BEFORE THE OFFICE OF STATE ADMINISTRATIVE HEARINGS
STATE OF GEORGIA

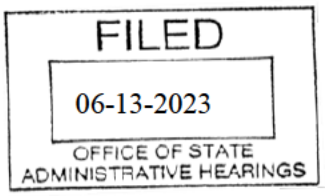
DR. ROGER SCOTT, O.D.,
Petitioner,

v.

DEPARTMENT OF COMMUNITY HEALTH,
Respondent.

Docket No.: 2221792
2221792-OSAH-DCH-PROP-110-Teate

Agency Reference No. OIG1500713



INITIAL DECISION

I. Introduction

Petitioner, Roger Scott, O.D., appeals the Department of Community Health's decision to recoup $15,371.00 in payments made to him under the Georgia Medicaid program. An evidentiary hearing was held via video conference on April 24, 2023. Petitioner represented himself. Kevin Spainhour. Esq. represented Respondent. The hearing record remained open until May 19, 2023 to allow the parties to submit post-hearing submissions. After careful consideration of all the evidence of record in this case, and based upon a preponderance of evidence, the Court **AFFIRMS** Respondent's recoupment of $15,371.00.

II. Findings of Fact

1. Petitioner is an optometrist. During the relevant period, he was an approved Medicaid provider.

2. Respondent has contracted with Alliant Health Solutions ("Alliant") to conduct audits of Medicaid providers.

3. Alliant conducted an audit of Petitioner in 2019. During this audit, it collected medical records concerning 40 Medicaid recipients from Petitioner.[1] These records covered service dates

[1] For confidentiality, the 40 patients reviewed are identified as Patient 1 through 40, respectively. This numeration

from January 1, 2017 through December 31, 2018. (Respondent's Exhibits 1-3; Testimony of Dr. Gottlieb).

4. Alliant retained the services of Dr. Sidney Gottlieb, an optometrist, to conduct a peer review of the medical records maintained by Petitioner and the corresponding claims for Medicaid reimbursement. (Respondent's Exhibits 1-3; Testimony of Dr. Gottlieb).

5. Dr. Gottlieb obtained his Doctor of Optometry degree from the Pennsylvania School of Optometry (now Salus University). He was licensed in 1985 and has continuously practiced optometry since that time. He also provides services as a peer reviewer. During his testimony, he estimated that he has performed between seven (7) and twenty (20) peer reviews. He was qualified as an expert in optometry and audit reviews. (Testimony of Dr. Gottlieb).

6. During his review, Dr. Gottlieb identified deficiencies in Dr. Scott's medical records. He determined that, in most instances, the records did not support medical necessity for the services provided or the procedure code billed. Some of the claims lacked documentation of referral for services by the patient's attending physician, or even lacked documentation entirely. (Respondent's Exhibits 1, 3; Testimony of Dr. Gottlieb).

7. In his testimony, Dr. Gottlieb explained that, for most of the claims reviewed, the frequency with which Petitioner saw each patient was not justified by the documentation. Based on each patient's history and the findings documented in their records, they should have been seen, at most, every six months. But Petitioner provided services to the patients approximately every two months. This frequency of care would only be justified if the patients had a new complaint or a deteriorating condition. If a patient had such a condition, it would be documented in his or her medical record.

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corresponds to the findings tables Respondent provided to Petitioner, as well as the demonstrative exhibit utilized by Dr. Gottlieb during his testimony.

However, of the patients reviewed, only one—who had undergone cataract surgery—had a condition that would justify this frequency of care. (Testimony of Dr. Gottlieb).

8. Dr. Gottlieb identified additional deficiencies in the medical records maintained by Petitioner. He noted that many of the records appeared to be "copy-pasted"; almost all of the records contained the terms "blurr, [sic] fatigue, and reduced use." According to the records, each patients' intraocular pressure was consistently between 13 and 16 millimeters. Dr. Gottlieb testified that such invariability is unusual; on a given day, he obtains measurements between 9 and 25 millimeters for his patients. A majority of the charts mentioned "optic nerve head abnormality" without describing what the abnormality was. (Testimony of Dr. Gottlieb).

9. Dr. Gottlieb also noted departures from the standard of care. He determined that, in one instance, Petitioner misdiagnosed esotropia as exotropia. Dr. Scott also used a Schiotz tonometer, an antiquated and unreliable instrument used for measuring eye pressure. Photographs of the patient's eyes were also of poor quality, and inadequate to serve as a baseline. Petitioner also used a Welch Allyn panoptic device to look at patients' retinas. According to Dr. Gottlieb, such a device is inadequate for viewing the peripheral part of the retina, especially without dilating the patients' eyes. However, despite use of this device, and without indicating that the patients' eyes were dilated, Petitioner often indicated the peripheral retina was "negative," meaning that it was normal. (Testimony of Dr. Gottlieb).

10. Based on the results of Dr Gottlieb's review, Respondent determined that Petitioner had received an overpayment of Medicaid reimbursements in the amount of $19,122.51. On July 30, 2021, Respondent notified Petitioner of the initial findings and of its intent to recoup the overpayment amount. Respondent subsequently revised the recoupment amount downward to $15,371.00, as provided in a notice dated February 16, 2022. (Respondent's Exhibits 1-3;

Petitioner's Exhibit 1).

11. Based on a review of the exhibits, Respondent's calculation of the overpayment amount may be summarized as follows:

	Claims	Amount Paid	Amount Allowed	Overpayment
Patient 1	10	$ 553.44	$ 56.90	$ 496.54
Patient 2	7	$ 421.11	$ 52.76	$ 368.35
Patient 3	3	$ 107.52	$ 56.76	$ 50.76
Patient 4	4	$ 122.41	$ 54.28	$ 68.13
Patient 5	3	$ 4.70	$ -	$ 4.70
Patient 6	5	$ 349.75	$ 83.38	$ 266.37
Patient 7	13	$ 705.12	$ 113.80	$ 591.32
Patient 8	1	$ 64.60	$ 64.60	$ -
Patient 9	3	$ 8.29	$ 7.69	$ 0.60
Patient 10	3	$ 233.88	$ 54.93	$ 178.95
Patient 11	17	$ 854.78	$ 199.15	$ 655.63
Patient 12	17	$ 964.76	$ 140.28	$ 824.48
Patient 13	9	$ 577.14	$ 230.00	$ 347.14
Patient 14	12	$ 701.06	$ 140.28	$ 560.78
Patient 15	3	$ 12.39	$ -	$ 12.39
Patient 16	11	$ 643.26	$ 111.83	$ 531.43
Patient 17	6	$ 175.44	$ 56.90	$ 118.54
Patient 18	16	$ 805.17	$ 197.30	$ 607.87
Patient 19	9	$ 598.24	$ 186.67	$ 411.57
Patient 20	7	$ 452.02	$ 101.32	$ 350.70
Patient 21	1	$ 8.51	$ -	$ 8.51
Patient 22	9	$ 550.94	$ 101.32	$ 449.62
Patient 23	6	$ 402.86	$ -	$ 402.86
Patient 24	16	$ 827.64	$ 166.56	$ 661.08
Patient 25	8	$ 393.51	$ 85.35	$ 308.16
Patient 26	14	$ 713.15	$ 85.35	$ 627.80
Patient 27	7	$ 458.62	$ 101.32	$ 357.30
Patient 28	17	$ 1,012.06	$ 138.11	$ 873.95
Patient 29	14	$ 724.58	$ 113.80	$ 610.78
Patient 30	14	$ 739.37	$ 113.80	$ 625.57
Patient 31	16	$ 823.20	$ 113.80	$ 709.40
Patient 32	17	$ 948.21	$ 158.22	$ 789.99
Patient 33	5	$ 331.68	$ -	$ 331.68
Patient 34	13	$ 669.46	$ 190.87	$ 478.59
Patient 35	7	$ 8.54	$ 0.85	$ 7.69
Patient 36	4	$ 247.33	$ 66.37	$ 180.96

Patient 37	9	$ 534.48	$ 132.47	$ 402.01
Patient 38	15	$ 778.33	$ 85.35	$ 692.98
Patient 39	7	$ 458.62	$ 56.90	$ 401.72
Patient 40	1	$ 4.10	$ -	$ 4.10
Total	**359**	**$ 18,990.27**	**$ 3,619.27**	**$ 15,371.00**

(Respondent's Exhibits 1, 3).

12. Petitioner disputed the findings of the peer review, as well as the Respondent's proposed recoupment. He testified that many of the patients were referred to him by interim medicine or family doctors, who requested that the patients be seen more frequently due to their conditions. He further testified that it was impracticable to administer certain tests to some of the patients due to their weight or medical conditions, so it was necessary to see them more frequently. According to Petitioner, when a patient has a certain ocular disease, the frequency with which he or she is provided care is left to the provider's discretion. (Testimony of Dr. Scott).

13. Regarding the lack of documentation, specifically the lack of indication that patients' eyes were dilated, Petitioner testified that he handwrites charts, and invariably notes that each patient's eyes have been dilated. (Testimony of Dr. Scott).

14. Regarding the photographs of patients, Petitioner testified that the quality of Respondent's copies was greatly diminished from the originals. According to Petitioner, the originals were clear and sufficient to serve as a baseline for each patient. (Testimony of Dr. Scott).

15. Petitioner testified that he used the Schiotz tonometer because many of the patients had behavioral issues, and would not sit still long enough to employ more up-to-date instruments. Although he acknowledged that the Schiotz tonometer was old, he averred that it at least gave some means of documenting intraocular pressure. (Testimony of Dr. Scott).

16. Dr. Scott did not tender himself as an expert witness, and his testimony was not corroborated with documentation.

III. Conclusions of Law

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

2. Medicaid is a joint federal-state program that provides comprehensive medical care for certain classes of eligible recipients whose income and resources are determined to be insufficient to meet the costs of necessary medical care and services. 42 U.S.C. § 1396 et seq.; Moore v. Reese, 637 F.3d 1220, 1232 (11th Cir. 2011). Participation is voluntary, "but once a state opts to participate it must comply with federal statutory and regulatory requirements." Moore, 637 F.3d at 1232. All states have opted to participate and, thus, each must designate a single state agency to administer its Medicaid plan. Id.; 42 C.F.R § 431.10(a), (b)(1). Georgia has designated Respondent as the "single state agency for the administration" of Medicaid. O.C.G.A. §§ 49-2-11(f), 49-4-142.

3. As the agency responsible for administering Medicaid in Georgia, Respondent must

> provide for procedures of . . . postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program[.]

42 U.S.C. § 1396a(a)(37); see also 42 C.F.R. § 447.45. If it discovers an overpayment in accordance with its policies and procedures, Respondent must take reasonable action to attempt to recover the overpayment in accordance with State law and procedures. 42 C.F.R. § 433.316(b).

4. The Georgia Medical Assistance Act of 1977 authorizes Respondent to publish terms and conditions governing Medicaid claims for each category of services authorized under the State Medicaid Plan. See O.C.G.A. § 49-4-142(a) ("The [Respondent] is authorized to establish the amount, duration, scope, and terms and conditions of eligibility for and receipt of such medical assistance as it may elect to authorize pursuant to this article. . . ."). Respondent has published

"Part I Policies and Procedures for Medicaid/Peachcare for Kids," which contains guidance for Medicaid services and claims. Dep't of Community Health, Part I Policies and Procedures for Medicaid/Peachcare for Kids [hereinafter Medicaid Manual].

5. Pursuant to the Manual, providers must submit claims "for only those covered services that are medically necessary and within accepted professional standards of practice. Medicaid Manual § 106(K). Providers must "[m]aintain such written records for Medicaid[] members as necessary to disclose fully the extent of services provided and the medical necessity for the provision of such services . . . ." Id. § 106(R). Respondent is authorized to recoup payments previously made to a provider if "the services provided have been determined to be medically unnecessary, of substandard quality[,] or not in keeping with currently accepted standards of medical practice or applicable law," or if the provider fails "to maintain the proper documentation required pursuant to [the Manual] or currently accepted standards of medical practice." Id. § 407.

6. In the present case, Respondent conducted a review of payments made to Petitioner, as it was required to do pursuant to the Medicaid Act and implementing regulations. 42 U.S.C. § 1396a(a)(37); see also 42 C.F.R. § 447.45. In conducting this review, Respondent enlisted the expertise of Dr. Gottlieb, an optometrist. See Medicaid Manual § 402.4. Dr. Gottlieb identified hundreds of instances in which the services for which Petitioner obtained reimbursement were medically unnecessary or unsupported by documentation. Dr. Gottlieb affirmed and explained his findings in his testimony at the evidentiary hearing. The Court finds his testimony to be credible and persuasive.

7. Petitioner was notified of the findings of Respondent's review and given an opportunity to respond. However, he has not refuted the findings of Dr. Gottlieb's review, nor justified reduction of the overpayment amount from $15,371.00. Petitioner's testimony, even if considered to be that

of an expert, fell short of establishing that the services underlying the claims at issue were medically necessary, especially in the absence of corroborating documentation. Petitioner did not, for instance, tender evidence of a patient's worsening condition, such as would justify the increased frequency of visits. Petitioner averred that he documented services in handwritten records, but produced no records to that effect. In sum, Petitioner's testimony amounted to generalized assertions unsupported by documentary evidence. Therefore, the Court concludes that Respondent proved its findings by a preponderance of the evidence.

IV. Decision

Based on the foregoing findings of fact and conclusions of law, the Respondent's finding of an overpayment in the amount of $15,371.00, as well as its decision to recoup said overpayment from Petitioner, are **AFFIRMED**.

SO ORDERED, this 13th day of June, 2023.

Steven W. Teate
Administrative Law Judge