Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART B SERVICES RENDERED BY A NEW JERSEY UROLOGIST

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Inspector General

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Office of Inspector General

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EXECUTIVE SUMMARY

BACKGROUND

Medicare Program

The Medicare program, established under Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance to people age 65 and over, to those suffering from permanent kidney failure, and to certain people with disabilities. The Medicare Part B program is administered by the Centers for Medicare & Medicaid Services (CMS), which contracts with local carriers to pay for physician and other medical services.

Office of Inspector General Reviews

In November 2002, a physician practicing medicine in New Jersey and specializing in general urology and urologic surgery (the urologist), reached a settlement with the Office of Inspector General, Office of Counsel to the Inspector General (OCIG) concerning improper Medicare claiming for pharmaceuticals received as free samples. As a result of the settlement, an independent review organization evaluated the urologist's compliance with Medicare reimbursement requirements, and found a 68-percent error rate. Because of the high error rate, OCIG referred the urologist to the Office of Audit Services for a more comprehensive audit.

OBJECTIVE

Our objective was to determine whether Medicare payments made to the urologist complied with Medicare reimbursement requirements.

SUMMARY OF FINDINGS

The urologist was paid for services that did not comply with Medicare reimbursement requirements. Of the 100 claims in our statistical sample, 90 claims for 185 services ($14,734) were unallowable for one or more reasons.

Pursuant to section 1862(a) of the Act, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness, injury, or dysfunction. In addition, section 1833(e) of the Act prohibits payment for services unless the provider maintains medical records including sufficient documentation to substantiate the nature and necessity of the services rendered.

The deficiencies noted for the 90 noncompliant claims are summarized below:

- 123 services were insufficiently documented;
- 54 services were incorrectly coded;

- 2 services were for services already paid as part of other surgical procedures (unbundling);

- 4 services lacked any documentation; and

- 2 services were not rendered.

In our opinion, these deficiencies occurred because the urologist did not maintain medical records sufficient to substantiate the nature and necessity of the services reimbursed by Medicare, and because of clerical billing errors.

As a result, for calendar year 2003, we estimate that the urologist improperly claimed $230,258 in Medicare reimbursement.

RECOMMENDATIONS

We recommend that the urologist:

- work with the New Jersey carrier to reimburse the Medicare program for the estimated overpayment of $230,258, and

- establish effective controls to ensure that only services rendered, sufficiently documented, and correctly coded are billed to Medicare.

AUDITEE COMMENTS

In his July 17, 2006, comments on our draft report, the urologist disputed the medical review results for 84 claims ($13,720) of the 90 claims ($14,734) identified as overpayments in our audit. He agreed with the results for the remaining 6 claims ($1,014).

The urologist also cited to support his position (1) his certification under the CMS Clinical Laboratory Improvement Amendments (CLIA) program,[1] (2) a Medicare carrier report showing that he billed for lower codes than his peer group in the period July 2005 through December 2005, and (3) a recertification by the American Board of Urology. The urologist's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Medicare reimbursement requirements and the urologist's comments on our draft report, we continue to believe that our findings are valid.

[1] The CMS regulates all laboratory testing (except research) performed on humans in the U.S. through CLIA.

We believe the PSC medical reviewer evaluated all available patient medical records, and we support the medical review results.

Regarding CLIA certification, the objective of the CLIA program is to ensure quality laboratory testing and has no direct Medicare program responsibilities, including reimbursement. Also, the Medicare carrier report cited by the urologist is not related to the results of our review and is for a period 2 years after the close of our audit period. Finally, recertification by the private American Board of Urology has no relevance to Medicare reimbursement requirements.

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Medicare Program

The Medicare program, established under Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance to people age 65 and over, to those suffering from permanent kidney failure, and to certain people with disabilities. The Medicare Part B program is administered by the Centers for Medicare & Medicaid Services, which contracts with local carriers to pay for physician and other medical services.

Office of Inspector General Reviews

In November 2002, a physician practicing medicine in New Jersey and specializing in general urology and urologic surgery (the urologist), reached a settlement with the Office of Inspector General, Office of Counsel to the Inspector General (OCIG) concerning improper Medicare claiming for pharmaceuticals received as free samples. As a result of the settlement, the urologist initiated a review by an independent review organization to evaluate the urologist's compliance with Medicare reimbursement requirements. The organization reviewed a judgmental sample of 25 Medicare claims for services rendered during the period January 6, 2003, through January 9, 2003, and found a 68-percent error rate. Because of the high error rate, OCIG referred the urologist to the Office of Audit Services for a more comprehensive audit.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments made to the urologist complied with Medicare reimbursement requirements.

Scope

Our review covered services rendered during calendar year 2003. For this period, Medicare made payments totaling $406,901 to the urologist for 2,440 claims.

We conducted our fieldwork at the New Jersey office of the urologist.

Methodology

To accomplish our objectives, we:

- reviewed applicable laws and Medicare guidelines for physician services;

- extracted, from the Centers for Medicare & Medicaid Services (CMS) National Claims History database, the urologist's claims for the audit period;

- selected a simple random sample of 100 paid claims, totaling $22,422 (see Appendix A for our sampling methodology);

- obtained supporting medical records documentation for each sampled claim;

- used a CMS program safeguard contractor (PSC) to review the urologist's medical record documentation to determine whether the urologist services claimed complied with Medicare reimbursement requirements;

- evaluated the results of the PSC's review;

- used a variables appraisal program to estimate overpayments made to the urologist (see Appendix B for the statistical sampling information and projection of sample results); and

- conducted an exit conference with the urologist to present him with the preliminary results of our review.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the 100 claims in our statistical sample, 90 did not comply with Medicare reimbursement requirements. The schedule below summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix C shows our determinations on the deficiencies in each sampled claim.

Deficiency Noted	Number of Claims	Number of Services	Amount Questioned
1. Insufficient Documentation	80	123	$ 11,131
2. Services Incorrectly Coded	52	54	$ 2,577
3. Surgical Procedures Unbundled	2	2	$ 966
4. No Documentation	4	4	$ 44
5. Services Not Rendered	2	2	$ 16
Totals	**90**[2]	**185**	**$ 14,734**

[2] Total exceeds 90 because 48 claims had more than one type of error.

DEFICIENCIES NOTED IN SAMPLED CLAIMS

The sections below discuss the criteria that we applied in determining whether claims complied with Medicare reimbursement requirements, and the five types of deficiencies noted in the sampled claims.

Medicare Criteria

Pursuant to section 1862(a) of the Act, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness, injury, or dysfunction. In addition, section 1833(e) of the Act prohibits payment for services unless the provider maintains medical records including sufficient documentation to substantiate the nature and necessity of the services rendered.

1. Insufficient Documentation to Support Services Billed

Contrary to these Medicare reimbursement requirements, 80 claims for 123 services ($11,131) lacked sufficient documentation for the medical reviewer to determine whether the services were ever actually rendered or were medically necessary. The services claimed were evaluation and management services, various urological procedures, chemotherapy and related drugs, urinalysis tests, and urine cultures.

2. Services Incorrectly Coded

The medical reviewer determined that there was a total of 52 claims for 54 services ($2,577) when the documentation furnished did not support the level of service rendered as required by Medicare reimbursement requirements. The services claimed were evaluation and management services and surgical services.

3. Surgical Procedures Unbundled

On two claims for two services ($966) the medical reviewer determined that the urologist had claimed services that were part of other surgical procedures for which the urologist had already been reimbursed.

4. No Documentation to Support Services Billed

The urologist was unable to furnish any documentation to support four claims for four services ($44) as required by the Medicare regulations.

5. Services Not Rendered

No documentation was provided to us for two claims for two services ($16). The urologist's staff indicated that the services had not been rendered and that billing errors had occurred.

CAUSES OF UNALLOWABLE CLAIMS

In our opinion, these deficiencies occurred because the urologist did not maintain medical records sufficient to substantiate the nature and necessity of the services reimbursed by Medicare, and because of clerical billing errors.

ESTIMATION OF THE UNALLOWABLE CLAIMS

90 of the 100 claims reviewed included one or more services that did not comply with Medicare reimbursement requirements. Extrapolating the results of our sample, we estimate that the urologist was improperly paid between $230,258 and $488,770 in Medicare funds. The midpoint of the confidence interval amounted to $359,514. The range shown has a 90-percent level of confidence with a sampling precision as a percentage of the midpoint of 35.95 percent. The details of our sample results and projection are shown in Appendix B.

RECOMMENDATIONS

We recommend that the urologist:

- work with the New Jersey carrier to reimburse the Medicare program for the estimated overpayment of $230,258, and

- establish effective controls to ensure that only services rendered, sufficiently documented, and correctly coded are billed to Medicare.

AUDITEE COMMENTS

In his July 17, 2006, comments on our draft report, the urologist disputed the medical review results for 84 claims ($13,720) of the 90 claims ($14,734) identified as overpayments in our audit. He agreed with the results for the remaining 6 claims ($1,014).

To support his dispute, the urologist provided copies of patient medical records, which had already been reviewed by the PSC medical reviewer, now with hand-written notations describing his disagreements.

The urologist also cited to support his position (1) his certification under the CMS Clinical Laboratory Improvement Amendments (CLIA) program,[3] (2) a Medicare carrier report showing that he billed for lower codes than his peer group in the period July 2005 through December 2005, and (3) a recertification by the American Board of Urology.

[3] The CMS regulates all laboratory testing (except research) performed on humans in the U.S. through CLIA. In total, CLIA covers approximately 189,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Medicaid and State Operations (CMSO) has the responsibility for implementing the CLIA Program.

The urologist's comments are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Medicare reimbursement requirements and the urologist's comments on our draft report, we continue to believe that our findings are valid.

We believe the PSC medical reviewer evaluated all available patient medical records, and we support the medical review results. We have not included as part of this report the voluminous patient medical records provided by the urologist. However, we will provide the records to the HHS action official as part of the audit resolution process.

Regarding CLIA certification, the objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare payments, CLIA has no direct Medicare program responsibilities, including Medicare reimbursement.

In addition, the Medicare carrier report cited by the urologist is not related to the results of our review and is for a period 2 years after the close of our audit period.

Finally, as with the CLIA certification, recertification by the private American Board of Urology has no relevance to Medicare reimbursement requirements.

APPENDIXES

SAMPLING METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether Medicare payments made to the urologist complied with Medicare reimbursement requirements.

POPULATION

The population consisted of Medicare claims paid to the urologist for services rendered during the period January 1 through December 31, 2003.

SAMPLING FRAME

The sampling frame was a database containing 2,440 claims paid to the urologist for urology services rendered during the period January 1 through December 31, 2003. There were a total of 5,602 services on 2,440 claims, for which total Medicare reimbursement was $406,901.

SAMPLE UNIT

The sample unit was a Medicare claim paid to the urologist for services rendered during the period January 1 through December 31, 2003.

SAMPLE DESIGN

We used a simple random sample to evaluate the 2,440 Medicare claims paid to the urologist.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services Statistical Sampling Software, dated September 2003. We used the random number generator for our sample.

METHOD OF SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame. The random numbers were correlated to the sequential numbers assigned to the claims in the sampling frame. We then created a list of sample items.

CHARACTERISTICS TO BE MEASURED

The determination of as to whether a claim was improper and unallowable was based on applicable Medicare reimbursement requirements. A claim was considered an error if services on the claim were:

- not covered by Medicare,
- not medically reasonable or necessary,
- not supported by the medical records,
- not commensurate with the level of service rendered, as evidenced within the medical records, or
- not actually provided.

ESTIMATION METHODOLOGY

We used the Office of Audit Services variables appraisal program in RAT-STATS to estimate the total amount of Medicare reimbursement for claims not paid in compliance with Medicare reimbursement requirements.

Appendix B

STATISTICAL SAMPLING INFORMATION

Sampling Results

Population			Sample Size			Sample Errors		
Claims	Services	Medicare Paid	Claims	Services	Medicare Paid	Claims	Services	Medicare Paid
2,440	5,602	$406,901	100	240	$22,422	90	185	$14,734

Projection of Sample Results
(Precision at the 90-Percent Confidence Interval)

Upper Limit	$488,770
Midpoint	$359,514
Lower Limit	$230,258
Precision Percent	35.95

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
1	05/15/2003	81000	-	$4.43	$4.43	Insufficient documentation
1	05/15/2003	99214	99213	$67.97	$24.39	Service incorrectly coded
2	07/29/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
2	07/29/2003	81000	-	$4.43	$4.43	Insufficient documentation
3	10/21/2003	99212	-	$31.12	$0.00	
3	10/21/2003	87086	-	$11.28	$11.28	Insufficient documentation
3	10/21/2003	81000	-	$4.43	$4.43	Insufficient documentation
4	08/28/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
4	08/28/2003	81000	-	$4.43	$4.43	Insufficient documentation
5	10/21/2003	50220	-	$414.32	$0.00	
5	10/21/2003	99253	99251	$80.26	$51.09	Service incorrectly coded
5	10/21/2003	60545	-	$951.06	$951.06	Unbundling, Part of Procedure 50220
6	02/06/2003	52281	52000	$555.06	$378.28	Service incorrectly coded
6	02/06/2003	87086	-	$11.16	$11.16	Insufficient documentation
6	02/06/2003	81000	-	$4.37	$4.37	Insufficient documentation
7	09/18/2003	81000	-	$4.43	$4.43	Insufficient documentation
7	09/18/2003	87086	-	$11.28	$11.28	Insufficient documentation
7	09/18/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
8	12/11/2003	99213	-	$43.58	$0.00	
8	12/11/2003	81000	-	$4.43	$4.43	Insufficient documentation
9	06/12/2003	81000	-	$4.43	$4.43	Insufficient documentation
9	06/12/2003	99214	99212	$67.97	$36.85	Service incorrectly coded
10	03/24/2003	81000	-	$4.43	$4.43	Insufficient documentation
10	03/24/2003	99212	-	$29.26	$0.00	
11	08/21/2003	99212	-	$31.12	$0.00	
11	08/21/2003	J9202	-	$357.19	$357.19	Insufficient documentation
11	08/21/2003	96400	-	$33.25	$33.25	Insufficient documentation
11	08/21/2003	81000	-	$4.43	$4.43	Insufficient documentation
12	11/06/2003	81000	-	$4.43	$4.43	Insufficient documentation
12	11/06/2003	87086	-	$11.28	$11.28	Insufficient documentation
12	11/06/2003	99244	99242	$140.22	$65.56	Service incorrectly coded
13	05/22/2003	81000	-	$4.43	$4.43	Insufficient documentation
13	05/22/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
14	09/18/2003	81000	-	$4.43	$4.43	Insufficient documentation
14	09/18/2003	99213	-	$43.58	$0.00	
15	02/06/2003	81000	-	$4.37	$0.00	

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
16	03/25/2003	81000	-	$4.43	$4.43	Insufficient documentation
16	03/25/2003	99213	99212	$40.99	$9.87	Service incorrectly coded
17	04/24/2003	81000	-	$4.43	$4.43	Insufficient documentation
17	04/24/2003	87086	-	$11.28	$11.28	Insufficient documentation
17	04/24/2003	52281	52000	$335.98	$122.80	Service incorrectly coded
18	12/09/2003	96400	-	$33.25	$33.25	Insufficient documentation
18	12/09/2003	J9217	-	$1,422.24	$1,422.24	Insufficient documentation
18	12/09/2003	81000	-	$4.43	$4.43	Insufficient documentation
18	12/09/2003	99211	-	$17.82	$0.00	
19	05/29/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
20	06/16/2003	99212	-	$31.12	$0.00	
21	08/14/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
21	08/14/2003	81000	-	$4.43	$4.43	Insufficient documentation
22	03/13/2003	99213	99212	$40.99	$9.87	Service incorrectly coded
22	03/13/2003	81000	-	$4.43	$4.43	Insufficient documentation
23	03/13/2003	99213	99212	$40.99	$9.87	Service incorrectly coded
23	03/13/2003	81000	-	$4.43	$4.43	Insufficient documentation
24	05/13/2003	81000	-	$4.43	$4.43	Insufficient documentation
24	05/13/2003	99214	99212	$67.97	$36.85	Service incorrectly coded
25	08/14/2003	99212	99211	$31.12	$13.30	Service incorrectly coded
25	08/14/2003	J9202	-	$1,071.58	$0.00	
25	08/14/2003	81000	-	$4.43	$4.43	Insufficient documentation
25	08/14/2003	96400	-	$33.25	$0.00	
26	11/24/2003	81000	-	$4.43	$0.00	
26	11/24/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
26	11/24/2003	87086	-	$11.28	$11.28	Insufficient documentation
27	09/25/2003	51741	-	$62.61	$62.61	Insufficient documentation
28	10/10/2003	55700	-	$36.96	$0.00	
29	09/18/2003	J9202	-	$1,071.58	$1,071.58	Insufficient documentation
29	09/18/2003	99212	-	$31.12	$0.00	
29	09/18/2003	96400	-	$33.25	$33.25	Insufficient documentation
29	09/18/2003	81000	-	$4.43	$4.43	Insufficient documentation
30	10/13/2003	87086	-	$11.28	$0.00	
30	10/13/2003	81000	-	$4.43	$0.00	
30	10/13/2003	99213	-	$43.58	$0.00	
31	07/10/2003	99213	99212	$43.58	$12.46	Service incorrectly coded

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
31	07/10/2003	81000	-	$4.43	$4.43	Insufficient documentation
32	10/07/2003	81000	-	$4.43	$0.00	
32	10/07/2003	99213	-	$43.58	$0.00	
33	04/22/2003	99243	-	$98.71	$0.00	
33	04/22/2003	81000	-	$4.43	$4.43	Insufficient documentation
33	04/22/2003	87086	-	$11.28	$11.28	Insufficient documentation
34	05/19/2003	99212	-	$31.12	$0.00	
34	05/19/2003	J9202	-	$357.19	$357.19	Insufficient documentation
34	05/19/2003	81000	-	$4.43	$4.43	Insufficient documentation
34	05/19/2003	96400	-	$33.25	$33.25	Insufficient documentation
35	01/23/2003	81000	-	$4.37	$4.37	Insufficient documentation
35	01/23/2003	87086	-	$11.16	$11.16	Insufficient documentation
36	04/14/2003	99244	99243	$140.22	$41.51	Service incorrectly coded
37	05/22/2003	J9202	-	$1,071.58	$1,071.58	Insufficient documentation
37	05/22/2003	96400	-	$33.25	$33.25	Insufficient documentation
37	05/22/2003	99212	-	$31.12	$31.12	Insufficient documentation
37	05/22/2003	81000	-	$4.43	$4.43	Insufficient documentation
38	11/04/2003	81000	-	$4.43	$4.43	Insufficient documentation
38	11/04/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
39	07/24/2003	99212	99211	$31.12	$13.30	Service incorrectly coded
39	07/24/2003	81000	-	$4.43	$4.43	Insufficient documentation
40	07/17/2003	81000	-	$4.43	$4.43	Insufficient documentation
40	07/17/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
41	12/15/2003	99213	-	$43.58	$0.00	
41	12/15/2003	81000	-	$4.43	$4.43	Insufficient documentation
42	08/21/2003	87086	-	$11.28	$11.28	Insufficient documentation
42	08/21/2003	81000	-	$4.43	$4.43	Insufficient documentation
42	08/21/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
43	08/07/2003	81000	-	$4.43	$4.43	Insufficient documentation
43	08/07/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
44	09/02/2003	99244	99212	$140.22	$109.10	Service incorrectly coded
45	02/27/2003	81000	-	$4.37	$4.37	Insufficient documentation
45	02/27/2003	87086	-	$11.16	$11.16	Insufficient documentation
46	12/18/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
46	12/18/2003	81000	-	$4.43	$4.43	Insufficient documentation
47	07/08/2003	81000	-	$4.43	$4.43	Insufficient documentation

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
47	07/08/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
48	07/24/2003	99244	99243	$140.22	$41.51	Service incorrectly coded
49	08/19/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
49	08/19/2003	81000	-	$4.43	$4.43	Insufficient documentation
50	05/07/2003	99231	-	$27.40	$0.00	
50	05/03/2003	99231	-	$27.40	$0.00	
50	05/02/2003	51701	51702	$22.43	($57.82)	Service incorrectly coded
50	05/02/2003	99253	99252	$80.26	$21.60	Service incorrectly coded
51	10/30/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
51	10/30/2003	81000	-	$4.43	$4.43	Insufficient documentation
52	06/11/2003	52204	-	$105.94	$0.00	
53	07/10/2003	J9202	-	$1,071.58	$1,071.58	Insufficient documentation
53	07/10/2003	99212	-	$31.12	$31.12	Insufficient documentation
53	07/10/2003	96400	-	$33.25	$33.25	Insufficient documentation
53	07/10/2003	81000	-	$4.43	$4.43	Insufficient documentation
54	03/13/2003	81000	-	$4.43	$4.43	Insufficient documentation
54	03/13/2003	87086	-	$11.28	$11.28	Insufficient documentation
55	03/03/2003	81000	-	$4.43	$4.43	Insufficient documentation
56	08/14/2003	99212	99211	$31.12	$13.30	Service incorrectly coded
56	08/14/2003	87086	-	$11.28	$11.28	Insufficient documentation
56	08/14/2003	81000	-	$4.43	$4.43	Insufficient documentation
57	09/08/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
57	09/08/2003	81000	-	$4.43	$0.00	
58	06/19/2003	81000	-	$4.43	$0.00	
59	03/04/2003	99213	99211	$40.99	$23.17	Service incorrectly coded
59	03/04/2003	81000	-	$4.43	$4.43	Insufficient documentation
60	08/07/2003	81000	-	$4.43	$4.43	Insufficient documentation
60	08/07/2003	99212	-	$31.12	$0.00	
61	12/02/2003	99212	-	$31.12	$0.00	
61	12/02/2003	81000	-	$4.43	$4.43	Insufficient documentation
62	09/17/2003	51726	-	$73.51	$73.51	Insufficient documentation
62	09/18/2003	99232	99231	$45.27	$17.87	Service incorrectly coded
62	09/15/2003	99253	99252	$80.26	$21.60	Service incorrectly coded
63	09/18/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
63	09/18/2003	87086	-	$11.28	$11.28	No documentation
63	09/18/2003	81000	-	$4.43	$0.00	

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
63	09/18/2003	J1580	-	$1.42	$1.42	Insufficient documentation
64	12/02/2003	81000	-	$4.43	$0.00	
64	12/02/2003	87086	-	$11.28	$11.28	Insufficient documentation
64	12/02/2003	99212	-	$31.12	$0.00	
65	04/22/2003	81000	-	$4.43	$4.43	Insufficient documentation
65	04/22/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
66	09/02/2003	87086	-	$11.28	$11.28	Insufficient documentation
66	09/02/2003	81000	-	$4.43	$4.43	Insufficient documentation
67	08/19/2003	81000	-	$4.43	$4.43	Insufficient documentation
67	08/19/2003	99212	-	$31.12	$0.00	
68	10/27/2003	81000	-	$4.43	$4.43	Insufficient documentation
68	10/27/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
68	10/27/2003	87086	-	$11.28	$11.28	Insufficient documentation
69	04/21/2003	99212	-	$31.12	$0.00	
69	04/21/2003	81000	-	$4.43	$4.43	Insufficient documentation
70	01/23/2003	99213	99212	$42.90	$11.96	Service incorrectly coded
70	01/23/2003	J1580	-	$1.56	$0.00	
70	01/23/2003	81000	-	$4.37	$0.00	
70	01/23/2003	87086	-	$11.16	$11.16	Insufficient documentation
71	04/03/2003	81000	-	$4.43	$4.43	Insufficient documentation
71	04/03/2003	99213	99212	$40.99	$9.87	Service incorrectly coded
72	01/02/2003	81000	-	$4.37	$4.37	Insufficient documentation
72	01/02/2003	51720	-	$115.40	$115.40	Insufficient documentation
72	01/02/2003	J9031	-	$133.18	$133.18	Insufficient documentation
73	10/02/2003	99212	-	$31.12	$0.00	
74	06/19/2003	96400	-	$33.25	$33.25	Insufficient documentation
74	06/19/2003	J9202	-	$357.19	$357.19	Insufficient documentation
74	06/19/2003	99212	-	$31.12	$0.00	
74	06/19/2003	81000	-	$4.43	$4.43	Services not rendered
75	04/14/2003	87086	-	$11.28	$11.28	Services not rendered
75	04/14/2003	81000	-	$4.43	$4.43	Insufficient documentation
75	04/14/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
76	06/26/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
76	06/26/2003	87086	-	$11.28	$11.28	Insufficient documentation
76	06/26/2003	81000	-	$4.43	$4.43	Insufficient documentation
77	10/02/2003	87086	-	$11.28	$11.28	Insufficient documentation

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
77	10/02/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
77	10/02/2003	81000	-	$4.43	$4.43	Insufficient documentation
78	03/27/2003	99214	99213	$63.91	$20.33	Service incorrectly coded
78	03/27/2003	81000	-	$4.43	$0.00	
78	03/27/2003	87086	-	$11.28	$11.28	Insufficient documentation
79	05/12/2003	55700	-	$164.40	$0.00	
79	05/12/2003	76942	-	$81.06	$0.00	
79	05/12/2003	76872	-	$83.06	$0.00	
79	05/12/2003	J1580	-	$1.56	$1.56	No documentation
80	04/14/2003	76942	-	$81.06	$0.00	
80	04/14/2003	55700	-	$164.40	$0.00	
80	04/14/2003	J1580	-	$1.56	$1.56	No documentation
81	08/21/2003	96400	-	$33.25	$33.25	Insufficient documentation
81	08/21/2003	J9202	-	$1,071.58	$1,071.58	Insufficient documentation
81	08/21/2003	99212	-	$31.12	$0.00	
81	08/21/2003	81000	-	$4.43	$4.43	Insufficient documentation
82	03/06/2003	99212	-	$29.26	$29.26	No documentation
82	03/06/2003	81000	-	$4.43	$4.43	Insufficient documentation
82	03/06/2003	51720	-	$101.98	$0.00	
82	03/06/2003	J9031	-	$133.18	$0.00	
83	07/31/2003	87086	-	$11.28	$11.28	Insufficient documentation
83	07/31/2003	81000	-	$4.43	$0.00	
83	07/31/2003	99214	99212	$67.97	$36.85	Service incorrectly coded
84	03/27/2003	81000	-	$4.43	$4.43	Insufficient documentation
84	03/27/2003	99213	99212	$40.99	$9.87	Service incorrectly coded
85	01/30/2003	G0050	-	$27.03	$27.03	Insufficient documentation
85	01/30/2003	51741	-	$61.15	$61.15	Insufficient documentation
86	11/06/2003	99212	-	$31.12	$31.12	Insufficient documentation
86	11/06/2003	81000	-	$4.43	$4.43	Insufficient documentation
86	11/06/2003	87086	-	$11.28	$11.28	Insufficient documentation
87	06/12/2003	J9202	-	$1,071.58	$1,071.58	Insufficient documentation
87	06/12/2003	99212	-	$31.12	$0.00	
87	06/12/2003	81000	-	$4.43	$0.00	
87	06/12/2003	96400	-	$33.25	$33.25	Insufficient documentation
88	01/28/2003	52281	52000	$555.06	$381.28	Service incorrectly coded
88	01/28/2003	81000	-	$4.37	$4.37	Insufficient documentation

Sample Review Results

Sample Item #	Date of Service	Procedure Code Reviewed	Revised Procedure Code	Medicare Paid Amount	Amount Questioned	Deficiency Noted
89	06/16/2003	J9217	-	$1,422.24	$1,422.24	Insufficient documentation
90	05/29/2003	52281	52000	$352.05	$138.87	Service incorrectly coded
90	05/29/2003	81000	-	$4.43	$4.43	Insufficient documentation
91	06/03/2003	99212	-	$31.12	$0.00	
91	06/03/2003	81000	-	$4.43	$4.43	Insufficient documentation
92	07/10/2003	99212	-	$31.12	$0.00	
93	04/10/2003	99212	-	$31.12	$0.00	
93	04/10/2003	J9202	-	$357.19	$357.19	Insufficient documentation
93	04/10/2003	96400	-	$4.42	$4.42	Insufficient documentation
93	04/10/2003	81000	-	$4.43	$4.43	Insufficient documentation
94	01/23/2003	81000	-	$4.37	$4.37	Insufficient documentation
94	01/23/2003	53660	-	$11.04	$11.04	Insufficient documentation
94	01/23/2003	87086	-	$11.16	$11.16	Insufficient documentation
95	10/13/2003	87086	-	$11.28	$11.28	Insufficient documentation
95	10/13/2003	99244	99242	$140.22	$65.56	Service incorrectly coded
95	10/13/2003	81000	-	$4.43	$4.43	Insufficient documentation
96	09/18/2003	81000	-	$4.43	$4.43	Insufficient documentation
96	09/18/2003	99213	99212	$43.58	$12.46	Service incorrectly coded
97	05/14/2003	74420	-	$15.33	$15.33	Unbundling, Part of Procedure 52005
97	05/14/2003	52281	52005	$125.02	($158.95)	Service incorrectly coded
98	08/05/2003	81000	-	$4.43	$4.43	Insufficient documentation
98	08/05/2003	99213	-	$43.58	$0.00	
99	09/25/2003	51741	-	$62.61	$62.61	Insufficient documentation
100	02/26/2003	52234	-	$189.57	$0.00	

Appendix D

[Auditee comments not reproduced]