IN THE COURT OF APPEALS OF IOWA

No. 8-712 / 07-1698
Filed October 15, 2008

AMERICAN EYECARE,
Petitioner-Appellant,

vs.

DEPARTMENT OF HUMAN SERVICES,
Defendant-Appellee.

Appeal from the Iowa District Court for Lee (South) County, Michael J. Schilling, Judge.

Petitioner appeals from the district court's judicial review of agency action upholding the department of human services' finding that petitioner improperly billed for comprehensive eye exams. **AFFIRMED.**

David A. Hirsch, Des Moines, for appellant.

Thomas J. Miller, Attorney General, and Diane M. Stahle, Assistant Attorney General, for appellee.

Considered by Sackett, C.J., and Miller and Potterfield, JJ.

SACKETT, C.J.

American Eyecare, appeals from the district court's ruling denying its petition for judicial review of the decision issued by the Department of Human Services (DHS) that found American Eyecare incorrectly coded certain exams as comprehensive and thus over-billed Medicaid. DHS determined a comprehensive eye exam required "the initiation of a diagnostic and treatment program" and found American Eyecare's exams on a substantial number of patients did not include such treatment but were nonetheless billed as comprehensive exams. We affirm.

I. BACKGROUND AND PROCEEDINGS. American Eyecare provides optometry services and treats patients covered by Medicaid. In order to be paid for its services, it must submit bills to DHS describing the services and procedures rendered for each Medicaid-covered patient. DHS oversees the operation of Iowa's Medicaid program and requires optometrists to categorize the services given to patients according to certain codes. The codes, also called CPTs, are defined and explained in a manual, the American Medical Association Physicians' Current Procedural Terminology. As part of its oversight duties, DHS performs audits to ensure proper billing and is authorized to seek reimbursement when an audit reveals a Medicaid provider has been overpaid. ACS State Healthcare (ACS) performs the audits on behalf of DHS.

In 2005, ACS performed an audit on the billings submitted by Dr. Kevin Jennings, an American Eyecare optometrist. ACS determined Jennings had overcharged Medicaid in several respects and sought reimbursement of the

overpayment. Specifically pertinent to this appeal, ACS alleged Jennings coded and billed exams as "comprehensive ophthalmological services" when they should have been coded and billed as "intermediate ophthalmological services." ACS sought to recoup $26,095.52 in overpayments for the "upcoding."[1] ACS extrapolated this figure by using an audit sample of two billing statements containing the error and then inferring all bills that charged for comprehensive exams during the audit period were improperly upcoded. American Eyecare denied any inappropriate billing and appealed ACS's findings.

An administrative hearing on the dispute was held on April 29, 2005. On behalf of DHS, an ACS supervisor, a DHS program manager, and a DHS policy specialist appeared. On behalf of American Eyecare, its operations manager appeared. The administrative law judge found, and the agency agreed, that DHS was entitled to recoupment for most of the errors ACS identified, including the upcoding of examinations.[2] American Eyecare petitioned for judicial review, challenging only the finding that it improperly upcoded examinations. It urged the exams in question were comprehensive and involved the "initiation of diagnostic and treatment program[s]" because glasses were prescribed for the patients, and

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[1] At the time Jennings examined the patients, providers were reimbursed $71.14 for each comprehensive examination and $47.24 for each intermediate examination. DHS sought to recoup the difference between these amounts, $23.90, for approximately 964 patients.

[2] The administrative law judge and agency determined DHS was entitled to recoup funds from American Eyecare for (1) upcoding eye examinations, (2) failing to provide proper documentation confirming services were actually rendered for services charged, (3) inappropriate billing of the refractive state, and (4) inappropriate billing of the dispensing fee. DHS was denied recoupment for "inappropriate use of the RP modifier" because the administrative law judge and agency found that DHS's materials did not give American Eyecare notice or instructions clarifying that "reimbursement for broken glasses would be denied unless their . . . records documented the broken glasses could not be repaired or indicated the extent of the damage to the frames."

refraction testing was done. It reasoned the exams analyzed qualified as comprehensive because Jennings's decisions to not provide treatment and instead order a return visit in twelve months was the initiation of a treatment program. DHS maintained that these services did not meet the definition of comprehensive exam under CPT codes in place in 2001 and 2002. It contended that all services listed in the definition of a comprehensive exam must be performed to qualify for this level of reimbursement, not just a prescription for glasses. The district court affirmed. Noting the agency's interpretation of the CPT definitions was entitled to deference, it found no irrational, illogical, or wholly unjustifiable interpretation or application of law. It further concluded the agency's finding was supported by substantial evidence and other relevant evidence was not ignored. American Eyecare appeals.

II. STANDARD OF REVIEW. Our judicial review of final agency action is for correction of errors at law. *Houck v. Iowa Bd. of Pharmacy Exam'rs*, 752 N.W.2d 14, 16 (Iowa 2008). We apply the standards of the Administrative Procedure Act, Iowa Code Chapter 17A, to the agency action to ascertain whether we reach the same results as the district court. *University of Iowa Hosps. & Clinics v. Waters*, 674 N.W.2d 92, 95 (Iowa 2004). We will reverse or grant appropriate relief if substantial rights of the person seeking relief have been prejudiced because the agency has committed any of the errors listed in Iowa Code section 17A.19(10) (2005). American Eyecare has not specified which of these errors occurred though we are able to discern the relevant sections from the substance of its arguments. American Eyecare argues the court should not have deferred to the

agency's interpretation of the codes, the services performed did meet the definition of comprehensive exam contained in the CPT codes and DHS manuals, and the agency's interpretation is absurd and illogical. Therefore, we will analyze its claims according to sections 17A.19(10)(c), (f), and (i). These sections allow us to grant the petitioner relief if the agency action is:

> (c) [b]ased upon an erroneous interpretation of a provision of law whose interpretation has not clearly been vested by a provision of law in the discretion of the agency[,]
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> . . .
>
> (f) [b]ased upon a determination of fact clearly vested by a provision of law in the discretion of the agency that is not supported by substantial evidence in the record before the court when that record is viewed as a whole[, or]
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> . . .
>
> (i) [t]he product of reasoning that is so illogical as to render it wholly irrational.

Iowa Code § 17A.19(10)(c), (f), (i).

III. ANALYSIS. Iowa's Medicaid program is governed by Iowa Code chapter 249A. It empowers and directs the DHS director to "adopt rules pursuant to chapter 17A in determining the method and level of reimbursement for all medical and health services referred . . . ." Iowa Code § 249A.4(9); *Strand v. Rasmussen*, 648 N.W.2d 95, 102 (Iowa 2002). One such rule lists the services optometrists are reimbursed for under the program and defines comprehensive and intermediate exams. Iowa Admin. Code r. 441-78.6. However, Iowa Administrative Code rule 441-79.1(7) states that physicians are reimbursed according to a fee schedule "based on the definitions of medical and surgical procedures given in the *most recent* edition of Physician's Current Procedural Terminology (CPT)." (emphasis supplied). At the time Jennings performed the

exams that were audited, the distinguishing feature between the definitions of intermediate and comprehensive ophthalmological services was that comprehensive services required the "initiation of diagnostic and treatment programs."[3] The 2001 American Medical Association CPT manual clarifies this requirement:

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[3] The 2001 American Medical Association CPT manual provided the following:

> ***Intermediate ophthalmological services*** describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy.
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> *For example:*
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> a. Review of history, external examination, ophthalmoscopy, biomicroscopy for an acute complicated condition (e.g., iritis) not requiring comprehensive ophthalmological services.
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> b. Review of interval history, external examination, ophthalmoscopy, biomicroscopy and tonometry in established patient with known cataract not requiring comprehensive ophthalmological services.
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> ***Comprehensive ophthalmological services*** describes a general evaluation of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. <u>It always includes initiation of diagnostic and treatment programs.</u>
>
> Intermediate and comprehensive ophthalmological services constitute integrated services in which medical decision making cannot be separated from the examining techniques used. Itemization of service components, such as slit lamp examination, keratometry, routine ophthalmoscopy, retinoscopy, tonometry, or motor evaluation is not applicable.
>
> *For example:*
>
> The comprehensive services required for diagnosis and treatment of a patient with symptoms indicating possible disease of the visual system, such as glaucoma, cataract or retinal disease, or to rule out disease of the visual system, new or established patient.
>
> (Underline emphasis supplied.)

> ***Initiation of diagnostic and treatment program*** includes the prescription of medication, and arranging for special ophthalmological diagnostic or treatment services, consultations, laboratory procedures and radiological services.
>
> ***Special ophthalmological services*** describes services in which a special evaluation of part of the visual system is made, which goes beyond the services included under general ophthalmological services, or in which special treatment is given. Special ophthalmological services may be reported in addition to the general ophthalmological services or evaluation and management services.
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> *For example:*
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> Fluorescein angioscopy, quantitative visual field examination, refraction or extended color vision examination (such as Nagel's anomaloscope) should be separately reported.

The parties have opposing views as to the meaning of "initiation of diagnostic and treatment program." DHS contends all of the services listed in the definition must be performed to qualify as the initiation of a diagnostic and treatment program. American Eyecare argues the definition only lists examples of an initiation of a diagnostic and treatment program and that requiring all of the listed services to be done to qualify for a comprehensive exam is an absurd interpretation.

A. Agency Discretion. The parties first disagree as to whether DHS's interpretation is entitled to deference under our judicial review. We "[s]hall give appropriate deference to the view of the agency with respect to particular matters that have been vested by a provision of law in the discretion of the agency." Iowa Code § 17A.19(11)(c). DHS argues, and the district court agreed, its interpretation is entitled to deference because the department has been clearly vested with discretion to construe the Medicaid Act. We agree that DHS

is charged with adopting rules to implement Medicaid and obliged to enforce the program rules through audits. *See* Iowa Code § 249A.4 (mandating the director of DHS to adopt rules for reimbursement of Medicaid service providers); Iowa Code § 249A.7 (requiring the department of inspections and appeals to cooperate with DHS to ensure audits comply with federal and state medical assistance laws). However, these statutes do not explicitly give DHS ultimate discretion in statutory and rule interpretations. *See State v. Public Employment Relations Bd.*, 744 N.W.2d 357, 360 (Iowa 2008); *Mosher v. Dep't of Inspections & Appeals, Health Facilities Div.*, 671 N.W.2d 501, 508-09 (Iowa 2003) (finding general delegations of regulatory power are not clear grants of discretion to interpret laws). Nonetheless, we will give an agency's interpretations of statutes and rules within its expertise limited deference. *Madrid Home for the Aging v. Iowa Dep't of Human Servs., Div. of Med. Servs.*, 557 N.W.2d 507, 510-11 (Iowa 1996); *see also Al-Khattat v. Eng'g & Land Surveying Examining Bd. of the State of Iowa*, 644 N.W.2d 18, 23 (Iowa 2002) ("[W]e defer to an agency's construction of statutes and rules within the agency's expertise, unless the interpretation is erroneous or unreasonable.").

In our attempt to discern the meaning of "initiation of diagnostic and treatment program," "[w]e seek a reasonable interpretation that will best effect the purpose of the statute and avoid an absurd result." *Public Employment Relations Bd.*, 744 N.W.2d at 361. But our interpretation should not render any part of the law superfluous. *Id.* If possible, we should give effect to every clause and word of the rule and give plain meaning to words, phrases, and

punctuations. *TLC Home Health Care, L.L.C. v. Iowa Dep't of Human Servs.*, 638 N.W.2d 708, 713 (Iowa 2002) (citations omitted). Turning to the definition of "initiation of diagnostic and treatment program," we note the words "includes" and the conjunctive use of, "and," indicate multiple types of services listed must be performed to qualify as the initiation of a diagnostic and treatment program and thus must be performed to be billed as a comprehensive exam. The word "includes" can operate to enlarge or restrict the meaning of a word. *Id.* "'Where a general term is followed by the word 'including,' which is itself followed by specific terms, the intent may be one of limitation.'" *Id.* (quoting *State Pub. Defender v. Iowa Dist. Ct.*, 633 N.W.2d 280, 283 (Iowa 2001)). Here the general term "initiation of diagnostic and treatment program" is followed by the word "includes," suggesting an intent to limit the class of services reimbursed as comprehensive exams to those services listed.

Also, "[o]rdinarily, the word 'and' is used as a conjunctive, requiring satisfaction of both listed conditions." *Casteel v. Iowa Dep't of Transp., Motor Vehicles Div.*, 395 N.W.2d 896, 898 (Iowa 1986). We will disregard such strict grammar rules if necessary to reach the legislative intent of a law but see no reason to ignore the common meaning in this context. *See id.* (applying "and" as conjunctive when there was no indication a contrary meaning was intended) *and compare In re Detention of Altman*, 723 N.W.2d 181, 187 (Iowa 2006) (applying "and" as disjunctive to achieve legislative purpose). Therefore, giving limited deference to DHS's interpretation and under our rules of statutory construction, we conclude the "initiation of a diagnostic and treatment program" in the 2001

CPT manual requires (1) the prescription of medication, (2) the arranging of special ophthalmological diagnostic or treatment services, (3) consultations, (4) laboratory procedures, and (5) radiological services.

B. Substantial Evidence. American Eyecare next contends the services provided during the exams did meet the requirements of the "initiation of a diagnostic and treatment program." It argues that prescribing lenses qualifies as the prescription of medication, and refraction testing constitutes "special ophthalmological diagnostic or treatment service." It also contends ordering a return visit within twelve months should be considered the initiation of a diagnostic and treatment program.

If the agency's findings of fact are "supported by substantial evidence in the record as a whole," we are bound by them. *Grant v. Dep't of Human Servs.*, 722 N.W.2d 169, 173 (Iowa 2006). "Substantial evidence means the quantity and quality of evidence that would be deemed sufficient by a neutral, detached, and reasonable person . . . ." Iowa Code § 17A.19(10)(f)(1). The ultimate question is not whether the evidence supports an alternative finding, but whether the record supports the findings the agency actually made. *Grant*, 722 N.W.2d at 173; *City of Hampton v. Iowa Civil Rights Comm'n*, 554 N.W.2d 532, 536 (Iowa 1996).

As explained above, there are multiple requirements to satisfy the "initiation of a diagnostic and treatment program" definition. Even if American Eyecare performed some services, it did not perform others under the definition. The patient records audited show no arrangements for consultations, laboratory

procedures, or radiological services. American Eyecare does not dispute that it billed for comprehensive exams and was reimbursed at the comprehensive exam rate. We find substantial evidence supports the agency findings that American Eyecare did not initiate diagnostic and treatment programs for the exams in question and was improperly reimbursed for the exams at the comprehensive rate for which DHS is entitled to recoupment.

C. Illogical Interpretation. American Eyecare's final argument is that the agency's interpretation of "initiation of diagnostic and treatment program" is the product of illogical reasoning. It contends DHS's interpretation requiring all services, including x-rays, to be done under the definition of "initiation of diagnostic and treatment program" is absurd. It reasons that comprehensive exams "will virtually never" be performed under these requirements. However, American Eyecare does not dispute that the definitions listed above were the ones in effect during the time at issue. It does not dispute that it did not order radiological services, arrange for consultations, or order laboratory work during either examination. We do not find it absurd to give meaning to those words in the CPT code definitions rather than disregard them as optional parts of a comprehensive exam and conclude the agency's interpretation was not the product of illogical reasoning.

IV. CONCLUSION. We affirm the district court. Granting limited deference to DHS's interpretation of "initiation of a diagnostic and treatment program" and applying statutory rules of construction indicates the agency's determination is not based on an erroneous interpretation of law and is not the product of illogical

reasoning. We further conclude the record provides substantial evidence to support DHS's finding that American Eyecare did not initiate any diagnostic or treatment program during the exams at issue. Therefore, American Eyecare's billing for comprehensive services on examinations where only intermediate services were provided was improper and DHS is entitled to recoup the amount overpaid.

AFFIRMED.

Miller, J., concurs specially; Potterfield, J., concurs.

MILLER, J. (concurs specially)

I concur in the result.