peer coordinator, who in turn, provided them to the reviewing nurse. The reviewing nurse then "comes up with a review finding that gives the reason for the adjusted or denied claim." As there were findings for adjusting or denying Respondent's claims, Jennifer Ellingen, an investigator for Petitioner, prepared a Preliminary Audit Report ("PAR").

15. On April 18, 2012, Petitioner issued the PAR to Respondent. The PAR advised Respondent that Petitioner had completed a review of claims for Medicaid reimbursement for the

audit period, and a preliminary determination had been made that Respondent was overpaid $1,051,992.99 for claims that in whole or in part were not covered by Medicaid. The PAR advised Respondent that the documentation he provided supported a lower level of office visit(s) than the ones for which he billed and received payment, and that some services for which he billed and received payment were not documented.

16. The PAR notified Respondent that he could (1) pay the identified overpayment within 15 days and wait for the issuance of the final audit report ("FAR"); (2) submit further documentation in support of the claims within 15 days; however, such additional documentation may "be deemed evidence of non-compliance with [Petitioner's] initial request for documentation;" or (3) not respond, and wait for the issuance of the final audit report.

17. The PAR further notified Respondent that the findings contained in the PAR were preliminary in nature, and that it was not a final agency action.

18. Respondent opted to submit further documentation in support of his claims. Upon doing so, the process repeated itself, with the reviewing nurse, now Karen Kinser, reviewing all of the submitted documentation, which was then forwarded to Dr. O'Hern for an additional review.

19. On January 8, 2013, Respondent issued a FAR. The amount previously determined as overpayment in the PAR remained unchanged in the FAR. The FAR further documented that a fine in the amount of $210,398.60 had been applied and costs had been assessed in the amount of $3,349.86.

20. As noted above, upon receipt of the FAR, Respondent timely requested a formal hearing.

21. Rather than examine the records of all recipients served by Respondent during the audit period, a random sample of 30 recipients (patients) was reviewed. For these patients, Respondent identified 701 reimbursements from Petitioner to Respondent during the audit period. At hearing, Petitioner presented evidence specific to three of the 30 patients. A review of the three patients is instructive.

22. Patient 1 was born premature at 33 weeks gestation, with a birth weight of three pounds seven ounces, and was two months old at time of the subject hospitalization. At birth, Patient 1's medical condition necessitated placement in the NICU for three weeks and required nasogastric tube feeding. During the hospitalization under review, the patient's discharge diagnoses included, inter alia, septicemia and streptococcal meningitis. During the hospitalization, Respondent provided pediatric infectious disease care to the recipient.

23. Patient 2 was born on January 27, 2009, at 27 weeks gestation. At the time of the subject admission, Patient 2 was 37 days old, with an adjusted gestation age of 32 weeks two days, weighing 1.040 kg (approximately two pounds five ounces). The admitting diagnoses were prematurity, possible sepsis, respiratory distress, and a femoral fracture. Respondent provided care and treatment concerning a pediatric infectious disease condition, sepsis. The patient was not discharged from the hospital until July 28, 2009.

24. Patient 3 was born prematurely on July 15, 2009. On August 27, 2009, the child was 43 days old with an adjusted gestation of 32 weeks five days and weighed 1.180 kg (approximately two pounds ten ounces). The admitting indications were prematurity, possible sepsis, and respiratory distress. Respondent provided care and treatment concerning potential sepsis, a pediatric infectious disease medical condition.

25. Consistent with the above-findings concerning Patients 1-3, Respondent testified that his typical patient/recipient is premature and weighs approximately 500 grams (approximately one pound). Respondent explained that his patients are immune-compromised and that patients under 28 weeks gestation do not possess an independent immune system. Respondent opined that the greatest cause of morbidity or mortality among these pediatric patients is infectious diseases.

CONCLUSIONS OF LAW

26. DOAH has personal and subject matter jurisdiction in this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes.

27. Section 409.913(7)(e) provides that a Medicaid provider is obligated to present claims that are "true and accurate" and reflect services that are provided in accordance with all Medicaid "rules, regulations, handbooks, and policies and in accordance with federal, state, and local law."

28. Section 409.913(2) requires Petitioner to conduct audits to detect overpayments. Section 409.913(11) requires Petitioner to "deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them . . . ."

29. The burden of proof is on Petitioner to prove the material allegations by a preponderance of the evidence. Dep't of Banking & Fin., Div. of Sec. & Inv. Prot. v. Osbourne Stern & Co., 670 So. 2d 932, 934 (Fla. 1996); see also Young v. Dep't of Cmty. Aff., 625 So. 2d 831 (Fla. 1993); Southpointe Pharmacy v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992). The sole exception is that the standard of proof is clear and convincing evidence for the fine that Petitioner seeks to impose. Osbourne, 670 So. 2d at 935.

30. Section 409.9131 sets forth special provisions relating to integrity of the Medicaid program. Section 409.9131(5) specifically addresses determinations of overpayment and provides, in pertinent part, as follows:

> In making a determination of overpayment to a physician, the agency must:
>
> (a) Use accepted and valid auditing, accounting, analytical, statistical, or peer-review methods or combinations thereof . . . . In meeting its burden of proof in any administrative or court proceeding, the agency may introduce the results of such statistical methods and its other audit findings as evidence of overpayment.
>
> (b) 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, and before any formal proceedings are initiated against the physician, except as require by s. 409.913.

31. Section 409.9131(2)(d) defines peer review as follows:

> "Peer review" means an 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.

32. To reiterate, a "peer" is defined as "a Florida licensed physician who is, to the maximum extent possible, of the same specialty or subspecialty, licensed under the same chapter, and in active practice." § 409.9131(2)(c), Fla. Stat. "Active practice" means "a physician must have regularly provided medical care and treatment to patients within the past two years." § 409.9131(2)(a), Fla. Stat.

33. The Florida Legislature has designed a statutory framework for reviewing potential Medicaid overpayments to a physician. Petitioner must seek to obtain a Florida licensed physician, to the maximum extent possible, of the same specialty or subspecialty to conduct the peer review. Respondent argues, and the undersigned concludes, that based upon the above-findings of fact, Dr. O'Hern is not Respondent's "peer" as the term is defined in section 409.9131(2)(c).[4/]

34. Having concluded that Dr. O'Hern was not a statutorily-defined peer of Respondent, it follows that an appropriate peer review was not performed before formal proceedings (the FAR) were initiated against Respondent, as required by section 409.9131(5)(b). This failure to satisfy a condition precedent to initiating formal proceedings is fatal to the agency's case and requires that the case be dismissed.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration issue a Final Order dismissing the Final Audit Report.

DONE AND ENTERED this 22nd day of May, 2014, in Tallahassee, Leon County, Florida.

TODD P. RESAVAGE
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 22nd day of May, 2014.

ENDNOTES

[1/] Hospital units providing neonatal care are classified according to the intensity and specialization of the care which can be provided. Florida Administrative Code Rule 59C-1.042(2)(g)(3) defines Level III Neonatal Intensive Care Services, in pertinent part, as follows:

> Services which include the provision of continuous cardiopulmonary support services, 12 or more hours of nursing care per day, complex neonatal surgery, neonatal cardiovascular surgery, pediatric neurology and neurosurgery, and pediatric cardiac catheterization, shall be classified as Level III neonatal intensive care services . . . .

> A facility with a Level III neonatal intensive care service that does not provide treatment of complex major congenital anomalies that require the services of a pediatric surgeon, or pediatric cardiac catheterization and cardiovascular surgery shall enter into a written agreement with a facility providing Level III neonatal intensive care services in the same or nearest service area for the provision of these services.

[2/] The record is silent as to when any particular medical record was provided to Petitioner for review.

[3/] The undersigned was unable to locate any evidence indicating Dr. O'Hern's experience treating premature infants with infectious disease medical issues.

[4/] The undersigned recognizes that Petitioner is not required to retain a reviewing physician who has the exact credentials as the physician under review. To the contrary, Petitioner's obligation in this regard is met when it retains a reviewing physician who is, to the maximum extent possible, of the same specialty or subspecialty as the physician under review. The undersigned has concluded that Dr. O'Hern is not of the same specialty as Respondent. As Petitioner failed to present any evidence concerning what efforts were undertaken to obtain an appropriate peer to review Respondent's claims, the undersigned is compelled to conclude Dr. O'Hern is not a peer.

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.