Circuit Court for Prince George's County
Case No. CAL17-23150

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 611

September Term, 2018

IN THE MATTER OF THE PETITION
OF SAMPSON SARPONG, M.D.

Berger,
Leahy,
Wilner, Alan M. (Senior Judge, Specially Assigned)

JJ.

Opinion by Wilner, J.

Filed: January 13, 2020

Appellant is a physician. Upon a complaint, an investigation, an evidentiary hearing before an Office of Administrative Hearings (OAH) Administrative Law Judge (ALJ), exceptions to the ALJ's proposed decision, and a hearing on those exceptions, the Maryland Board of Physicians (Board) revoked appellant's license to practice medicine in Maryland. That sanction was based on findings by the Board that appellant had engaged in unprofessional conduct in the practice of medicine by (1) billing for services not provided, (2) performing tests on patients that were unnecessary and unindicated, (3) improper upcoding for billing purposes, (4) failure to meet the applicable standards of care, and (5) failure to keep adequate records.

In this action for judicial review, the Circuit Court for Prince George's County affirmed the Board's decision. Appellant complains in this appeal that the Board applied an incorrect legal standard in judging the charges against him, that there was legally insufficient evidence to sustain the charges, and that the sanction of revocation was arbitrary and capricious. We find no legal error or abuse of discretion and therefore shall affirm the judgment of the Circuit Court.

BACKGROUND

Appellant was first licensed to practice medicine in Maryland in 1989. He also practiced in the District of Columbia. Although his only area-of-practice certification is in pediatrics, he specializes in the field of allergy and immunology.

What burgeoned into this case began on September 15, 2014, when the Board received a complaint from a former patient of appellant (henceforth referred to as Patient 10) that appellant was late for an initial appointment and failed to appear for two follow-up appointments, and that the pin prick test he conducted and seven allergy skin patches he applied at the first appointment and for which he billed both Blue Cross and a Johns Hopkins entity were not necessary.

Procedure for Processing Complaints

The procedure for dealing with complaints against physicians is set forth in Md. Code, §§ 14-401.1 and 14-405 of the Health Occupations Article (HO) and § 10.32.02.03 of the Code of Maryland Regulations (COMAR). The complaint is initially referred to a compliance analyst for a preliminary investigation. It is then referred to a disciplinary panel or the Board itself, which reviews the complaint in light of the preliminary investigation.

The disciplinary panel or Board may direct a further investigation, refer the matter for peer review, enter a consent order, or close the matter. If the physician desires a hearing, one will be held before an ALJ, after which the ALJ will refer proposed factual findings to a disciplinary panel or the Board for disposition. The Administrative Prosecutor or the physician may file exceptions to the proposed findings, in which event the Board must hold a hearing on the exceptions. *See* COMAR 10.32.02.04C. Any person aggrieved by a final decision of a disciplinary panel or the

Board may seek judicial review pursuant to the State Administrative Procedure Act. HO § 14-408.

Procedural History In This Case

The compliance analyst testified that, because the complaint by Patient 10 raised issues as to the standard quality of care, the Board ordered a full investigation, beyond what allegedly happened just to Patient 10. That led the compliance analyst to contact insurers to which appellant submitted claims for payment, to get a list of appellant's patients, from which, on a random basis, billing practices involving those patients could be reviewed. On February 6, 2015, the compliance analyst, on behalf of the Board, issued a subpoena to appellant directing him to produce, within 10 days, "a **COMPLETE** copy of any and all medical records and billing records" for 10 patients randomly selected by the compliance analyst from insurance company records.[1]

On March 9, the Board received records for eight of those patients. With the records were certificates by appellant for each of the eight patients attesting, under penalty of perjury, that he had personally reviewed the entire medical record of the respective patients and that he provided the Board with "the **COMPLETE MEDICAL**

[1] Unless otherwise indicated, all bolded language in quoted passages is as it appears in the original.

RECORDS" of those patients in his possession or control. That turned out not to be true.

On July 13, 2015, the Board, through its compliance analyst, issued a second subpoena for the records of the other two patients (9 and 10). With the subpoena, the Board enclosed a copy of Patient 10's complaint and requested a response to that complaint. The subpoenaed records were to be produced by July 23.

In a face-to-face interview with the compliance analyst on July 23, appellant acknowledged that he had failed to produce the complete medical records requested in March, which led to a demand the next day that the full records be submitted by July 27. On July 27, appellant submitted a new certificate, under the penalty of perjury, that he provided the Board with "the **COMPLETE MEDICAL RECORDS**" requested. Between July 27 and July 30, appellant submitted additional records of Patients 1 through 8 and an initial set of records for Patients 9 and 10, along with written summaries of his treatment of the 10 patients.

In accordance with HO § 14-401(e), the Board had contracted with a company called Permedion to supply peer review specialists. The compliance analyst had been sending the records she received – and ultimately her entire investigative file – to Permedion. Two peer reviewers were eventually selected – Dr. Alpa Jani and Dr. Jeremy Drelich, each of whom separately reviewed the material regarding the 10 patients in the context of a Standard of Quality Care Peer Review Form prepared by the Board. Their

Reports were filed with the Board on February 29, 2016. Both peer reviewers concluded that appellant had engaged in unprofessional conduct, grossly overutilized health care services, violated the standard of care, and kept inadequate medical records. We shall describe their findings more specifically in the DISCUSSION portion of this Opinion.

The Reports were sent to appellant on March 1, 2016. Three weeks later, on March 22, appellant submitted a third set of documents pertaining to the 10 patients. He acknowledged later that those records did not exist when he responded to the two subpoenas but were created after he received the peer review reports.

On May 26, 2016, the Board formally charged appellant with violations of:

- HO § 14-404(a)(3): unprofessional conduct in the practice of medicine;
- HO § 14-404(a)(19): grossly overutilizes health care services;
- HO § 14-404(a)(22): fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical and surgical care performed in an outpatient surgical facility, office, hospital, or any other location in this State; and
- HO § 14-404(a)(40): fails to keep adequate medical records as determined by appropriate peer review;

The case was then referred to OAH for a hearing. At that hearing, Drs. Jani and Drelich testified, as experts, to their review of appellant's treatment and billing practices and to their conclusions. Appellant did not testify, but he did produce a fourth set of documents pertaining to Patients 4 and 6.

On the evidence presented, the ALJ made findings mostly consistent with the opinions of the reviewers and recommended that appellant's license to practice medicine be revoked. Appellant filed exceptions to the ALJ's findings and recommendation, and a hearing before the Board was held. On August 8, 2017, the Board issued its final decision revoking the license upon findings that appellant (1) billed for services not provided, (2) performed unnecessary and unindicated testing, (3) engaged in upcoding – inappropriately billing under the highest billing level when that level of service was not actually provided, (4) violated the standard of care by his gross overutilization, and (5) failed to keep adequate records. Appellant sought judicial review of that decision, and, in a brief Order entered on April 27, 2018, the Circuit Court affirmed the Board's ruling.

DISCUSSION

Standard of Review

Where the issue on appeal is the correctness of a decision of an administrative agency, such as the Board, we stand in the shoes of the Circuit Court and evaluate the decision of the agency. In so doing, we examine the findings of fact and the conclusions of law made by the agency, and, to the extent that the agency's decision was a discretionary one, whether the agency exercised that discretion and did not abuse it.

In reviewing findings of fact, we look to see only if there is substantial evidence in the record to support those findings. We do not substitute our judgment for that of the

agency with respect to the credibility or weight of the evidence but determine only if it is legally sufficient. We review conclusions of law *de novo* and may substitute our judgment if we believe the agency erred, although the courts traditionally give some deference to an agency's interpretation of a statute or regulation it is authorized by law to administer. *See Comm'r of Labor & Ind. v. Whiting-Turner,* 462 Md. 479, 490 (2019); *Gigeous v. ECI*, 363 Md. 481, 495-97 (2001).

In applying these standards, we take note that the Board relied, to a large extent, on findings made by the ALJ which, in turn, were based largely on the expert testimony of Drs. Jani and Drelich.

Findings of Fact; Sufficiency of the Evidence

Terminology

The first two sets of findings by the Board involve five kinds of procedures – the skin prick test (SPT), patch testing (PT), spirometry (SP), radioallergosorbent test (RAST), and the Open Food Challenge (OFC). As described by the Board:

- An SPT is used to identify a person's allergic disorder. Small amounts of an allergen are loaded into pricks or needles, which are then pricked into a patient's skin. A specific allergen is placed into an individual prick, so, if 40 allergens are tested, there will be 40 pricks. After 15-20 minutes, the

physician examines the skin. A hive response is indicative of an allergic disorder.

- A PT is used to diagnose disorders in a patient who has contact dermatitis. Generally, seven to eight large patches are placed on a patient, each of which has 10 individual patch tests. Each individual patch test concerns an individual allergen. It requires three visits – one to apply the patches and two to evaluate the reaction.
- SP is a pulmonary function test to diagnose asthma and other lung conditions. The patient exhales into a machine that measures the amount of air exhaled and the velocity of the air.
- RAST is a form of blood testing for allergic disorders.
- OFC is used to substantiate an allergy to certain foods. The physician observes the patient ingesting food and checks for symptoms to determine if a food allergy exists.

Billing for Services Not Provided

HO § 14-404(a) (23) expressly permits a disciplinary panel to revoke a physician's license to practice medicine if the licensee "willfully submits false statements to collect fees for which services are not provided." The Board did not cite that provision in

concluding that appellant had engaged in "unprofessional conduct," but cited instead § 14-404(a)(3)(ii), which permits revocation for "unprofessional conduct in the practice of medicine." Whether willfully billing for services not provided constitutes unprofessional conduct is at least a quasi-legal judgment, but one that necessarily calls for the court to give considerable deference to the expertise of the Board.[2] At this point, we merely examine the evidence relied on by the Board to reach its conclusion.

The Board cited numerous examples of incidences when appellant submitted bills for services not rendered. We need not get into all of them. One was submission of a bill for $2,990 for Patient 1 for spirometry and skin prick tests administered on March 24, 2014, when appellant's records show that the patient's first visit was not until April 15. Appellant claims that there is no evidence that he submitted the bill to the Cigna insurance company but neglects to acknowledge that the patient was insured by Blue Cross, not Cigna, and he objected to the admission of Blue Cross records. Moreover, appellant failed to except to the ALJ's finding that the claim was, in fact, submitted, so the Board was entitled to rely on it.

[2] Although appellant disputes the Board's conclusion that he submitted bills for services he did not perform, his argument is either that he did not actually submit such bills or that he actually performed the service for which he billed. No claim is made that an improper submission was not willful. In its recent Opinion in *Frazier v. McCarron*, Md. (No. 4, S.T. 2019, Op. filed November 20, 2019, the Court of Appeals defined willful as knowing and intentional – deliberate with knowledge that the act or omission was unlawful. *See* also *Deibler v. State*, 365 Md. 185 (2001). There is no claim here that appellant submitted bills inadvertently or that he was unaware that submitting false claims was both unlawful and unprofessional.

Another incident involved a similar $2,990 bill submitted for services provided to Patient 6 on April 15, 2014. Appellant does not contest that he submitted that bill but claims that he actually provided the service on that date. The records submitted to the Board for Patient 6 in response to the Board's subpoena did not include any mention of a visit from Patient 6 on April 15 but instead showed that the services provided to Patient 6 began on March 24 and ended on March 31, 2014.

Evidence was presented that appellant billed $100 for spirometry procedures performed for Patients 4, 7, and 8, when there is no indication in the patient records that those procedures were performed. Evidence was presented with respect to overbilling for patch testing – that, although he performed such tests, he billed for far more patches that he actually applied.

Overutilization; Unnecessary Testing

HO § 14-404(a)(19) permits a license to be revoked if a physician "grossly overutilizes health care services." The Board found that appellant "routinely performed testing that was unnecessary, unindicated, and excessive" by performing patch testing "when there is no indication" – unnecessarily testing a full panel of allergens in skin prick testing, and testing of food allergens "when there were no complaints, symptoms, or indicators for these tests."

This was an area in which the Board relied heavily on the testimony of Drs. Jani and Drelich which, if credited, supported the finding of unnecessary testing and over-testing. Appellant's response essentially is that there was other evidence in the form of excerpts from medical texts that contradicted their conclusions. The credibility and weight of the expert testimony is not for us to determine, however. The Board had a right to rely on the expert opinions of the reviewers it had selected.

Upcoding

A similar situation exists with respect to upcoding. Relying largely on findings made by the ALJ, based on testimony by the expert reviewers, the Board concluded that, with respect to Patients Nos. 1, 2, 5, 7, and 9, "[o]n almost every patient visit, [appellant] billed under the highest billing level (CPT code 99245), which Dr. Drelich explained is meant for an 'initial consultation, and in none of the records is there a level of complexity documented in the record to bill for that level of complexity.'" The Board accepted the ALJ's determination that appellant "upcoded (billed under Code 99245 when the level of services required for that Code were not provided) for those patients" and found that conduct to constitute unprofessional conduct in the practice of medicine under HO § 14-404(a)(3)(ii).

Appellant responds that the Board should not have relied on the ALJ's finding. In dealing with the charge of upcoding, the ALJ noted that, under the American Medical

Association's Current Procedural Terminology Code, the "99245 code is the code for an office consultation for a new or established patient and requires three components, including a comprehensive history, a comprehensive examination, and medical decision making of high complexity." She observed further that "[f]or a 99245, the physician typically spends eighty minutes face-to-face with the patient and/or family" and that the 99245 code "is not appropriate for follow-up visits unless the physician again conducts a comprehensive history and exam and makes complex medical decisions."

The ALJ rejected appellant's testimony that he billed that code based on the time he spent with the patient and found it unreasonable to believe that he spent 80 minutes with every patient each time he saw them. The Board obviously accepted that credibility determination.

Appellant's response is that the AMA code does not *require* the physician to spend 80 minutes with the patient in order to use the 99245 code and that he *did* conduct comprehensive testing and make complex medical decisions during each visit. The ALJ did not believe him, and the Board was entitled to accept the ALJ's finding which, as noted, was supported by Dr. Drelich's testimony that no comprehensive testing was revealed in appellant's records of follow-up visits.

Failure To Keep Adequate Medical Records

Appellant has not challenged the Board's conclusion that he failed to keep adequate medical records. There is no basis for such a challenge.

Finding of Unprofessional Conduct – Legal Standard

HO § 14-404 permits the Board to revoke a license upon a finding that the physician (1) is guilty of unprofessional conduct in the practice of medicine (§ 14-404(a)(3)(ii)), (2) grossly overutilizes health care services (§ 14-404(a)(19)), (3) fails to meet appropriate standards as determined by appropriate peer review for the delivery of quality medical care (§ 14-404(a)(22)), (4) willfully submits false statements to collect fees for which services are not provided (§ 14-404(a)(23)), or (5) fails to keep adequate medical records as determined by appropriate peer review (§ 14-404(a)(40)).

Based on evidence from appellant's medical records (or lack thereof), the Board found that appellant violated at least one of those provisions with respect to each of the 10 patients and that, with respect to some of those patients, he violated more than one.[3] In Section IV of its Final Decision and Order, the Board addressed the applicable Standard of Care. It stated:

> "While the focus of this decision is the Respondent's unprofessional conduct and his gross overutilization, his conduct constitutes a violation of the standard of care, as described here. Concerning Patient 1, according to the experts for the State, the Respondent's repeated unnecessary testing violated the standard of care. The Panel accepts the testimony of the experts. Concerning Patient 9, the State's experts agreed that the

[3] The Board found that, in one manner or another, appellants billed for services not rendered as to Patients 1, 4, 6, 7, 8, and 10, that he conducted unnecessary and unindicated testing of Patients 1, 2, 3, 4, 5, 7, 8, 9, and 10, that he engaged in upcoding with respect to Patients 1, 2, 5, 7, and 9, and that he failed to keep adequate medical records for Patients 1 and 5.

> Respondent's excessive and unnecessary testing violated the standard of care. The Panel agrees with the State's experts. Based on the above findings, with respect to Patients 1 and 9, the Respondent failed to meet the appropriate standards as determined by appropriate peer review for the delivery of quality medical care performed in this State, in violation of Health Occ. § 14-404(a)(22)."

Appellant treats the Board's express finding that he violated the appropriate standard of care by excessive and unnecessary testing with respect to only two patients as an implicit finding that he did **not** violate that standard with respect to the other eight patients, notwithstanding findings that appellant overbilled or conducted unnecessary tests with respect to them as well. He finds that inconsistent and insists that the Board must have erred in finding that the standard of care was breached with regard to Patients 1 and 9. He insists that we remand the case for a determination that he did not violate the standard of care with respect to Patients 1 and 9.

The State's first response is that the issue is not preserved because it was not included in the Exceptions appellant filed to the ALJ's report and that, in any event, the Board had discretion in deciding which charges to act upon.

The record shows that Dr. Jani found that appellant met the standard of care with respect to Patients 4, 6, 7, and 8, but not as to Patients, 1, 2, 3, 5, 9, and 10. Dr. Drelich found that appellant met the standard of care with respect to Patients 2, 3, 4, 6, 7, and 10 but not as to Patients 1, 5, 8, and 9. The ALJ noted the differences but found them not to be dispositive. She stated that "while the evidence did not establish in all instances that

the Respondent engaged in unprofessional conduct, failed to meet the standards for the delivery of quality medical care, or over-utilized medical services, the weight of the evidence supports Dr. Jani's and Dr. Drelich's opinion that Respondent violated the Maryland Medical Practices Act."

Although as jurists, we may find it odd that performing medical tests on a patient that are not necessary or indicated does not violate applicable standards of care, the statutory test is the "appropriate standards **as determined by appropriate peer review**" (emphasis added), not as determined by a reviewing court. It is a medical judgment. The peer reviewers looked at **all** of the medical records and determined whether the totality of the treatment provided met the applicable standard of care, not just whether one procedure that caused no harm was appropriate. That is precisely the kind of medical judgment that the statute anticipates. We find no basis for a remand.

The Sanction

Appellant's final complaint is that the sanction of revocation was arbitrary and capricious in light of the fact that he had no prior disciplinary record, that the violations were merely record-keeping deficiencies, and that no patient was harmed. We disagree. The Board explained its reasoning:

> "The Panel finds the Respondent's practices disturbing and intolerable. Certainly, the Respondent's over-billing was not isolated. It consumed his practice. His practice was replete with different schemes to bill for services that were not performed and for services that were performed but not

> indicated. And there is no doubt his conduct was deliberate. The Panel also finds unacceptable the number of inaccurate, contradictory, and false documents he produced. The Panel agrees with the ALJ that revocation is appropriate."

This Court can take judicial notice that the exorbitantly high cost of health care is one of the most, if not **the** most, pressing problem in this country. It is not inappropriate, much less arbitrary or capricious, for government regulators, when they see it documented, to act vigorously to discipline those who contribute to the problem by "gaming the system."

JUDGMENT AFFIRMED; APPELLANT TO PAY THE COSTS.