STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH, BOARD OF OPTOMETRY,

Petitioner,

vs. Case No. 18-6323PL

ALBERT C. EVANS, O.D.,

Respondent.
_______________________________/

RECOMMENDED ORDER

Administrative Law Judge Elizabeth W. McArthur of the Division of Administrative Hearings (DOAH) conducted the disputed-fact hearing on April 4, 2019, by video teleconference at sites in Fort Myers and Tallahassee, Florida.

APPEARANCES

For Petitioner: Kimberly Lauren Marshall, Esquire
Amanda M. Godbey, Esquire
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For Respondent: William Gus Belcher, Esquire
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STATEMENT OF THE ISSUES

The issues in this case are whether Respondent used fraudulent, false, misleading, or deceptive advertising and

whether Respondent willfully submitted a claim to a third-party payor for services not rendered to a patient; and, if so, what is the appropriate sanction.

PRELIMINARY STATEMENT

On August 2, 2018, the Department of Health (Petitioner or Department) filed the First Amended Administrative Complaint (Administrative Complaint) before the Board of Optometry (Board), against Respondent, Albert C. Evans, O.D. (Respondent or Dr. Evans). Dr. Evans disputed material facts alleged in the complaint and requested an administrative hearing. The case was forwarded to DOAH on November 30, 2018, for assignment of an Administrative Law Judge to conduct the requested hearing.

Respondent filed two unopposed motions, the first to delay setting the hearing, and the second to continue the hearing initially set for March 4 and 5, 2019. Both motions were granted and the hearing was ultimately set for April 4 and 5, 2019. Only one day proved to be necessary for the hearing.

Prior to the hearing, the parties filed a Joint Pre-hearing Stipulation, in which they agreed to a number of facts that would not require proof at hearing, and they stipulated to several statements of law. The parties' stipulations are incorporated below to the extent relevant.

At the hearing, Petitioner presented the live testimony of N.P., a patient. Petitioner's Exhibits 1 through 4 were

admitted. Petitioner's Exhibit 4 is the transcript of the deposition testimony of Thomas Kline, O.D., who testified for Petitioner as an expert in optometry.

Respondent testified on his own behalf, and also presented the testimony of Hope Fior, Joseph Acuna, and Todd Dutton. Respondent's Exhibits 1 and 2 were admitted. Exhibit 2 is the transcript of the deposition testimony of Angel Dickinson, who testified for Respondent as an expert in billing vision insurance plans. The Department's motion in limine, arguing for exclusion of the deposition testimony on grounds that the witness lacked expertise and did not satisfy the Frye test, was denied. The Frye test was deemed inapplicable in the context asserted.[1/] As to the general qualifications of the proposed expert--developing self-proclaimed expertise in billing vision insurance plans through 18 years of "trial and error" experience--although the undersigned acknowledged they were marginal, the objections would be considered in determining the weight, if any, to be given to the deponent's opinions. The deponent was accepted as an expert to the extent of her experience. § 90.702, Fla. Stat.

At the conclusion of the hearing, the parties were informed that the deadline for filing proposed recommended orders (PROs) would be ten days after the filing of the hearing transcript at DOAH. The one-volume Transcript was filed April 25, 2019. Respondent subsequently filed a motion to extend the PRO

deadline, which was granted.[2/] The parties timely filed their PROs by the extended deadline. Respondent also filed a separate Closing Argument. The parties' post-hearing submissions have been given due consideration in the preparation of this Recommended Order.

Unless otherwise noted, citations to statutes and rules are to the versions in effect at the time of the alleged violations.

FINDINGS OF FACT

1. Petitioner is the state agency charged with regulating the practice of optometry pursuant to section 20.43, Florida Statutes, and chapters 456 and 463, Florida Statutes.

2. At all times material to this proceeding, Respondent was a licensed optometrist in the State of Florida, having been issued license number OPC 1738.

3. Respondent is the owner of One Price Optical in Cape Coral, Florida, where he practices optometry and sells eyeglasses. He opened his business in 2000.

4. For the first 13 years of his business, Respondent advertised in an area newspaper, offering a free eye exam for glasses. The advertisement that he published in newspapers until sometime in 2013 is in evidence. At the top of the ad, the words "FREE EYE EXAM" appeared in large, white, all capital letters, against a solid black background. Immediately below, also on the

black background in smaller white, all capital letters, was the following:

FOR YOU • FOR GLASSES • PATIENTS 7 YEARS & UP

Below the prominent white-on-black section, the ad contained information about the business in black print against a white background. The name of the business was the only print as large as the "FREE EYE EXAM" message at the top of the ad. Looking at the ad as a whole, the eyes are drawn to two messages: "FREE EYE EXAM" and "ONE PRICE OPTICAL." The smaller black print on the white background identified Respondent as the optometrist, provided the address, telephone number, and hours, and listed names of third-party payors, including Medicare, vision plans, and insurance plans. The bottom of the ad contained one more very small black banner with tiny white print, setting forth a disclaimer required by statute and Board rule, regarding a patient's right to a refund.

5. N.P. saw the newspaper advertisement, and on October 4, 2012, he went to One Price Optical to obtain his free eye exam for glasses. N.P. already had glasses, but wanted to get an updated prescription. N.P. brought the ad with him. N.P. was greeted by staff member Hope Fior who asked what brought him to One Price Optical that day. N.P told her that he wanted the free eye exam.

6. Patients are asked to complete a two-sided patient information form provided to them on a clipboard. Ms. Fior does not recall whether she was the staff person who gave N.P. the clipboard paperwork to fill out, but her initials, "HF," appear at the top of the first page in the blank for "staff," suggesting that it was her.

7. Just as Ms. Fior did not specifically recall that she was the "staff" initialing N.P.'s paperwork--after all, it has been nearly seven years since the encounter--N.P. also did not recall filling out paperwork, although he remembers that he spoke with a female staff member (and Ms. Fior was the only female staff member). Nonetheless, N.P. was able to identify his handwriting on the form, such as his name, address, and telephone number on the first page (the front of the two-sided page).

8. At the bottom of the first page, the form instructs Medicare patients that they "MUST READ & SIGN THE OTHER SIDE." (Pet. Ex. 2, handwritten p. 29, lower left corner).

9. The second page (the other side of the two-sided form) was referred to by Respondent as the "how are you going to pay" page, requiring patients to select one of several options, initial and/or sign the selection, and sign at the bottom of the page. One section is designated for "If You Have Medicare." This section states that if a patient has Medicare, "We will bill Medicare for your eye exam according to the Medicare Laws [CPT

code] 92004: New Patient, Comprehensive [or CPT code] 92014: Previous Patient, comprehensive. Please provide the staff with your: 1) Medicare card; 2) Medicare Advantage Card; 3) Any supplemental card; 4) Any other non-governmental health insurance card." Below these provisions, the Medicare section concludes with the following: "If you do not have all of your insurance cards today, we will not be able to exam [sic] you today and will reschedule you." (Pet. Ex. 2, p. 30).

10. N.P.'s completed "how are you going to pay" page has a handwritten "X" in the box selecting the "If You Have Medicare" section, with N.P.'s initials next to the "X" (because he was a Medicare patient, and, therefore, required to complete this section as written). A check mark also appears next to "Medicare Advantage Card" in the portion requiring the patient to provide staff with insurance cards.

11. Above the "If You Have Medicare" section, a separate section is provided for "Free Exam For Glasses," with the following description: "The free eye exam for glasses is free. You do not have to buy anything at all. <u>The free exam does not come with any prescription</u>. If you wish, you may pay an exam fee and get a prescription for eye Glasses to take with you." (emphasis added). At the bottom of this section, two options are provided, with spaces for the patient's signature. One option

is: "I would like the free exam with no RX"; the other option is: "I would like the $48 exam and get my RX."

12. On N.P.'s completed form, the "Free Exam For Glasses" section has no "X" in the selection box, and neither of the two options was signed by N.P. However, there are hand-drawn circles around the $48 exam option and the signature space to select that option, suggesting that this option was called to N.P.'s attention. There were no circles around the "free exam with no RX" option--the only option that was truly "free." That option would not have met N.P.'s objective in coming into One Price Optical, which was to get an updated eyeglasses prescription.

13. Another section on the second page is called "Vision Plans." This section provides: "We will follow all the procedures, rules, and regulations according to the terms of your plan. The free exam for glasses above can not [sic] be combined with any part of your vision plan. You may not mix and match different coupons, promotions, store discounts, etc. with your Vision Plan." On N.P.'s completed form, there is no "X" in the box provided to select this section, no initials by N.P., and no hand-drawn circles to indicate that this provision was called to N.P.'s attention as potentially applicable.

14. N.P. signed the bottom of the "how are you going to pay" page (with only the Medicare/Medicare Advantage section initialed), next to the handwritten date, October 4, 2012.

15. According to Respondent, his staff would have carefully walked N.P. through the examination and payment options when he came in and asked for the advertised free eye exam. This would have included asking Respondent whether he was covered by Medicare, whether he had "Medicare supplement" insurance coverage, and whether he had any other "vision plan" coverage. If so, he would have been asked to produce his insurance cards and the staff would have investigated what type of coverage was available for eye examinations.

16. According to Respondent, N.P. made the voluntary election to undergo a comprehensive eye examination, which would be paid for under his Medicare Advantage insurance plan, instead of the "free eye exam." Respondent acknowledged that a comprehensive eye examination must be completed on a patient in order to write a prescription for eyeglasses. One required component of a comprehensive eye examination is an internal examination of the eyes, to the back of the eyes (examination of the fundus). See Fla. Admin. Code R. 64B13-3.007.

17. Respondent admitted that the so-called free eye exam for glasses offered by the advertisement was actually only a "screening" or a "consultation" with a patient to determine if the patient might need eyeglasses. Respondent admitted that the "free eye exam" (screening/consultation) would not be sufficient to enable Respondent to write a prescription for glasses. The

advertisement does not mention this. What is offered for "free" is called an "eye exam for glasses," not a screening that would be insufficient for Respondent to write a prescription for glasses.

18. Staff person Hope Fior acknowledged that the advertisement caused confusion, not only for N.P., but for others. She blamed their confusion on the failure to read the fine print that she believed was in the ad, which she described as making clear that the offer of a free eye exam for glasses could not be used in combination with vision plans. That language did not appear in the advertisement, in fine print or otherwise.

19. Respondent's claim that N.P. made the voluntary election to forego the advertised free eye examination is contrary to the credible evidence. What N.P. wanted was a "free eye exam for glasses," as advertised. N.P. was not offered a free eye exam that would have allowed him to obtain an updated prescription for his glasses.

20. Respondent performed an eye examination on N.P. However, Respondent did not complete all steps required for a comprehensive eye examination. In particular, as the parties stipulated, Respondent did not perform a fundus examination on N.P.

21. A comprehensive eye examination, including fundus examination, can be done with or without dilation. Examination of the fundus, the interior examination to the back of the eyes, is generally done after dilation drops are administered. The fundus examination can be done by other means if the patient does not want dilation, but generally dilation is preferable. In fact, Respondent testified that he "always" administers dilation drops, unless a particular patient asks him not to, in which case he makes them sign a form declining dilation.

22. Respondent administered dilation drops to N.P. There is no persuasive evidence establishing that N.P. was resistant to receiving dilation drops, but there is also no persuasive evidence that N.P. was offered a choice or told that he could decline dilation. More importantly, there is no persuasive credible evidence that N.P. was informed before the drops were administered that he would be charged $39.00 as a dilation fee.[3/] Instead, N.P. credibly testified that he was not told he would have to pay any fee until later.

23. After Respondent put dilation drops in N.P.'s eyes, he directed N.P. to go down the hall to the reception/store area where eyeglasses are displayed for purchase, and was told he could wait there and look at glass frames while the drops took effect in 15 to 20 minutes.

24. While N.P. was in the optical area, staff member Todd Dutton spoke with him about whether he might want to purchase glasses. The conversation about glasses did not progress, however, because Mr. Dutton also told N.P. that there was a $39.00 charge for dilation, and asked him to pay.

25. N.P. got very upset with this new information, because up until that point, he was still under the impression that he was getting a free eye exam, as advertised.

26. When Mr. Dutton did not retreat from the position that N.P. would have to pay $39.00 for the dilation drops he had received, N.P. walked out, rather than returning to the examination room for Respondent to complete the comprehensive examination. He did not ever return.

27. Inexplicably, Respondent said he was not aware until much later on October 4, 2012, that N.P. walked out. Respondent did not come back for N.P., or send a staff person to bring N.P. back to the examination room, after the short period of time needed for the dilation drops to have taken effect. No explanation was provided for this lapse.

28. It was not until an hour or two later, when Respondent was going over the patient paperwork for the day, that he realized that he never retrieved N.P. to complete N.P.'s comprehensive examination by performing the fundus examination. Respondent completed the patient record form as best he could, as

the form he had created did not have an option to indicate an incomplete comprehensive examination, nor did his form provide the option of recording that an intermediate examination was done (which would not require a fundus examination, but would not be sufficient for writing a prescription for eyeglasses). Respondent selected the option called "No Dilation" and circled "Yes" to indicate that dilation was declined. Then he attempted to clarify in handwriting that there was no internal examination because the patient left the office.

29. Despite not performing a fundus examination, Respondent produced a prescription for N.P. that he said he prepared after the incomplete examination. N.P. testified that he does not recall whether he asked for a prescription before he left the office, but he is sure that no prescription was offered to him. Todd Dutton confirmed that there was no discussion with N.P. about a prescription. The prescription presumably could not have been finalized and actually issued to N.P. before the comprehensive examination was completed, so whatever Respondent prepared must be viewed, at best, as preliminary.

30. Respondent's advertisement that offered a "free eye exam . . . for glasses" was misleading and deceptive. A reader would have been led to believe, just as N.P. did believe, that there would be no charge to anyone--the patient or the patient's insurer--for an eye exam that would be sufficient to allow

Respondent to prescribe glasses. N.P. was misled and deceived by the advertisement, as were others who were confused by the ad's offer of a free eye exam for glasses.

31. Respondent testified that he discontinued the advertisement, after 13 years of publishing it in the newspaper, sometime the next year (2013) when it came up for renewal. He said that he discontinued it, in part, in response to N.P.'s complaint to the Department, but also because he did not believe the ad was worth the cost of publication. Respondent did not say that he discontinued the advertisement out of remorse for falsely advertising free eye exams for glasses. He was steadfast in disputing the charge that his advertisement was in any way false, misleading, or deceptive.

32. After N.P.'s incomplete examination, Respondent proceeded to bill N.P.'s vision insurance plan. He submitted a claim under CPT code 92004 in the amount of $139.00, and a claim under CPT code 92019 in the amount of $39.00.

33. Current Procedural Terminology (CPT) codes are used by optometrists to define the services provided to patients in submitting claims to third-party payors for payment. Each CPT code has a definition set forth in a book maintained and distributed by the American Medical Association. The CPT code book has been officially adopted by the Department of Health and Human Services as the standard medical data code set, which must

be used by “covered entities” under the Health Insurance Portability and Accountability Act, for physician services and other health care services, including vision services. See 45 C.F.R. §§ 162.1000 and 162.1002(a)(5)(vi) and (b)(1).

34. CPT codes have uniform objective definitions that do not change based upon the type of practitioner or setting in which they are used.

35. CPT code 92004 is defined as a comprehensive ophthalmological examination, including fundus examination.

36. CPT code 92019 is defined as an ophthalmological examination and evaluation under general anesthesia.

37. Respondent admits that he did not complete the comprehensive eye examination of N.P. The parties stipulated that Respondent did not perform the fundus examination.

38. Respondent stated that by submitting a claim to N.P.’s vision insurance plan using CPT code 92004, he intended to bill the vision plan for performing a dilated fundus examination on N.P. He admits to having willfully submitted a claim to a third-party payor for services not provided to a patient.

39. Respondent contends he should be excused for submitting the claim because the reason Respondent did not perform the dilated fundus examination on N.P. is that N.P. walked out. While that explains why Respondent did not provide the service to

N.P., it does not justify Respondent's claim seeking insurance reimbursement for a service he admittedly did not provide.

40. Respondent testified that he was left in a quandary as to how to handle the billing, as there was no option for billing the vision plan for three-quarters or some other fraction of CPT code 92004.

41. Petitioner's expert, Dr. Kline, offered a viable alternative that would have solved Respondent's quandary without submitting a claim for a service that was not provided.
Dr. Kline testified that Respondent could have submitted a claim under CPT code 92002, for an intermediate eye examination. CPT code 92002 is appropriate to use by an optometrist who has performed a less extensive examination than a comprehensive examination. In particular, the fundus does not have to be examined in an intermediate exam. While an intermediate eye examination was insufficient to meet N.P.'s objective of securing a legal updated prescription (which requires a comprehensive eye examination), the unrebutted evidence in this record shows that submitting a claim using CPT code 92002 would have been accurate in identifying the service actually provided to N.P.

42. Dr. Kline opined that submitting no claim to N.P.'s third-party payor was also an option that would have solved Respondent's quandary, and in his opinion, would have been the most reasonable course of action under the circumstances. It

would have been what he would have done. In light of Respondent's advertisement for a "free eye exam," Dr. Kline's opinion is credited: the most appropriate option would have been to not submit a claim to N.P.'s third-party payor, thereby providing a "free," albeit incomplete exam.

43. Respondent defended his claim under CPT code 92004 for a comprehensive eye exam, under the guise of it being acceptable practice to perform a comprehensive eye examination in more than one sitting. According to Respondent, as long as the examination is going to be completed, it is acceptable to bill the third-party payor for the entire examination after only part of it has been done. This may be true when (as Respondent was told in a seminar), the completion of the exam is scheduled for the next day, within the next few days, or perhaps as much as a week later. For example, on occasion a patient might request to not be dilated on the day the examination is initiated and mostly completed, and arrangements are made for the patient to return for the dilation and fundus examination on a day when dilated eyes do not present a problem for the patient.

44. However, that is not what occurred with N.P. N.P. never contacted Respondent to complete the examination, nor did Respondent ever attempt to contact N.P. to schedule his return for the fundus examination. It was obvious that N.P never intended to return. Indeed, Respondent admitted that he would

not have attempted to contact N.P. because of N.P.'s anger when he left One Price Optical.

45. Respondent's justification for billing the vision insurance plan under the CPT code for a comprehensive examination could only be accepted if, at the time Respondent submitted the bill, arrangements had already been set for the examination to be completed, either because N.P. had scheduled a return visit before leaving, or because Respondent had called the patient and succeeded, before submitting the bill, in scheduling N.P.'s return visit to complete the exam.

46. Under the circumstances here, at the time Respondent submitted the claim to N.P.'s vision plan, he knew that he had not completed a comprehensive eye examination of N.P., and he knew that no arrangements had been made to complete the examination. A fundus examination is a service that is a required component of CPT code 92004. Respondent willfully submitted a claim to a third-party payor for a service that was admittedly not provided to N.P.

47. Respondent also admitted that he did not provide an eye examination to N.P. while under general anesthesia, which is the service defined by CPT code 92019, but he submitted a claim to the third-party payor using that CPT code. Respondent contended that he intended to use that CPT code to submit a claim for dilation charges. Respondent attempted to explain that some

vision plans do not strictly follow the CPT code definitions, and some of them use CPT code 92019 to mean dilation. He testified that he just does his best using their claim forms and the descriptions they use for the CPT codes.

48. Respondent did offer evidence that a different vision plan, not the one administering N.P.'s Medicare Advantage plan's vision benefits, described CPT code 92019 as "dilation" in its online claim form. If a claim submitted to that other vision plan were at issue here, Respondent's explanation might be accepted as evidence that Respondent did not willfully submit a claim for a service not provided.

49. However, the evidence does not support Respondent's explanation in this instance. In the "Explanation of Payment" printed from N.P.'s vision insurance plan's website, CPT code 92019 was specifically described (in the available space) as "ophthalmological examination and evaluation under general an" and not as dilation. (Pet. Ex. 2, p.35) (emphasis added).

50. Respondent said that he does all of the billing and coding for One Price Optical, and that he has tried to find out what is required. His claim that so-called "vision plans" are not considered insurance and do not strictly follow the CPT code definitions rings hollow, at least as applied to the facts here, where everything in N.P.'s patient records speaks to Medicare Advantage health care insurance. The "how are you going to pay"

form completed by N.P. directed him, as a Medicare patient with Medicare Advantage insurance, to authorize billing under that coverage, which Respondent's form assured would be done in compliance with Medicare laws and rules. The claim processing paperwork calls N.P.'s plan "Universal Health Care – Medicare," and the plan's explanation of denied payment for the claim under CPT code 92019 used the code definition from the CPT code book.[4/]

51. Respondent testified that he always very carefully checks to see how a particular vision plan uses and defines the CPT codes, and that he submits his claims using the CPT codes as defined by the particular plan. He therefore admitted that he willfully submitted a claim to N.P.'s vision plan under CPT code 92019, defined as "ophthalmological examination and evaluation under general an[esthesia]."

52. The undersigned is not persuaded by Respondent's assertion that in billing under CPT Code 92019, he should be found to have not willfully submitted a claim for a service not rendered because he knew that the claim would not be paid. The fact remains that Respondent knowingly, intentionally, and willfully submitted a claim to N.P.'s vision insurance plan, coded under CPT code 92019, claiming to have performed an eye exam under general anesthesia on N.P. on October 4, 2012, as explained in the Explanation of Payment. (Pet. Ex. 2, p. 35). Whether Respondent intended to get paid or expected to get paid

is not germane to the question of whether he willfully submitted the claim for a service not provided.

CONCLUSIONS OF LAW

53. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto, pursuant to sections 120.569 and 120.57(1), Florida Statutes (2018).

54. A proceeding, such as this one, to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Accordingly, to impose such discipline, Petitioner must prove the allegations in the Administrative Complaint by clear and convincing evidence. Dep't of Banking & Fin., Div. of Sec. & Investor Prot. v. Osborne Stern & Co., 670 So. 2d 932, 933-34 (Fla. 1996) (citing Ferris v. Turlington, 510 So. 2d 292-294-95 (Fla. 1987)); Nair v. Dep't of Bus. & Prof'l Reg., Bd. of Med., 654 So. 2d 205, 207 (Fla. 1st DCA 1995).

55. As stated by the Supreme Court of Florida,

> Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and lacking in confusion as to the facts at issue. The evidence must be of such a weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Henson, 913 So. 2d 579, 590 (Fla. 2005) (quoting Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)). This burden of proof may be met where the evidence is in conflict; however, "it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 988 (Fla. 1st DCA 1991).

56. Penal statutes and rules authorizing discipline against a professional license must be strictly construed, with any ambiguity resolved in favor of the licensee. Elmariah v. Dep't of Prof'l Reg., Bd. of Med., 574 So. 2d 164, 165 (Fla. 1st DCA 1990).

57. As a matter of due process, as well as procedural statutory and rule requirements, an administrative complaint must provide "reasonable notice to the licensee of the facts and conduct which warrant" disciplinary action. See § 120.60(5), Fla. Stat.; Cottrill v. Dep't of Ins., 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996).

58. Count I charges Respondent with a violation of section 463.016(1)(f), Florida Statutes (2012), providing that the following is grounds for disciplinary action: "Advertising goods or services in a manner which is fraudulent, false, deceptive, or misleading in form or content."

59. The Administrative Complaint alleges that Respondent violated section 463.016(1)(f) "by publishing an advertisement

for a free eye exam for glasses when he required a $39.00 fee if the patient wanted to obtain a prescription."[5/]

60. The credible evidence, as found above, was clear and convincing that Respondent's advertisement for a free eye exam for glasses violated the charged statute. It was fraudulent, false, deceptive, and misleading. Respondent admitted as much when he conceded that, contrary to the ad's representation, no "eye exam" was provided for free; the only service he provided for free was a limited "screening" or a "consultation" to see if further examination might be necessary.

61. Under the Board's rule 64B13-3.007 (as amended through 2008), the "free" service that Respondent would provide pursuant to the advertisement is inadequate for an eyeglass prescription; a comprehensive eye examination, which must include an internal examination, is required. In fact, the same rule recognizes a more limited service, called a "screening," might be performed in public service settings or for governmental agencies, but only if "each recipient of such screening" is informed in writing of the limitations of the screening, that the screening is not a substitute for a comprehensive eye examination, and that "the screening will not result in a prescription for visual correction." Fla. Admin. Code R. 64B13-3.007(6)(c).

62. The evidence was clear and convincing that if a patient wanted an eye examination that would be adequate to allow

Respondent to issue a prescription for eyeglasses, that examination would not be free. Respondent admitted this. Rather than a "free eye exam for glasses," Respondent charged fees to be paid by the patient and/or the patient's vision insurance coverage (which is, in turn, paid for by the patient).

63. The Administrative Complaint plainly gave Respondent reasonable notice of the facts and conduct warranting this charge. That the complaint referred to the $39.00 fee charged to N.P. without also referring to the other ways in which Respondent charged fees to patients and/or third-party payors for eye examinations yielding eyeglass prescriptions does not detract from the reasonableness of the notice of the facts and conduct warranting this charge. An administrative complaint is required to provide "reasonable" notice; it is not required to spell out each and every variant detail. See, e.g., Omulepu v. Dep't of Health, Bd. of Med., 249 So. 3d 1278, 1281 (Fla. 1st DCA 2018) (rejecting doctor's challenge of final order due to alleged disparities between complaint allegations and evidence at hearing, finding that the proof at hearing was "consistent" with the allegations, which provided "reasonable" notice of the facts and conduct on which the charges were predicated). As in Omulepu, all of the variant details, which were consistent with the allegations, were fully fleshed out and proven by clear and convincing evidence in the record developed at hearing.

64. Count II charges Respondent with a violation of section 463.016(1)(j), which provides that the following is grounds for disciplinary action: "Willfully submitting to any third-party payor a claim for services which were not provided to a patient."

65. Respondent, by his own admission, intentionally submitted a claim to N.P.'s vision plan for a comprehensive eye exam using CPT code 92004. He intended to bill the vision plan for a dilated fundus examination, as a required part of the comprehensive examination. Yet he knew he did not provide that service.

66. Respondent also intentionally submitted a claim to N.P.'s vision plan using CPT code 92019, which N.P.'s vision plan defined as an ophthalmological examination and evaluation under general anesthesia, which is the CPT code manual's definition. There is no question that Respondent submitted this claim, but did not provide the service defined by CPT code 92019.

67. The evidence was clear and convincing that in both instances, Respondent willfully submitted a claim to a third-party payor for services not provided to N.P. Either instance is sufficient to support the charged violation of section 463.016(1)(j).

68. Florida Administrative Code Chapter 64B13-15 contains the rules to consider regarding the appropriate penalty. Rule 64B13-15.005 addresses whether violations are to be considered

"major" or "minor" administrative violations. A separate rule makes the same distinction among patient care violations; it is noted that here, the two statutory violations do not involve patient care. Respondent's violation of section 463.016(1)(f) is designated a major administrative violation. A violation of section 463.016(1)(j) is not specifically designated. Rule 64B13-15.005(3) provides that when a violation is not classified as major or minor, the Board will apply the penalty guideline applicable to a listed offense that is most comparable to the charged offense. Here, the offense charged is most similar to section 463.016(1)(e) (making or filing a report or record which the licensee knows to be false), which is classified as a major administrative violation. Accordingly, Respondent's violation of section 463.016(1)(j) is also treated as a major administrative violation.

69. Rule 64B13-15.003(2) prescribes the penalty guidelines for major administrative violations. The recommended penalty range for a first-time major administrative violation is an "administrative fine of not less than $1,000.00 nor more than $4,000.00 per count or offense and, if appropriate, a period of probation or suspension of not less than 6 months nor longer than 12 months."

70. Consideration of the mitigating and aggravating circumstances pursuant to rule 64B13-15.007 do not support a

recommendation to deviate from the normal penalty guideline range. That these are first-time offenses is already considered in the Board's categorization scheme, as is the categorization of the violations as "administrative" in nature as opposed to "patient care" violations. Respondent's advertisement ran for 13 years, and although N.P. was the first patient to lodge a formal complaint, he was not the first patient confused by the false promise of a free eye exam for glasses, or the first patient baited into switching to vision insurance coverage.

71. For Respondent's two counts of first-time major administrative violations, a fine of $6,000.00 is appropriate.[6/] In addition, 12-month probationary period is appropriate, with such terms and conditions governing the probation as the Board deems appropriate.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Optometry, issue a final order finding Respondent guilty of violating section 463.016(1)(f) and (1)(j), Florida Statutes (2012); and, as discipline, imposing a fine of $6,000.00 and issuing a 12-month probationary period on such terms and conditions as the Board deems appropriate.

DONE AND ENTERED this 12th day of June, 2019, in Tallahassee, Leon County, Florida.

ELIZABETH W. MCARTHUR
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 12th day of June, 2019.

ENDNOTES

[1/] After the final hearing, in In Re Amendments to the Florida Evidence Code, No. SC19-107, 219 Fla. LEXIS 818, 44 Fla. L. Weekly S170 (Fla. May 23, 2019), the Florida Supreme Court receded from its prior refusal to adopt the Legislature's amendment of the Florida Evidence Code to codify the standard established by Daubert v. Merrell Dow Pharmaceuticals, Inc., 509 U.S. 579 (1993) (Daubert standard), instead of the standard established by Frye v. United States, 293 F. 1013, 1014 (D.C. Cir. 1923) (Frye standard). The Daubert standard would generally require a trial judge to act as gatekeeper by determining whether the scientific tests, theories, and methodologies underlying proposed expert testimony are scientifically reliable before the expert is permitted to testify. The Frye standard was more limiting, applying only to new or novel scientific techniques, which were to be assessed for general acceptance before they could be introduced in evidence and used as the basis for expert testimony. The undersigned did not exclude Respondent's expert's testimony based on a failure to meet the then-applicable Frye standard, as argued in the Department's motion in limine. The Respondent's expert gave fairly narrow testimony, with little by way of expert opinion. Instead, her testimony simply recounted her experience coding eye examinations and submitting claims to vision insurance plans. Based on her experience, she offered a

very limited opinion about the propriety of one CPT code (92004) used by Respondent in submitting a claim to N.P.'s vision insurance plan. While her opinion was inconsistent with her testimony regarding what services she understood were provided and what should have been provided for the billing code used, the opinion would not have been rendered inadmissible by application of the Daubert standard. She also attempted to offer an opinion about a second CPT code (92019) used by Respondent, but her testimony made clear that any opinion she could offer on that subject was outside the scope of her experience-based expertise. This opinion, if tested under the Daubert standard, would have been excluded, as her explanation for having "researched" the code solely for purposes of this hearing was wholly inadequate to show a scientifically reliable mode of research. As it stands, even without application of Daubert, her opinion purporting to legitimize use of a CPT code when she admitted that she had never heard of or used that code in her 18 years of experience, cannot be given weight to support Respondent's position.

2/ By agreeing to an extended deadline for post-hearing submissions beyond ten days after the filing of the transcript, the parties waived the 30-day time period for filing the Recommended Order. See Fla. Admin. Code R. 28-106.216.

3/ In making this finding, the undersigned did not overlook the testimony of Joseph Acuna, who was one of the staff members working at One Price Optical in 2012. Mr. Acuna's testimony was not credible. He claimed to recall being the one who went over the patient paperwork with N.P. on the clipboard, but he is the not the staff person who initialed that paperwork. (Pet. Ex. 2, p. 29-30). He also testified that upon being provided N.P.'s insurance cards, Respondent looked up the benefits online and provided the benefits summary in N.P.'s patient file. (Pet. Ex. 2, p. 31-32). Although Mr. Acuna's testimony was less than clear or consistent regarding what he actually remembers doing with N.P. versus what he or some other staff member generally did, Mr. Acuna seemed to testify that he reviewed with N.P. the benefits summary pages printed out for N.P.'s plan, "Universal-FL-Medicare HMO 001 In Network," before N.P.'s examination. Mr. Acuna identified the handwritten "Dilation $39" as Respondent's note to remind the staff person going over the benefits summary with the patient to inform the patient that there would be a $39 dilation fee. Mr. Acuna said that he did that: using the benefits summary page, with its $39 dilation fee reminder, he claims that he went over the dilation fee with N.P. at least once, and maybe twice, before the examination. However, the benefit summary pages, printed from the third-party payor's

website, bear the date December 3, 2012, in the top left corner. (Pet. Ex. 2, p. 31-32). The next page after the two-page benefits summary is a "Utilization Summary," showing what the available benefits are for N.P. (taking into account claims already paid during the benefit period), and this page bears the same printout date--December 3, 2012. The utilization summary page makes absolutely clear that December 3, 2012, was the date this website information was printed out, by defining the "issue date" of the utilization review information for N.P.'s plan as "12/3/2012." (Pet. Ex. 2, p. 33). Accordingly, the benefits summary pages could not have been reviewed with N.P. on October 4, 2012; they were not printed out until two months later. And if the benefit summary pages were not printed out until two months after N.P.'s visit, quite obviously the "Dilation $39" note could not have been written until after the benefits summary was printed out on December 3, 2012, for some purpose other than to prompt staff to discuss the fee with N.P. in October 2012. These pages are included in the group of N.P. patient records that were certified by Respondent on December 13, 2012, as true and correct copies of patient records for N.P. (Pet. Ex. 2, p. 26). In context, then, the benefits summary with handwritten "Dilation $39" note and the utilization review issued December 3, 2012, were generated to provide to the Department in the course of its investigation of N.P.'s complaint.

[4/] In an effort to confuse what is essentially a straightforward matter, Respondent claimed that N.P. was actually not covered under an insurance plan, because his Medicare Advantage insurance had a department or division, or a contractual arrangement with a vision plan, to process or administer the vision benefits under N.P.'s Medicare Advantage insurance plan. Respondent testified variously that: vision plans are not considered insurance, and it is "against the law" to refer to vision plans as insurance (though no such law was identified); or there are two types of vision plans, those that are an "arm" of a Medicare Advantage insurance plan to administer that plan's vision benefits, and freestanding plans that provide vision benefits to employer groups to provide benefits to employees who pay into a fund in advance. Respondent acknowledged that N.P. had a Medicare Advantage insurance plan, and that the vision benefits under that plan were administered by a "vision plan"; yet he still seemed to contend that the administrator would not have to adhere to billing, coding, and claims requirements of the Medicare Advantage insurance plans. He offered no evidence or legal authority to support the notion that N.P.'s Medicare Advantage insurance plan was somehow not considered insurance. His assertion was contradicted by his own expert who said that vision

plans are insurance plans. Respondent's expert could not validate the use of CPT code 92019 to bill vision plans for dilation based on her experience, which was the sole basis for qualifying her as an expert. In fact, her 18 years of experience coding vision services provided by optometrists, without having ever heard of or used CPT code 92019, is evidence undermining Respondent's attempt to legitimize its use for dilation. Ms. Dickinson testified that CPT code 92004 encompasses a comprehensive eye examination, including fundus examination, with or without dilation. Thus, in her 18 years of experience coding comprehensive eye examinations performed by optometrists, when dilation was provided with those examinations, she considered it included under CPT code 92004.

[5/] The facts found above portray a more nefarious, multi-pronged scheme to impose charges in more ways than one when patients came in the door as a result of the advertisement, asking for their free eye exam for glasses. As the "how will you pay" form makes clear, if a patient wanted a "free eye exam" that would result in a prescription for glasses, the patient would be charged $48.00. However, a "bait and switch" approach was also employed, whereby patients were asked about insurance coverage and, if they were a Medicare patient, they were required to produce any Medicare Advantage or Medicare Supplement insurance cards before they would be examined. And, as found above, at least in the instance of N.P., the patients may have been led to believe that they would still be examined for free (in the sense that their insurance covered, i.e., would pay for the exam), but may not have been told, as N.P. was not told, that he would be charged a "dilation fee" of $39.00. Regardless of approach, the proof was consistent with the allegation that the advertisement promised a free eye exam for glasses, but Respondent ended up charging one way or the other--sometimes $39.00 (plus charges to the third-party payor), sometimes $48.00--for an examination that would be sufficient to allow Respondent to write a legal prescription.

[6/] Petitioner proposed somewhat more lenient discipline. However, Petitioner mistakenly relied on the penalty ranges for minor administrative violations after concluding that Respondent's two counts were both major administrative violations. The recommended discipline here is equivalent to Petitioner's proposed discipline, which was found to be appropriate when adjusted to the higher ranges applicable to major administrative violations.

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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.