BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

VANESSA PHAN,	:	
Petitioner,	:	
	:	**Docket No.:**
v.	:	**OSAH-DCH-PROP-1331784-44-Miller**
	:	
DEPARTMENT OF COMMUNITY HEALTH,	:	
Respondent.	:	

INITIAL DECISION

I. SUMMARY OF PROCEEDINGS

This matter is an appeal by the Petitioner, Vanessa Phan, of a decision by the Department of Community Health ("Department"), Respondent herein, to recoup $18,792.00 previously paid to the Petitioner under the Medicaid and PeachCare for Kids programs. The evidentiary hearing took place on May 8 and June 4, 2013,[1] pursuant to O.C.G.A. §§ 50-13-13 and 49-4-153(a)(2), before the undersigned administrative law judge of the Office of State Administrative Hearings. The Petitioner appeared *pro se*. The Department was represented by Elizabeth Brooks, Esq.

After careful consideration of the evidence and the arguments of the parties, the Department's decision to recoup $18,792.00 from the Petitioner is hereby **AFFIRMED**.

II. FINDINGS OF FACT

A. Background

1.

The Department is the agency responsible for administering the Medicaid and PeachCare for Kids programs in Georgia. Through these programs, health care providers are paid to deliver health care services to individuals and families with low income and limited resources. (Testimony of Terri Kight; Exhibit R-1.)

[1] The record closed on June 31, 2013, upon the filing of the parties' post-hearing submissions.

2.

The Petitioner is a dentist in private practice in Clarkston, Georgia. She is enrolled as a provider in the Department's Dental Services Program, through which the Department pays for dental services furnished to recipients of Medicaid and PeachCare for Kids. As a condition of her participation, the Petitioner has agreed to abide by the requirements of the Department's applicable policy and procedure manuals, including Part I, Policies and Procedures for Medicaid/PeachCare for Kids ("Provider Manual") and Part II, Policies and Procedures for Dental Services ("Dental Services Manual"). (Testimony of Ms. Kight and Petitioner; Exhibits R-1, R-2, R-3, R-7, R-8.)

3.

As a participating provider, the Petitioner is required to "[m]aintain such written records for Medicaid/PeachCare for Kids members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services . . . ." (Exhibit R-1 at § 106(R).)

4.

Participating providers are subject to periodic utilization review audits carried out by the Department. An audit may serve multiple purposes, including a determination of whether:

(A) Services rendered were reasonable, appropriate, and medically necessary.

(B) Providers comply with Federal and Georgia law, and all Departmental policies and procedures.

(C) Documentation adequately supports the services billed and correct payment is reimbursed for services rendered.

(D) The quality of services meets professionally recognized standards of health care.

(E) Services and items provided were compatible with the provision of appropriate medical care and the services were effectively provided at the most economical level of care available.

(F) The coding of diagnoses, procedures, and revenue codes are correct and in compliance with correct coding initiatives and mandates.

(G) Correction measures or policy modifications should be recommended based on data or information obtained during the review process.

(Testimony of Ms. Kight; Exhibit R-1 at § 402.2.)

5.

The Department is authorized, pursuant to the Provider Manual, to recoup amounts identified as overpayments following a utilization review audit. The Department is further authorized to calculate the amount of an overpayment through the use of extrapolation techniques based on statistically valid sampling methodology. (Testimony of Ms. Kight and Ed Kemp; Exhibit R-1 at § 402.)

B. Audit of the Petitioner

6.

In November 2010, representatives of the Georgia Department of Audits and Accounts ("auditors"),[2] audited claims submitted by the Petitioner during the period January 1, 2008, through December 31, 2009. In particular, the auditors sought to determine: (1) whether the Petitioner provided the services for which she was paid, as evidenced by documentation in her patients' medical records; (2) whether the Petitioner provided services in accordance with the Department's policies;[3] and (3) whether the Petitioner received an overpayment or underpayment

[2] The Department contracted with the auditors to perform the audit. (Testimony of Ms. Kight and Mr. Kemp.)

[3] To make this determination, the auditors relied, in part, on information received from the Department's dentist peer reviewers. (Testimony of Ms. Kight and Mr. Kemp; Exhibit R-9.)

from the Department. On June 1, 2012, after compiling and analyzing the data collected during the audit, the auditors issued their report. (Testimony of Ms. Kight and Mr. Kemp; Exhibit R-8.)

7.

The auditors' report identified four deficiencies in the Petitioner's records. Based on these deficiencies, and using statistical extrapolation, the report recommended a total recoupment of $20,514.00 from the Petitioner. Thereafter, on July 13, 2012, the Department issued a notice of proposed adverse action to the Petitioner. The notice of proposed adverse action included a copy of the audit report and requested that the Petitioner refund $20,514.00 to the Department. (Testimony of Ms. Kight and Gregory Jones; Exhibits R-6, R-8.)

8.

On August 6, 2012, after receiving the notice of proposed adverse action, the Petitioner requested an administrative review of a portion of the audit's findings. Specifically, the Petitioner questioned the audit's extrapolation techniques and requested review of its findings regarding eleven of the patient encounters[4] that had been audited. By limiting her request for administrative review to the audit's extrapolation methodology and its findings regarding these eleven patient encounters, the Petitioner waived her right to challenge other aspects of the audit.[5] (Testimony of Ms. Kight; Exhibits R-1 at § 402.6, R-5, R-6.)

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[4] A patient encounter consists of all claims paid by the Department for a particular patient on a particular date of service. For example, if the Petitioner performed two procedures for the same patient on the same day, thereby generating two claims, it was considered one patient encounter. (Testimony of Mr. Kemp; Exhibit R-8.)

[5] Although the Petitioner attempted to raise other issues at the evidentiary hearing, she was not authorized to do so. The Department's notice of proposed adverse action specifically informed the Petitioner that her "request must include all grounds for Administrative Review and must be accompanied by all supporting documentation and explanation that the provider wishes the Department to consider." This is consistent with the Provider Manual. The Court's review is limited to the issues specifically identified by the Petitioner, even where, as here, the Department presented evidence regarding its review of the audit's findings involving patients that were not identified by the Petitioner. It appears from the record that the Department obtained a second peer review of all the claims that its first peer reviewer had identified as improper. However, this was not required. (Exhibits R-1 at § 402.6, R-6.)

9.

After evaluating the Petitioner's request for administrative review, the Department's auditors revised their determinations regarding some of the individual claims that were part of the audit sample. Thereafter, by letter dated February 13, 2013, the Department notified the Petitioner that the recoupment amount sought had been reduced to $18,792.00. The Petitioner timely appealed. (Testimony of Ms. Kight, Dr. Jones, and Kerrie Fields; Exhibits R-4, R-9.)

10.

The following four issues remained for determination at the evidentiary hearing: first, whether the auditors used extrapolation techniques based on statistically valid sampling methodology; second, whether the Petitioner provided treatment to the patients identified in patient encounters 35, 36, 38, 44, 47, 55, 64, 66, and 77 that was medically necessary and met the standards of acceptable dental practice; third, whether the Petitioner provided appropriate radiographic documentation of the medical necessity of the services she provided to the patient identified in patient encounter 48; and fourth, whether the Petitioner was authorized to bill the Department for behavior management of the patient identified in patient encounter 52.

1. Sampling Methodology

11.

The Department's auditors began the audit by gathering and confirming claims data regarding the 960 patient encounters that occurred during the audit period. The claims data was then provided to an independent consulting statistician, Joseph Katz, who developed the sampling plan used in the audit. Dr. Katz's sampling plan was later reviewed and approved by

another independent consulting statistician, Gregory Jones.[6] The sampling plan was governed by generally accepted scientific principles. (Testimony of Mr. Kemp and Gregory Jones; Exhibit R-8.)

12.

The sampling plan provided for the selection of a stratified random sample of 80 of the 960 patient encounters in the audit population. The first stratum consisted of 30 randomly sampled patient encounters in the payment range of $71.40-$249.99. The second stratum consisted of 50 randomly sampled patient encounters in the payment range of $250.00-$500.00. In the audit population, 535 patient encounters fell into the first stratum, while 425 patient encounters fell into the second stratum. The sampling plan established two strata to ensure that the samples would not be clustered at either end of the payment curve, thereby ensuring low variance and high precision. After the auditors drew the stratified random sample, Dr. Katz verified that the sampling plan had been executed correctly. Dr. Jones later reviewed Dr. Katz's assessment and confirmed that the sampling plan was statistically sound.[7] (Testimony of Dr. Jones; Exhibit R-8.)

[6] Dr. Jones is a professor of statistics at Georgia State University, and he is an expert in the field. His testimony was credible, reliable, and unrebutted. (Testimony of Dr. Jones.)

[7] The Petitioner argued that the sampling plan incorrectly drew more samples from the second stratum than the first. However, Dr. Jones explained that the number of samples was allocated based on the dollar value of patient encounters within each stratum. In the Petitioner's case, since approximately 61% of the $261,974.04 paid on claims during the audit period was for patient encounters with dollar values between $250.00 and $500.00, a corresponding proportion of samples was drawn from the second stratum. Further, drawing more samples from the second stratum decreased the level of variance in the payment amounts, which would otherwise have been greater in the second stratum. The Petitioner also argued that the sampling plan was defective because certain billing codes could be found in both strata. However, because the strata were divided based on patient encounters rather than individual procedures, this argument carries no weight. (Testimony of Dr. Jones; Exhibit R-8.)

13.

During the audit, the auditors reviewed each sample item to determine whether the Petitioner had received an overpayment (or underpayment), and if so, the amount of the overpayment (or underpayment). When the audit was complete, Dr. Katz used the data gathered from the audit sample to project that an overpayment of $20,677.53 had occurred during the audit period. During the administrative review process, Dr. Jones reconstructed and verified Dr. Katz's original projections.[8] Dr. Jones also revised the original projections based on changes to the sample data that were made at that time,[9] resulting in a reduction of the recoupment amount. (Testimony of Dr. Jones; Exhibit R-8.)

14.

After accounting for changes made during the administrative review, Dr. Jones used extrapolation techniques based on a statistically valid sampling methodology to calculate, with 95% certainty, that the Petitioner received an overpayment of at least $18,792.00 during the audit period. This means that while there is a 5% likelihood that the Petitioner received an overpayment of less than $18,792.00, there is a 95% likelihood that she received an overpayment greater than this amount. (Testimony of Dr. Jones; Exhibit R-8.)

15.

The audit results cannot be guaranteed with 100% certainty absent an audit of all 960 patient encounters during the audit period. However, the Department is not required to conduct a

[8] Dr. Katz and Dr. Jones used different statistical computer programs to calculate their projections. However, both programs applied generally accepted scientific principles, and their results were identical. (Testimony of Dr. Jones.)

[9] The Department obtained a second peer review during the administrative review process. In several instances where the second peer reviewer allowed claims that had been disallowed by the first peer reviewer, the Department reversed its previous determination that an overpayment had occurred. (Testimony of Ms. Fields.)

census.[10] Moreover, the Department's methodology likely inured to the Petitioner's benefit, as the probability that the Petitioner owes more than the Department seeks to recoup far exceeds the probability that she owes less than the proposed recoupment. (Testimony of Dr. Jones; Exhibits R-1 at § 402, R-8.)

2. Inadequate Treatment

16.

Participating providers are authorized to submit claims "for only those covered services that are medically necessary and within accepted professional standards of practice." A licensed dentist has a duty to diagnose dental problems in patients and provide treatment sufficient to correct the problems. Undertreatment of a patient's condition violates the standards of the profession regarding medical necessity and quality of care. (Testimony of Demetrios Arfanakis; Exhibit R-1 at § 106(K).)

17.

The Petitioner billed the Department for treatment that was inadequate to correct the dental problems of the patients identified in patient encounters 35, 36, 38, 44, 47, 55, 64, 66, and 77 of the audit sample, as follows:

(a) Patient encounter 35 (N.S.,[11] age 3): occlusal[12] restorations of teeth J, K, and L. (Exhibits R-9 at 1-3, R-10, R-11, R-12, R-13.)

(b) Patient encounter 36 (H.P., age 5): mesial, distal, and lingual restoration of tooth F; mesial, facial, and lingual restoration of tooth G; and occlusal restoration of tooth K. (Exhibits R-9 at 4-6, R-14, R-15, R-16, R-17, R-18, R-19.)

[10] The Department is authorized to use extrapolation to determine the amount of an overpayment where, as here, there is "a determination of sustained or high level of payment error" regarding a particular provider. However, a participating provider may challenge the Department's audit findings by performing his or her own census. (Testimony of Ms. Kight and Mr. Kemp; Exhibits P-21 at 4-5, R-1 at § 402.)

[11] To protect their privacy, patients are referred to herein by their initials.

[12] Each tooth has five surfaces: occlusal, mesial, distal, buccal, and lingual. (Testimony of Dr. Arfanakis.)

(c) Patient encounter 38 (W.A., age 18): occlusal restoration of tooth 19. (Exhibits R-9 at 7, R-20, R-21, R-22, R-23, R-24.)

(d) Patient encounter 44 (M.R., age 12): lingual restoration of tooth H. (Exhibits R-9 at 11-12, R-28.)

(e) Patient encounter 47 (M.W., age 16): occlusal restoration of teeth 3 and 14. (Exhibits R-9 at 13-14, R-33.)

(f) Patient encounter 55 (L.P., age 5): occlusal and lingual restoration of tooth A. (Exhibits R-9 at 17-18, R-45, R-46, R-47, R-48.)

(g) Patient encounter 64 (S.L., age 4): occlusal restoration of tooth T. (Exhibits R-9 at 22, R-65, R-66, R-67, R-68, R-69, R-70, R-71.)

(h) Patient encounter 66 (H.K., age 10): occlusal restoration of teeth A and T. (Exhibits R-9 at 23-24, R-73, R-74, R-75.)

(i) Patient encounter 77 (S.A., age 4): occlusal and buccal restoration of tooth T. (Exhibits R-9 at 33-34, R-95, R-87.)

In each of the instances listed above, the Petitioner failed to restore all affected surfaces of the tooth in question and/or failed to recognize that decay had infiltrated the pulp chamber of the tooth. When a tooth is pulpally involved, a filling does not provide adequate treatment because it cannot halt the decay process. Instead, a dentist has the option of either extracting the tooth or performing a pulpotomy, which must be followed by a crown. (Testimony of Dr. Arfanakis.)

18.

The Petitioner testified that she placed pulp caps in all instances where tooth decay had extended to (but not inside) the pulp chamber of a tooth.[13] However, the Petitioner's testimony in this regard lacks credibility because she did not document the procedure in her records for any

[13] Dr. Arfanakis agreed that this procedure could have been appropriate for some of the patients at issue, depending on their clinical presentation. However, in keeping with the standards of her profession, the Petitioner was required to document the placement of a pulp cap in her patients' records. This is true whether or not she intended to bill the Department for the pulp cap. (Testimony of Dr. Arfanakis.)

of the patients at issue. (Testimony of Dr. Arfanakis; Exhibits R-11, R-15, R-21, R-28, R-33, R-47, R-67, R-73, R-87.)

19.

The Petitioner further testified that her definition of the occlusal surface was more expansive than the Department's definition, which gave the appearance that her restorations were inadequate. More specifically, the Petitioner defined the occlusal surface to include, in addition to the chewing surface, the uppermost portions of the mesial, distal, buccal, and lingual surfaces. However, the Court declines to credit this testimony because the Petitioner's definition of the occlusal surface is inconsistent with the standards of her profession. (Testimony of Petitioner and Dr. Arfanakis.)

20.

Finally, the Petitioner argued that pulpotomy is an overly aggressive and costly treatment for a child's deciduous tooth, inasmuch as the deciduous tooth will eventually be replaced by a permanent tooth.[14] However, deciduous teeth are important to a child's oral and systemic health, and it is difficult to predict with accuracy when a particular tooth will be lost. Therefore, the standards of the profession require dentists to treat deciduous teeth as well as permanent teeth.[15] The Department does not distinguish between deciduous and permanent teeth when it decides whether or not to accept claims for payment. (Testimony of Petitioner and Dr. Arfanakis; Exhibit R-2 at § 902.5, R-3 at § 902.5.)

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[14] Deciduous teeth, commonly known as "baby teeth," are identified by letter, while permanent teeth are identified by number. (Testimony of Dr. Arfanakis.)

[15] Under certain circumstances, the imminent eruption of a permanent tooth may warrant the undertreatment of a deciduous tooth. The Petitioner, however, presented no evidence that such circumstances existed, and, in any event, she failed to ensure that her patient records contained proper documentation. (Testimony of Petitioner and Dr. Arfanakis.)

3. Radiographic Documentation

21.

Participating providers are required to maintain radiographs of diagnostic quality, meaning that they must be "clearly readable[] and free from defect." Additionally, "[t]he density and clarity must be such that interpretation can be made without difficulty by use of a conventional view box." (Exhibit R-2 at § 902.1, R-3 at § 902.1.)

22.

For patient encounter 48 in the audit sample (B.M., age 17), the Petitioner submitted two claims to the Department that were not supported by appropriate radiographic documentation of medical necessity. More specifically, the Petitioner billed the Department for a mesial, distal and lingual restoration of tooth 8 and a mesial, facial, and lingual restoration of tooth 10. However, the radiographs she provided in conjunction with the audit were not of diagnostic quality. In fact, they are so dark as to appear almost completely black. (Testimony of Dr. Arfanakis; Exhibits R-2 at § 902.1, R-3 at § 902.1, R-9 at 15-16, R-41, R-42.)

23.

The Petitioner argued that the radiographs in question were difficult for the Department's peer reviewers to read because they were copies rather than originals. This testimony by the Petitioner was not credible, given that the peer reviewers had no difficulty with the other radiographs they reviewed during the audit. Further, the Petitioner had the opportunity to provide the originals to the Department during the peer review process and/or to offer them as evidence at the hearing. She did not do so. (Testimony of Petitioner, Ms. Kight, and Dr. Arfanakis.)

4. Behavior Management

24.

It is undisputed that the Petitioner billed the Department for the behavior management of the patient identified in patient encounter 52 of the audit sample. It is further undisputed that this patient, D.M., was four years and three days old at the time of the encounter. Participating providers are not authorized submit claims for the behavior management of patients who exceed age three – regardless of their behavior – absent documentation of a disability. (Testimony of Petitioner and Ms. Fields; Exhibits R-2 at § 902.9(e), R-3 at § 902.9(e), R-96.)

III. CONCLUSIONS OF LAW

1.

The Department bears the burden of proof in this matter. Ga. Comp. R. & Regs. r. 616-1-2-.07(1). The standard of proof is a preponderance of the evidence. Ga. Comp. R. & Regs. r. 616-1-2-.21(4).

2.

The Georgia Medical Assistance Act of 1977 (O.C.G.A. §§ 49-4-141 et seq.) affords a provider participating in the state Medicaid program the opportunity to request an administrative hearing in order to appeal a determination by the Department regarding the amount of Medicaid reimbursement due to the provider. O.C.G.A. § 49-4-153(b)(2). The administrative hearing is *de novo*, and this Court must make an independent determination on the basis of the evidence presented at the hearing. Ga. Comp. R. & Regs. r. 616-1-2-.21(1), (3). See also Longleaf Energy Assocs., LLC v. Friends of the Chattahoochee, Inc., 298 Ga. App. 753, 769 (2009) (administrative law judge may not accord deference or presumption of correctness to the decision of the agency).

3.

The relationship between the Petitioner and the Department is a contractual one. See Pruitt Corp. v. Dept. of Commty. Health, 284 Ga. 158, 160 (2008). The Petitioner, as a participating provider in the Medicaid and PeachCare for Kids programs, is required to abide by the Department's Manual. "Providers of services are not required to participate in a state's Medicaid program, but if they do choose to participate, they must agree to accept payment in accordance with the state plan provisions." Briarcliff Haven, Inc. v. Dept of Human Resources, 403 F. Supp. 1355, 1362-63 (N.D. Ga. 1975). Given the plain language of the contract between the parties, the contract must be enforced according to its terms. See O.C.G.A. § 13-2-3; Budd Land Co. v. K & R Realty Co., 159 Ga. App. 448, 449 (1981), citing Lee v. Lee, 191 Ga. 728 (1941).

4.

The Department proved, by a preponderance of the evidence and as detailed in the Findings of Fact, above, that its auditors used extrapolation techniques based on statistically valid sampling methodology to determine the amount of the Petitioner's overpayment.[16] The Department's action conformed to the requirements of its contract with the Petitioner and Provider Manual § 402 (Exhibit R-1).

5.

The Department proved, by a preponderance of the evidence, that the Petitioner undertreated the patients identified in patient encounters 35, 36, 38, 44, 47, 55, 64, 66, and 77, as

[16] The Petitioner argues that the Department's determination of a "sustained or high level of payment error" regarding her submitted claims was improper, and the Department was therefore not authorized to seek recoupment based on extrapolation. However, this determination by the Department is not subject to administrative or judicial review. Pub. 100-08, Medicare Program Integrity, Centers for Medicare and Medicaid Services, at 3.10.1.2 (Exhibit P-21).

detailed in the Findings of Fact, above. The Petitioner's undertreatment of these patients was not medically necessary and failed to conform to the accepted standards of professional practice, in violation of her contract and Provider Manual § 106(K) (Exhibit R-1).

6.

The Department proved, by a preponderance of the evidence and as detailed in the Findings of Fact, above, that the Petitioner failed to provide the Department with diagnostic radiographs of the patient identified in patient encounter 48, in violation of her contract and Dental Services Manual § 902.1 (Exhibits R-2, R-3).

7.

The Department proved, by a preponderance of the evidence and as detailed in the Findings of Fact, above, that the Petitioner billed the Department without authorization for the behavior management of the patient identified in patient encounter 52, in violation of her contract and Dental Services Manual § 902.9(e) (Exhibits R-2, R-3).

8.

The Court concludes that the Department properly exercised its right to recoupment under the terms of its contract with the Petitioner. Therefore, the Department is authorized to recoup the full amount of $18,792.00.

IV. DECISION

In accordance with the foregoing Findings of Fact and Conclusions of Law, the Department's decision to recoup $18,792.00 previously paid to the Petitioner under the Medicaid and PeachCare for Kids programs is hereby **AFFIRMED**.

SO ORDERED, this 31st **day of July, 2013.**

KRISTIN L. MILLER
Administrative Law Judge