STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

vs. Case No. 16-4735MPI

ASON MAXILLOFACIAL SURGERY, P.A.,

Respondent.
_____/

RECOMMENDED ORDER

On February 1 and 2, 2017,[1/] an administrative hearing in this case was held in Tallahassee, Florida, before Administrative Law Judge Lynne A. Quimby-Pennock of the Division of Administrative Hearings.

APPEARANCES

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STATEMENT OF THE ISSUES

Whether the Agency for Health Care Administration (Petitioner or AHCA) is entitled to recover: certain Medicaid payments made to Respondent, Ason Maxillofacial Surgery, P.A., pursuant to section 409.913(11), Florida Statutes (2016); an amount of sanctions imposed pursuant to section 409.913(15); and the amount of any investigative, legal, and expert witness costs that AHCA incurred pursuant to section 409.913(23).

PRELIMINARY STATEMENT

By Final Audit Report (FAR) dated July 6, 2016, Petitioner alleged that Respondent, a Medicaid provider, had received overpayments totaling $654,485.81 "for services that in whole or in part are not covered by Medicaid." AHCA computed the sanction amount to be $118,000.00. Respondent disputed the alleged overpayments and requested a formal administrative hearing. Following receipt of additional documentation from Respondent, just prior to the hearing, AHCA revised the overpayment total amount to $640,493.77 and the sanction was reduced to $106,000.00.

On August 19, 2016, Petitioner forwarded the request to the Division of Administrative Hearings (DOAH) which scheduled the hearing to commence on November 1, 2016. The hearing was continued twice, and the re-scheduled hearing commenced on February 1, 2017.

Prior to the hearing, the parties submitted a Joint Prehearing Stipulation, including a statement of undisputed facts. To the extent that the stipulated facts are relevant, the facts are adopted and incorporated herein as necessary.

At the hearing, the parties' Joint Exhibits 1 through 31 were offered and admitted into evidence. Petitioner presented the testimony of: AHCA Administrator Robi Olmstead; AHCA Nurse Consultant Karen Kinser; and John H. Hardeman, D.D.S., M.D. Petitioner did not offer any additional exhibits. Respondent presented the testimony of: Raphael Ason, D.M.D., M.D.; Raymond Fonseca, D.M.D.; and Steven Dicksen. Respondent did not offer any additional exhibits into evidence.

The three-volume Transcript was filed on February 17, 2017. On February 20, 2017, a Notice of Filing Transcript was issued directing the parties to file their post-hearing submissions on or before 5:00 p.m. on February 27, 2017. Both parties timely submitted their proposed recommended orders, and each has been considered in the preparation of this Recommended Order.

Except as otherwise indicated, citations to Florida Statutes or rules of the Florida Administrative Code refer to the versions in effect during the time in which the alleged overpayments were made.

FINDINGS OF FACT

Based upon the testimony and documentary evidence presented at hearing, the demeanor and credibility of the witnesses, and the entire record of this proceeding, the following factual findings are made:

1. Petitioner is the state agency authorized to administer and make payments for medical and related services under Title XIX of the Social Security Act, the Medicaid Program, relevant to this proceeding.

2. At all times pertinent to this case, Respondent, an oral and maxillofacial surgery practice operated by Dr. Ason, was enrolled in the Florida Medicaid Program as a Medicaid dental provider. Respondent's Medicaid provider number was 007294600.

3. Petitioner engaged the services of Dr. Hardeman as its expert and peer reviewer. Dr. Hardeman is a Florida-licensed medical doctor and dentist, who is board-certified in oral and maxillofacial surgery. He practices in the same specialty or subspecialty as Respondent's provider, Dr. Ason. Respondent stipulated and agreed that Dr. Hardeman meets the requirements and qualifications of a "peer" as defined in section 409.9131, Florida Statutes. Dr. Hardeman's testimony is credible.

4. Petitioner offered the testimony of AHCA Administrator Olmstead to describe the process by which the audit was conducted.

Administrator Olmstead has years of experience in this process, and her testimony is credible.

5. Nurse Kinser holds a Bachelor of Science degree in nursing and is a Florida-licensed registered nurse. She is employed as a registered nurse-consultant for Petitioner. Nurse Kinser is a certified professional coder, having received her credentials from the American Academy of Professional Coders. Her testimony is credible.

6. Respondent offered the testimony of Dr. Fonseca, of North Carolina, as an expert in the field of oral and maxillofacial surgery to opine on the medical necessity of the services provided by Respondent.

7. Respondent offered the testimony of Mr. Dicksen as a coding expert. Mr. Dicksen holds a degree in health information management and is licensed as a registered health information administrator. Mr. Dicksen is not licensed as a medical doctor, oral surgeon or dentist in Florida, and is not trained to read a panorex, X-ray or CT scan in his scope of work. Mr. Dicksen's lack of medical or dental training in reading medical/dental records seriously detracted from his testimony regarding the proper coding of services.

8. Respondent's representative, Dr. Ason is a well-educated, board-certified oral and maxillofacial surgeon. His lack of understanding in the various aspects of his coding for services

rendered is a disservice to his practice, as it is apparent from his testimony that he cares for his patients. Dr. Ason does not watch the clock during a procedure, but instead he "takes care of [his] patients."

9. Title XIX of the Social Security Act establishes Medicaid as a collaborative federal-state program in which the state receives federal funding for services provided to Medicaid-eligible recipients in accordance with federal law. The Florida Statutes and rules relevant to this proceeding essentially incorporate federal Medicaid standards.

10. In order to receive payment, a provider must enter a Medicaid provider agreement, which is a voluntary contract between AHCA and the provider. Respondent, as an enrolled Medicaid provider must comply fully with all state and federal laws pertaining to the Medicaid Program, including Medicaid Provider Handbooks incorporated by reference into rules which were in effect during the audit period.

11. AHCA's Bureau of Medicaid Program Integrity (MPI) is required to identify and recover overpayments to ensure that Medicaid funds are appropriately utilized and to reduce fraud and abuse to the Medicaid Program. Pursuant to section 409.913, MPI conducted an audit of Respondent's paid Medicaid claims for services rendered to Medicaid recipients between January 1, 2013, and June 30, 2014.

12. The Florida Medicaid Dental Program (Dental Program) covers all medically necessary and dental services to eligible children. The Dental Program is limited in the services and treatments available to persons over 21 years of age. These limited services include relief of pain, suffering, and trauma, and preparation for dentures. The Dental Program does not cover preventive dental care for adults.

13. Administrator Olmstead provided the framework by which this audit was opened, investigated, reviewed and reported. The investigation followed all the required procedures and the audit was properly conducted.

14. On July 6, 2016, AHCA issued a FAR[2/] alleging that Medicaid overpaid Respondent $654,485.81 for services that were not covered, in whole or in part, by Medicaid. Additionally, pursuant to section 409.913(23), AHCA sought to assess a sanction of $118,000.00 for the alleged violations.

15. In the FAR, the following "Findings" were set forth (and will be discussed in this Order below):

> 1. The 2008 and 2012 Florida Medicaid Provider General Handbooks, page 5-4, state that when presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to present a claim for goods and services that are medically necessary. A review of your medical records by a peer consultant in accordance with Sections 409.913 and 409.9131, F.S. revealed that the medical necessity for some claims submitted was not supported by the documentation. Payments made

to you for these services are considered an overpayment. (NMN)

2. The 2008 and 2012 Florida Medicaid Provider General Handbooks, page 5-4, require that when presenting a claim for payment under the Medicaid program, a provider has an affirmative duty to present a claim that is true and accurate and is for goods and services that have actually been furnished to the recipient. A review of your medical records revealed that some services rendered were erroneously coded on the submitted claim. The appropriate dental code was applied. These dental services are not reimbursable by Medicaid. Payments made to you for these services are considered an overpayment. (ERROR IN CODING)

3. The 2008 Florida Medicaid Provider General Handbook, pages 2-57 and 5-8 and the 2012 Florida Medicaid Provider General Handbook, pages 2-60 and 5-9, define incomplete records as records that lack documentation that all requirements or conditions for service provision have been met. A review of your medical records revealed that the documentation for some services for which you billed and received payment was incomplete or was not provided. Payments made to you for these services are considered an overpayment. (INSUFFICIENT/NO DOC)

4. The 2011 Dental Services Coverage and Limitations Handbook, page 2-40, states use of Evaluation and Management Services must follow guidelines set by the Physicians' Current Procedural Terminology (CPT) for E&M code levels. A review of your medical records by a peer consultant in accordance with Sections 409.913 and 409.9131, F.S. revealed that the level of service for some claims submitted was not supported by the documentation. The appropriate code was applied and the payment adjusted. Payments made to you for these services, in excess of the adjusted amount, are considered an overpayment. (LOS)

5. The 2011 Dental Services Coverage and Limitations Handbook, pages 2-38 and 2-39, defines a consultation as a type of service provided by an accredited dental specialist whose opinion or advice regarding the evaluation or management of the specific problem is request by another dentist. The following components must be recorded in the recipient's dental records: a request and need for consultation from the attending or requesting provider; the consultant's opinion and any services ordered or performed; and a written report of the findings and recommendations provided to the attending or requesting provider. If the referring provider will not participate in the on-going care of the recipient for this problem, this is not a consultation, but is instead a referral, and should be billed as an examination or appropriate evaluation and management code. The documentation you provided did not meet the criteria for a consultation service. The appropriate code was applied and the payment adjusted. Payments made to you for these services, in excess of the adjusted amount, are considered an overpayment. (NOT A CONSULT)

6. The 2008 and 2012 Florida Medicaid Provider General Handbooks, page 1-3, define global reimbursement as a method of payment where the provider is paid one fee for a service that consists of multiple procedure codes that are rendered on the same date of service or over a span of time rather than paid individually for each procedure code. A review of your medical records revealed that some services, for which you billed and received payment, were covered under a global procedure code. Payments made to you for these services are considered an overpayment. (GLOBAL)

7. The 2011 Dental Services Coverage and Limitations Handbook, page 2-1, states that only those services designated in the applicable provider handbook and fee schedule are reimbursed by Medicaid. You billed and

> received payment for services that are not covered by Medicaid after the correct code was assigned. Payments made to you for these services are considered overpayments. (NOT A COVERED SERVICE) (emphasis added).

16. AHCA used a statistical analysis to review claims. AHCA obtained a list of claims for 35 randomly selected recipients from the cluster sample program. Petitioner then requested the medical records for those 35 recipients from Respondent. Respondent provided the medical records, and throughout the process has provided additional records when requested. Further, Respondent has not contested the process of the statistical sampling or the statistical methods utilized to establish the validity of the overpayment calculation.

17. Following the issuance of the FAR, and after receiving and reviewing additional documentation, AHCA amended Respondent's overpayment downward to $640,493.77 and the sanction amount to $106,000.00.

18. Teeth are numbered 1 through 16 from right to left on the upper jaw, and 17 through 32 from left to right on the lower jaw. The wisdom teeth are numbered 1, 16, 17, and 32, and are also called the 3rd molars. Additionally, the mouth is divided into four quadrants: upper jaw left and right, and lower jaw left and right.

Not Medically Necessary (NMN)

19. Recipient 7 had seven claims labeled as NMN. Of claims 3, 4, 5, 6, 9, and 12,[3/] Dr. Hardeman agreed that the bone grafts were necessary and medically appropriate; however, other causes for disallowance of the claims shall be addressed below.

20. Recipient 23 had two claims labeled as NMN regarding lower jaw bone grafts on teeth 17 and 32. Recipient 23 was a 22-year-old male with impacted wisdom teeth. Dr. Ason extracted the wisdom teeth and then completed bone grafts on the areas. Dr. Hardeman opined that bone grafts were not indicated in this young patient as he would heal without the grafts.[4/]

21. Recipient 24 had one claim labeled as NMN regarding a lower jaw bone graft on tooth 17. Tooth 17 is the lower left wisdom tooth. Dr. Ason extracted the wisdom tooth and then completed a bone graft on the area. Dr. Hardeman opined that the graft was not medically necessary because following the extraction, the site should have granulated and healed naturally.

Error in Coding

22. CPT code "21210 Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)" is explained with a coding tip as follows:

> The physician reconstructs the nasal, maxillary, or malar area bones with a bone graft to correct defects due to injury, infection, or tumor resection. The procedure may also be performed to augment atrophic or thin bone, or to aid in healing fractures.

> The physician harvests bone from the patient's hip, rib, or skull. Incisions are made overlying the harvest site. Tissues are dissected away to the desired bone. The physician removes the bone as needed for grafting to the defect area. After the bone is harvested, the donor site is repaired in layers. Access incisions are made to the recipient site and the area of bony defect is exposed. The graft is placed to repair the defect and may be held in place with wires, plates, or screws. The access sites are irrigated and sutured closed.
>
> Harvesting of the bone graft is not reported separately. If bone graft is not harvested from the patient, modifier 52 Reduced services, should be appended. For harvest of graft by another physician, append modifier 62 Two surgeons, to the applicable bone graft code.

23. CPT code "21215 Graft, bone; mandible (includes obtaining graft)" is explained with a coding tip as follows:

> The physician reconstructs the mandible with a bone graft to correct defects due to injury, infection, or tumor resection. The procedure may also be performed to augment atrophic or thin mandibles, or to aid in healing fractures. The physician harvests bone from another site on the patient's body, most commonly the rib, hip, or skull, and repairs the surgically created wound. The physician makes facial skin incisions to expose the mandible and place the graft from the donor site. Occasionally, intraoral incisions are used. The graft is held firmly positioned with wires, plates or screws. The incisions are sutured with a layered closure.
>
> Harvesting of the bone graft is not reported separately. If bone graft is not harvested from the patient, modifier 52 Reduced services, should be appended. For harvest of graft by another physician, append modifier 62 Two surgeons, to the applicable bone graft

code. For interdental wiring, see code 21497. For application, including removal of an interdental fixation device for conditions other than fracture or dislocation, see code 21110. Because this procedure may be performed for cosmetic purposes, verify coverage with insurance carrier. Supplies used when providing this procedure may be reported with appropriate HCPCS Level II code. Check with specific payer to determine coverage.

24. CPT code 41823 is for the "Excision of osseous tuberosities, dentoalveolar structures."

25. CDT code D7140 is explained as follows:

> [E]xtraction, erupted tooth or exposed root (elevation and/or forceps removal) Includes routine removal of tooth structure, minor smoothing of socket bone, and closure, as necessary.
>
> Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Postoperative Care)

26. CDT code D7210 is explained as follows:

> [S]urgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated Includes related cutting of gingiva and bone, removal of tooth structure, minor smoothing of socket bone and closure.

27. CDT code D7220 is explained as follows:

> [R]emoval of impacted tooth – soft tissue Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation.

28. CDT code D7230 is explained as follows:

> [R]emoval of impacted tooth – partially bony Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

29. CDT code D7240 is explained as follows:

> [R]emoval of impacted tooth –completely bony Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal.

30. CDT code D7250 is explained as follows:

> Surgical removal of residual roots (cutting procedure), includes cutting of soft tissue and bone, removal of tooth structure and closure.

31. CDT code D7310 is explained as follows:

> [A]lveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant
> The alveoloplasty is distinct (separate procedure) from extractions and/or surgical extractions. Usually in preparation for a prosthesis or other treatments such as radiation therapy and transplant surgery.

32. CDT code D7953 is explained as follows:

> [B]one replacement graft for ridge preservation – per site Graft is placed in an extraction or implant removal site at the time of the extraction or removal to preserve ridge integrity (e.g., clinically indicated in preparation for implant reconstruction or where alveolar contour is critical to planned prosthetic reconstruction). Does not include obtaining graft material. Membrane, if used should be reported separately.

33. Recipient 2's claim 3, coded as 21210, related to a face bone graft for tooth 15. Following the extraction of tooth 15,

Dr. Ason used a bone graft to close the opening in the sinus. Dr. Hardeman opined there was "a hole in the alveolus, the socket." Dr. Hardeman further opined that "This fee (using code 21210) would be applicable for augmentation of an atrophic ridge, but not for a small graft used in conjunction with the treatment of a sinus exposure." Dr. Ason testified that when he extracted the tooth "a part of the floor of the sinus . . . came with the root, leaving a defect." He then saw the Schneiderian Membrane,[5/] placed the bone graft, and closed the site. There was no break in the membrane, and a small graft closure was more appropriate. For Recipient 2's claim at issue, the appropriate code should be D7953.

34. Recipient 4's claims 3 and 4, both coded as 21215, related to the lower jaw bone grafts for teeth 17 and 18. Dr. Hardeman reviewed the operative note that provided "a large periodontal defect in the area adjacent to Tooth No. 19. It was therefore grafted." Dr. Hardeman did not find tooth 19 on the panorex, and the reasoning for a graft was "invalid." Dr. Hardeman opined the grafting was a socket preservation. For Recipient 4's claims at issue, the appropriate code is D7953.

35. Dr. Ason qualified his operative note, which discussed the "area of teeth #'s 17, 18 where a sulcular incision was made. . . . There was a large defect of bone distal to tooth #19," with a comment that when he referred to "Area 19" that does

not mean that tooth 19 was there, just that he was referring to the area. Dr. Ason's attempt to re-write the operative note to reflect his current testimony is not persuasive.

36. Recipient 6's claims 3, 4, 6, and 7, coded as 21215, related to lower jaw bone grafts for teeth 21, 22, 27, and 28; and claim 5, coded as 21210, related to a face bone graft for tooth 12. Recipient 6 had multiple teeth extracted from the lower jaw, and one removed from the upper jaw. Dr. Ason grafted both the bottom and the top where the extractions were completed. Dr. Hardeman opined that these "were merely socket preservation grafts," and the appropriate code for all the claims should be D7953.

37. Recipient 7's claims 3, 4, 5, and 6, coded as 21210, related to face bone grafts for teeth 1, 2, 15 and 16. Recipient 7 had teeth 1, 2, 15, and 16 surgically extracted,[6/] and Dr. Ason used allograft bone to preserve the alveolar ridge in all four locations. Dr. Hardeman reviewed the panorex, and teeth 1 and 16 were not present on it. Dr. Hardeman could not find a "clear-cut" clinical indication for the grafting done on Recipient 7. For Recipient 7's claims at issue, the appropriate code should be D7953.

38. Recipient 8's claims 3 and 4, both coded as 21215, related to the lower jaw bone grafts for teeth 17 and 32. Recipient 8 had multiple wisdom teeth and a supernumerary wisdom

tooth removed. Dr. Ason testified that there were "wide-rooted molars with chronic infection" and because of the infection, "it spreads throughout the bone and you can't predictably take out a root and leave a socket." Dr. Hardeman found nothing remarkable about these extractions, and opined that these were socket preservation grafts. Dr. Hardeman agreed that it was reasonable to put a graft distal to teeth 18 and 31, but did not alter his opinion that these were socket preservations. For Recipient 8's claims at issue, the appropriate code should be D7953.

39. Recipient 13's claim 3, coded as 21215, related to the lower jaw bone graft for tooth 32. Recipient 13 had multiple decayed teeth which were extracted; however, only claim 3 is at issue here. Dr. Hardeman opined the bone graft was not warranted because the distal bone was at the appropriate height. For this claim, the appropriate code should be D7953.

40. Recipient 14's claim 2, coded as 21210, related to the face bone graft for tooth 1. Recipient 14 had one wisdom tooth extracted. Dr. Hardeman agreed there was a "good defect on the back side of" the tooth and agreed that a graft "could be medically appropriate." Dr. Hardeman further stated that he would have "tried to do something for that," however this involved socket preservation grafting, not the higher medical grafting code. The appropriate code should be D7953.

41. Recipient 17's claims 5 through 8, coded as D41823, related to excision of gum lesions for teeth 2, 3, 4, and 5. These four teeth are in the upper right quadrant; however, Dr. Ason billed for alveoloplasties in four quadrants. AHCA allowed claims 1 through 4, but denied claims 5 through 8 because that would have been double-billing for the same procedure, which is not allowed.

42. Recipient 21's claim 6 was coded as 21210 for a face bone graft for tooth 16, and claim 8 was coded as 21215 for a lower jaw bone graft for tooth 32. Recipient 21 had four wisdom teeth extracted, and a repair of a sinus exposure on tooth 16. Initially, there was no documentation for a peer review of the procedures billed. After receiving the documentation, Dr. Hardeman opined that these "were socket preservation grafts." The appropriate code should be D7953.

43. Recipient 23's claims 3 and 4 were coded as 21215 for lower jaw bone grafts to teeth 17 and 32, and claims 7 and 8 were coded as D7230 for impacted teeth removed for teeth 1 and 16. Recipient 23 had four wisdom teeth removed. Dr. Hardeman opined that bone grafts were not indicated to preserve the integrity of the bone adjacent to the second molars in this young patient. The appropriate codes for claims 3 and 4 are D7953, and the appropriate codes for claims 7 and 8 are D7220 and D7210, respectively.

44. Recipient 25's claims 4 and 5 were coded as 21215 for a lower jaw bone graft for teeth 19 and 30, and claims 6 and 7 were coded as 21210 for a face bone graft for teeth 1 and 16. Recipient 25 had five teeth surgically removed (1, 16, 17, 19 and 30), and bone grafts placed at sites 1, 16, 19 and 30. Dr. Hardeman opined that some bone grafting may have been medically necessary, but that he would have coded these claims as D7953. The appropriate code for all these claims is D7953.

45. Recipient 26's claims 3 and 4 were coded as 21215 for a lower jaw bone graft for teeth 22 and 27, and claims 5, 6, 7, and 8 were coded as 21210 for a face bone graft for teeth 2, 3, 14, and 15. Recipient 26, a 30-year-old male had all the teeth in the maxilla removed and all the teeth present in the mandible removed. Bone grafts were placed at sites 2, 3, 14, 15, 22, and 27. Dr. Ason testified that there were a few sinus exposures (of the upper jaw) in "common locations" and he used bone graft to those areas. Dr. Ason also testified that for teeth 22 and 27, these teeth were infected, and when he extracted them, he placed bone graft at those sites. Dr. Ason did not testify that he saw infection in the vacated sites. Dr. Hardeman opined that the procedures may have been medically necessary, but were not properly coded. The appropriate code for all of these claims is D7953.

46. Recipient 28's claim 7 was coded as D7240 for removal of an impacted tooth 16. Dr. Hardeman reviewed the panoramic X-ray and determined that this tooth was just a partially impacted tooth, as opposed to a completely bone-impacted tooth. The appropriate code for this claim is D7230.

47. Recipient 29's claim 8 was coded 20680 for the removal of support for tooth 3. Dr. Hardeman candidly admitted that he made an error in determining that Dr. Ason had simply put a screwdriver on hardware in Recipient 29's mouth to remove screws and plates. Upon an additional review of the operative report, Dr. Hardeman opined that Dr. Ason did make an incision to remove the screws and plates.[7/]

48. Recipient 31's claims 3 and 4 were coded as 21215 for a lower jaw bone graft for teeth 22 and 27, and claims 5, 6, 7, and 8 were coded as 21210 for a face bone graft for teeth 5, 6, 11, and 12. There was no direct testimony on the bone grafts performed on this Recipient. The documentation (Exhibit 18-31: Bates-stamped pages 1031 through 1062) reflected Dr. Hardeman wrote "socket graft" at each claim. However, this is insufficient to support a finding of fact.

Insufficient or No Documentation

49. Recipient 3's claims 2, 3 and 4 included a panoramic image, a primary closure of a sinus perforation at tooth 1, and a primary closure of a sinus perforation at tooth 16, respectively.

Initially claim 2 was denied because of a lack of documentation, however, additional documentation was received and claim 2 was allowed. As to claims 3 and 4, Dr. Hardeman opined there was insufficient documentation to support the claims as he could find "no sinus exposure was noted" in the "op [operation] note." Dr. Ason's testified that he had "to get a primary closure for this patient on both sides," and his operative note provides:

> The roots were in the radiograph close to or into the sinus. As a precaution, a primary sinus closure was performed on both sites #1 and #16 by using chromic gut 3-0 to get a watertight seal.

Dr. Ason's operative note did not document that there was sinus exposure during the operation. There is insufficient documentation to support these two claims. The claims should not be allowed.

50. Recipient 5's claim 3 involved insufficient documentation to support a "Repair Tooth Socket" for an unknown tooth. Dr. Hardeman agreed that an alveoloplasty was appropriate in this case; however, there was no documentation for the site at which it was performed. Dr. Ason recited four sentences from his operative note; however, he did not provide a tooth number for the procedure. There is insufficient documentation to support this claim, and the claim should not be allowed.

51. Recipient 7's claim 2 involved a missing panoramic image, claims 7 and 8 involved no documentation for the "Repair

Tooth Socket" for unknown teeth, and claims 9 and 12 involved the removal of impacted teeth 1 and 16. During the hearing, Petitioner's counsel affirmed that "claim 7, page 2" was paid,[8/] and claims 2, 9, and 12[9/] were paid. No testimony was received regarding claims 7 and 8. The claims (7 and 8) are allowed.

52. Recipient 10's claim 4 involved the lack of documentation for the "Excision Of Gum Flap" for tooth 32. Dr. Hardeman opined there was no documentation of this procedure. The claim should be disallowed.

53. Recipient 13's claim 9 involved insufficient documentation to support a "Repair Tooth Socket" for an unknown tooth. The documentation (Exhibit 18-13: Bates-stamped page 600) reflected Dr. Hardeman wrote "What socket was repaired? I would allow if site was #30, that is what is in the op note. But the cover sheet does not indicate tooth#." Dr. Hardeman adopted his written notations as his testimony. This claim should not be allowed.

54. Recipient 22's claim 1 involved the lack of documentation to support an office consultation claim. Dr. Hardeman did not find any documentation to support an office consultation visit. The claim should be disallowed.

55. Recipient 29's claim 2 involved the lack of documentation to support an inpatient consultation claim, and claim 6 involved the lack documentation of a "CT" scan of the

maxillofacial region without dye. Dr. Hardeman did not find any documentation to support an in-patient consultation on the date specified, nor could he find a CT scan for this recipient in any of the records. These claims should be disallowed.

56. Recipient 34's claim 1 lacks documentation of a "CT" scan of the maxillofacial region without dye. Dr. Hardeman did not see a CT scan for this recipient in any of the records. This claim should be disallowed.

Level of Service and Not a Consult

57. As provided in paragraph 15.5. above, the description for an office consultation is clear. The Dental Handbook details the components of a consultation. The Dental Handbook provides guidance between a "Consultation Versus Referral" as:

> If a provider sends a recipient to another provider for specialized care that is not in the referring provider's domain, and the referring provider will not participate in the on-going care of the recipient for this problem, this is not a consultation. This is a referral and should be billed as an examination or appropriate evaluation and management code.
>
> The distinguishing feature between a consultation and an established or new patient visit will depend on whether the referring provider is going to continue to care for the patient for that particular problem. If this condition can be met, then the referral should be billed as a consultation. If this condition cannot be met, then the referral should be billed as a new or established patient.

58. Respondent billed an office consultation for the vast majority of the 35 recipients.[10/] Respondent consistently billed CPT codes 99424, 99243 or 99244. AHCA adjusted the codes downward, uses CPT codes 99202, 99203, or 99204 as warranted, and AHCA seeks to recover the difference as overpayment.

59. Respondent did not provide a written report of the findings and recommendations to the attending or requesting provider, but instead provided treatment to each of the 35 recipients in this sample.

60. For Recipient 22, there was no documentation to support an office visit.

61. For Recipient 29, the consultation was covered within a global surgery code, and will be discussed below.

62. Respondent's surgeon, Dr. Ason, mistakenly thought that he was providing a consult because the "patients were receiving care for their oral health by a general dentist. . . . So they [general dentists] sent the patient to me to consult on the area and confirm that the extraction or whatever procedure was needed, and after I was done with the procedure, I would then hand the patient right back to the dentist." Dr. Ason's explanation does not justify coding as a consult.

Global

63. Codes 21462, 21453, and 13132 involve the surgical procedures in the treatment of a fractured jaw with the insertion of hardware or an oral splint.

64. Code 20680 involves the removal of support, i.e., the hardware that was used in the surgical procedure to treat a fractured jaw.

65. The Florida Medicaid Provider General Handbook provides the following regarding global reimbursements:

> Global reimbursement is a method of payment where the provider is paid one fee for a service that consists of multiple procedure codes that are rendered on the same date of service or over a span of time rather than paid individually for each procedure code. If a provider bills for several individual procedure codes that are covered under a global procedure code, which is referred to as "unbundling," Medicaid Program Integrity will audit the provider's billing.

66. The Florida Medicaid Dental Services Coverage and Limitations Handbook provides the following description regarding surgery services:

> Surgical services are manual and operative procedures for correction of deformities and defects repair of injuries, and diagnosis and cure of certain diseases.
>
> The following services are included in the payment amount for a global surgery:
>
> • The preoperative visit on day one (the day of surgery);

- Intraoperative Services – Intraoperative services area usual and necessary part of a surgical procedure; examples are local anesthesia and topical anesthesia;

- Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery, because of complications that do not require additional trips to the operating room;

- Post Surgical Pain Management – By the surgeon;

- Miscellaneous Services and Supplies – Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, splints; routing peripheral intravenous lines, nasogastric tubes; and changes and removal of tracheostomy tubes; and

- Postoperative Visits – Follow-up visits within the postoperative period of the surgery that are related to recovery from the surgery.

Note: See the Florida Medicaid Provider Reimbursement Schedule for the number of follow-up days that are included in the surgical fee. The reimbursement schedule is available on the Medicaid fiscal agent's Web site at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider support, then Fee Schedules.

The following services are not included in the payment amount for a global surgery:

- Diagnostic tests and procedures, including diagnostic radiological procedures; or

- Treatment for postoperative complications, which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing

> surgical procedures. It does not include a patient's room, a minor treatment room, a post-anesthesia care unit, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR.

67. The Physician Surgical Fee Schedule in the Florida Medicaid Provider Reimbursement Schedule provides the global treatment period (also known as follow-up days, FUD) for codes 21453, 21454, 21461, and 21462, as 90 days.

68. Recipient 29 had a fractured jaw. On March 18, 2014, Dr. Ason performed a "closed reduction of bilateral condylar fracture of the mandible," and an "open reduction and internal fixation of symphysis fracture of the mandible" on Recipient 29. On March 26, 2014, this recipient presented to Respondent's practice for an office follow-up visit. On May 15, 2014, another surgical procedure was performed on Recipient 29 to remove the hardware that had been inserted into Recipient 29's mouth during the March surgery.

69. The March 26 office follow-up visit was eight days after the surgery, and within the 90 FUD. Claim 7 was coded as an office consultation on March 26, 2014. Claim 7 should not be allowed as the office visit occurred eight days after the surgery and was included with the global billing code.

70. Recipient 29's claims 8 through 13 involved the removal of support implants from teeth 3, 8, 14, 19, 24, and 30, dated May 15, 2014. Claims 9 through 13 were appropriately denied as

occurring within the 90 FUD period, and were excluded because they were covered under the global billing code. Nurse Kinser adjusted claim 8 downward, but admitted that claim 8 should have been denied as it occurred within the 90 FUD period.

71. Nurse Kinser testified that when an error is made to the provider's benefit, the benefit stays. However, if an error was made that was not to the provider's benefit, it would be appropriately adjusted.

Not a Covered Service

72. The Florida Medicaid Dental services coverage and limitations handbook provides the following overview introduction of dental services:

> This chapter defines the services covered by the dental services programs, the services that are limited and excluded, services that must be prior authorized, and the services that are specialty specific.

73. Those claims that were not initially coded appropriately fall under "Not a Covered Service" finding. Now that the correct codes have been assigned, the claims are not allowed per Medicaid guidelines.

Other Findings

74. Administrative sanctions shall be imposed for failure to comply with the provision of Medicaid law. For the first offense, Florida Administrative Code Rule 59G-9.070(7)(e) authorizes AHCA to impose a penalty in the amount of $1,000.00 per violation.

AHCA is seeking to impose a fine of $106,000.00 for 106 separate offenses. The sanction should be imposed for the claims that have been sustained; however, the actual sanction amount is unknown at this time due to the adjustments that must be made based on the findings of fact above.

75. Section 409.913(23) provides that AHCA is entitled to recover all investigative, legal, and expert witness costs if the agency ultimately prevails. At this time, the total costs are unknown.

76. Dr. Fonesca is not licensed to practice either medicine or dentistry in Florida. Dr. Fonesca testified he has an "expert witness certificate as it relates to" Florida. However, this matter is not a medical negligence litigation action, or a criminal child abuse or neglect case. This case revolves around whether Respondent coded certain services appropriately for Medicaid reimbursement. Dr. Fonseca is not a qualified Florida peer, and his testimony, while informative, is not competent in this case.

CONCLUSIONS OF LAW

77. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding. §§ 120.569 and 120.57, Fla. Stat. (2016).

78. The burden of proof is on Petitioner to prove the material allegations by a preponderance of the evidence. See

e.g., S. Med. Servs., Inc. v. Ag. for Health Care Admin., 653 So. 2d 440, 441 (Fla. 3d DCA 1995); Southpointe Pharm. v. Dep't of HRS, 596 So. 2d 106, 109 (Fla. 1st DCA 1992).

79. Section 409.913(22) provides:

> The audit report, supported by agency work papers, showing an overpayment to a provider constitutes evidence of the overpayment. A provider may not present or elicit testimony on direct examination or cross-examination in any court or administrative proceeding, regarding the purchase or acquisition by any means of drugs, goods, or supplies; sales or divestment by any means of drugs, goods, or supplies; or inventory of drugs, goods, or supplies, unless such acquisition, sales, divestment, or inventory is documented by written invoices, written inventory records, or other competent written documentary evidence maintained in the normal course of the provider's business. A provider may not present records to contest an overpayment or sanction unless such records are contemporaneous and, if requested during the audit process, were furnished to the agency or its agent upon request. This limitation does not apply to Medicaid cost report audits. This limitation does not preclude consideration by the agency of addenda or modifications to a note if the addenda or modifications are made before notification of the audit, the addenda or modifications are germane to the note, and the note was made contemporaneously with a patient care episode. Notwithstanding the applicable rules of discovery, all documentation to be offered as evidence at an administrative hearing on a Medicaid overpayment or an administrative sanction must be exchanged by all parties at least 14 days before the administrative hearing or be excluded from consideration.

AHCA can make a prima facie case by proffering a properly supported audit report, which must be received in evidence. See

Maz Pharm., Inc. v. Ag. for Health Care Admin., Case No. 97-3791 (Fla. DOAH Mar. 20, 1998; Fla. AHCA June 26, 1998).

80. AHCA is authorized to impose sanctions on a provider, including administrative fines. § 409.913(16), Fla. Stat. To impose an administrative fine, AHCA must establish by clear and convincing evidence the factual grounds for doing so. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 935 (Fla.1996); Dep't of Child. & Fams. v. Davis Fam. Day Care Home, 160 So. 3d 854, 857 (Fla. 2015). AHCA has done so in some of the claims listed above.

81. Section 409.913(11) provides the following:

> The agency shall deny payment or require repayment for inappropriate, medically unnecessary, or excessive goods or services from the person furnishing them, the person under whose supervision they were furnished, or the person causing them to be furnished.

82. AHCA established a prima facie case, and proved by a preponderance of the evidence that Respondent should not have been paid: for the services that were not medically necessary identified above; for the errors in coding (including the bone grafts claims) identified above; for those claims that had insufficient or no documentation to support the claim as identified above; for those claims involving the incorrect level of services or consultation codes as identified above; for claims that were covered through the global coding as identified above; or those claims that were for services not covered by Medicaid.

AHCA is entitled to reimbursement from Respondent for the claims he billed for these services.

83. Rule 59G-9.070 provides in pertinent part:

> (7) Sanctions: In addition to the recoupment of the overpayment, if any, the Agency will impose sanctions as outlined in this subsection. Except when the Secretary of the Agency determines not to impose a sanction, pursuant to Section 409.913(16)(j), F.S., sanctions shall be imposed as follows:
>
> * * *
>
> (e) For failure to comply with the provisions of the Medicaid laws: For a first offense, $1,000 fine per claim found to be in violation. For a second offense, $2,500 fine per claim found to be in violation. For a third or subsequent offense, $5,000 fine per claim found to be in violation (Section 409.913(15)(e), F.S.);

84. Section 409.913(23)(a) provides:

> In an audit or investigation of a violation committed by a provider which is conducted pursuant to this section, the agency is entitled to recover all investigative, legal, and expert witness costs if the agency's findings were not contested by the provider or, if contested, the agency ultimately prevailed.

85. Petitioner seeks an award of costs, including the investigation and litigation (including an expert) of this FAR pursuant to section 409.913(23). Petitioner incurred pre-hearing expenses of $5,112.88. Petitioner also incurred expenses in the preparation for and presentation at hearing. The exact cost for the preparation and presentation is unknown at this time.

RECOMMENDATIONS

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Agency for Health Care Administration enter a final order finding that Respondent was overpaid, and is liable for reimbursement to AHCA for the claims detailed above (AHCA shall rework the claims detailed above to determine the overpayment); finding that an administrative fine should be imposed based on each violation; and finding that Petitioner is entitled to recover all investigative, legal, and expert witness costs. Jurisdiction is retained to determine the amount of appropriate costs if the parties are unable to agree. Within 30 days after entry of the final order, either party may file a request for a hearing on the amount. Failure to request a hearing within 30 days after entry of the final order shall be deemed to indicate that the issue of costs has been resolved.

DONE AND ENTERED this 23rd day of March, 2017, in Tallahassee, Leon County, Florida.

LYNNE A. QUIMBY-PENNOCK
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 23rd day of March, 2017.

ENDNOTES

[1/] The hearing was conducted via telephone between Tallahassee and Asheville, North Carolina, on February 1, 2017, to accommodate a witness; and via video teleconferencing between sites in Tampa and Tallahassee, Florida, on February 2, 2017, to accommodate a witness.

[2/] On January 22, 2016, AHCA issued a Preliminary Audit Report (PAR). Following receipt of this PAR, Respondent provided additional documentation which was reviewed and utilized for the preparation of the FAR.

[3/] One claim, claim 2 was resolved and allowed when the panorex was received and evaluated by AHCA.

[4/] Other causes for disallowance shall be addressed in another section.

[5/] The Schneiderian Membrane is the lining of the maxillary sinus.

[6/] Other teeth were extracted but they are not the subject of these claims.

[7/] See Endnote 4 above.

[8/] In Exhibit 18-7, claim 7 is on the first page of the claims. The undersigned finds that counsel was referring to claim 12, page 2 regarding tooth 16.

[9/] Dr. Hardeman testified that teeth 1 and 16 were not on the panorex, so that they were not present to be removed. However, during Dr. Ason testimony, Petitioner's counsel advised that claim 12 was adjusted. Tr., p. 373.

[10/] For Recipient 17, no office consultation was billed.

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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.