Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EMPIRE MEDICARE SERVICES: AUDIT OF MEDICARE CLAIMS BY PODIATRISTS AND OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

JUNE GIBBS BROWN
Inspector General

AUGUST 2000
A-09-00-00090

OFFICE OF INSPECTOR GENERAL

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Region IX

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.

JUNE GIBBS BROWN
Inspector General

AUGUST 2000
A-09-00-00090

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

CIN: A-09-00-00090

August 29, 2000

Ms. Loretta Conyers
Manager of Quality Assurance and Coordination
Empire Medicare Services
2651 Strang Boulevard
Yorktown Heights, NY 10598

Dear Ms. Conyers:

The purpose of this letter report is to provide Empire Medicare Services (Empire) with the results of our audit of New York claims by podiatrists and optometrists for comprehensive nursing facility (CNF) assessments during Calendar Years 1995 through 1998. Our objectives were to determine whether podiatrists' and optometrists' medical licenses permitted them to perform CNF assessments and whether Empire paid podiatrists and optometrists for these services which were outside the scope of their licenses.

We found that podiatrists and optometrists were not licensed to perform CNF assessments. Nonetheless, podiatrists and optometrists submitted claims for these services totaling $4,821,810 and $517,461, respectively. Of the total amount claimed by podiatrists, Empire allowed $3,732,291 and paid $2,905,205. Of the total amount claimed by optometrists, Empire allowed $409,697 and paid $320,896. Empire's payments for services billed by 86 podiatrists represented 77 percent of the paid $2,905,205, and its payments for services billed by 5 optometrists represented 94 percent of the paid $320,896. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

We recommended that Empire: (1) issue a reminder to podiatrists and optometrists to bill Medicare only for services performed within the scope of their licenses, and (2) implement computer edits to prevent payment to podiatrists and optometrists for CNF assessments.

In a written reply to our draft report, Empire indicated agreement with our recommendations. The company notified podiatrists and optometrists in its May 2000 issue of The Medicare News Brief that they are not to bill for CNF assessments, and stated that it implemented computer edits to prevent payment to podiatrists and optometrists for CNF assessments. Although Empire has taken corrective action on our recommendations, it believed that the improper payments may not have been as great as we reported. It was of the view that the providers may have performed other, less expensive services and wrongly billed for the higher paid CNF assessments. Empire's comments are included in their entirety as an appendix to this report, except we excluded detailed calculations of its estimated invalid payments.

We request that Empire not seek recovery of the overpayments at this time as we are still evaluating the issue.

INTRODUCTION

BACKGROUND

The Medicare program, established by the Social Security amendments of 1965, consists of two parts:

- Part A which covers services rendered by hospitals, skilled nursing facilities (SNFs), home health agencies and hospice providers, and
- Part B which covers physician care, among other services.

Payments for medical benefits under Part B are administered by carriers, usually existing private insurance companies that contract with the Federal Government for this purpose. In addition to processing and paying claims, carriers also make coverage determinations and provide administrative guidance to providers.

Medicare Part A regulations require SNFs to perform a comprehensive assessment of each resident's functional capacity within 14 days of admission and after significant changes in a resident's condition or at least every 12 months. These resident assessments cover the patient's entire well-being, such as physical functioning, sensory impairments, nutritional requirements, mental and psychosocial status, cognitive state, etc.

The responsibility for completion of the resident assessment lies with the SNF which must assure that appropriate health professionals participate. However, some of the information required to be collected can only be provided by a physician, and, thus, physicians play a crucial role in the assessment process.

The Health Care Financing Administration (HCFA) issued guidance to carriers in a Program Memorandum (Carriers) No. B-93-5, dated August 1, 1993 (the Memorandum), which states that there are three key components in selecting the level of evaluation and management (E&M) service when performing a CNF assessment: (1) a history, (2) a comprehensive examination and (3) medical decision making that includes either the creation of a new comprehensive medical care plan or a review and affirmation of the current comprehensive medical care plan. The Memorandum also describes how physicians participating in resident assessments of beneficiaries in nursing facilities are to bill for their services. Physicians should use the Physicians' Current Procedural Terminology[1] (CPT) codes for CNF assessments (99301-99303) to report E&M services involving resident assessments. The CPT codes 99301-99303 represent the E&M of a new or established patient involving an annual nursing facility assessment.

The complexity of the E&M service performed determines the CPT code. The CPT manual defines the key components and gives examples[2] of the types of services performed for CNF assessments (CPT codes 99301-99303) as follows:

99301	detailed interval history; comprehensive examination; and medical decision making that is straightforward or of low complexity;

[1] The Physicians' Current Procedural Terminology is published by the American Medical Association. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.

[2] The CPT code examples are from the 1998 version of the American Medical Association's Physicians' Current Procedural Terminology.

Example: Annual nursing facility history and physical and a uniform minimum data set/resident assessment instrument (MDS/RAI) evaluation for a 2-year nursing facility resident who is an 84-year old female with multiple chronic health problems, including: stable controlled hypertension, chronic constipation, osteoarthritis, and moderated stable dementia;

99302 detailed interval history;
comprehensive examination; and
medical decision making of moderate to high complexity;

Example: Nursing facility assessment of an 88-year old male resident with a permanent change in status following a new cerebral vascular accident (CVA) that has triggered the need for a new MDS/RAI and medical plan of care.

99303 comprehensive history;
comprehensive examination; and
medical decision making of moderate to high complexity.

Example: Nursing facility assessment and creation of medical plan of care upon readmission to the nursing facility of an 82-year old male who was previously discharged. The patient has just been discharged from the hospital where he had been treated for an acute gastric ulcer bleed associated with transient delirium. The patient returns to the nursing facility debilitated, protein depleted, and with a stage III coccygeal decubitus.

For all CNF assessments, the required examination must be a comprehensive examination. The CPT manual defines a comprehensive examination as a general multi-system examination or a complete examination of a single organ system.

In addition to the comprehensive examination for CNF assessments, the CPT manual requires either a detailed interval history or a comprehensive history. A detailed history includes, "...chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; and pertinent past, family, and/or social history directly related to the patient's problems." A comprehensive history includes, "...chief complaint; extended history of present illness; review of systems which is directly related to the problem(s)

identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history." (emphasis added)

For other physician visits of new or established patients, the Memorandum states, "Physicians should use the CPT codes for subsequent nursing facility care (99311-99313) when reporting services that do not involve resident assessments."

Because of the limited scope of their medical licenses, some providers should not be performing comprehensive assessments of patients in nursing homes. Limited scope providers are not licensed to perform the key medical service components required to bill Medicare for CPT codes 99301-99303, such as preparation of a comprehensive medical care plan that is outside the scope of their specialty. These providers may include dentists, chiropractors, podiatrists, and optometrists. Our survey showed that two of these provider types, dentists and chiropractors, billed Empire for a very insignificant number of CNF assessments and, therefore, they were excluded from this review.

With regard to CNF assessments performed by podiatrists and optometrists, the Social Security Act covers the services of these providers to the extent the services performed comply with Medicare regulations and are within the scope of their State license.

> *Podiatry*. The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, ... (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them...." (emphasis added)
>
> *Optometry*. The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, ... (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them...." (emphasis added)

OBJECTIVES, SCOPE AND METHODOLOGY

The first objective of our audit was to ascertain whether the New York State Education Department[3] licensed podiatrists and optometrists, respectively, to perform CNF assessments. The second objective was to determine the extent to which Empire allowed payment on invalid New York Medicare claims[4] submitted by podiatrists and optometrists for CNF assessments during the Calendar Years 1995 through 1998.

Our review was conducted in accordance with generally accepted government auditing standards. Accordingly, we performed such tests and other auditing procedures as necessary to meet the objectives of our review. We did not review the overall internal control structure of Empire or of the Medicare program. Our review of internal controls was limited to obtaining an understanding of Empire's payment procedures and system edits for processing New York CNF assessment claims for podiatrists and optometrists. We obtained a general understanding of these procedures and system edits through discussions with Empire personnel and an analysis of claims data.

We reviewed the New York State Consolidated Education Laws to ascertain the scope of medical practice authorized for podiatrists and optometrists. We also wrote to the New York State Education Department's Boards for Podiatry and Optometry to determine what services, if any, a podiatrist or an optometrist is licensed to perform in addition to foot-related and eye-related services, respectively.

Our audit included an analysis of Empire CNF assessment payments for services billed by New York podiatrists and optometrists. The data for this payment analysis were obtained from HCFA's National Claims History database. We did not perform an analysis of the procedures used to accumulate the Claims History data nor did we validate the accuracy of the data.

The text of Empire's written comments is included as an appendix to this report, except we excluded Empire's detailed calculation of the estimated invalid payments. We have summarized Empire's comments following our RECOMMENDATIONS section of this report.

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[3] The New York State Education Department is responsible for the licensing of the podiatry and optometry professions.

[4] Empire processes New York Medicare Part B claims for the counties of Manhattan, Brooklyn, Bronx, Richmond, Westchester, Rockland, Nassau, Suffolk, Putnam, Sullivan, Orange, Dutchess, Ulster, Columbia, Delaware, and Greene.

The fieldwork was performed from February 2000 through April 2000 at the Office of Audit Services' San Diego Field Office, San Diego, California.

FINDINGS AND RECOMMENDATIONS

We found that the New York State Education Department did not license podiatrists and optometrists, respectively, to perform CNF assessments. However, Medicare payment data showed that podiatrists and optometrists submitted claims for these services totaling $4,821,810 and $517,461, respectively. Of the total amount claimed by podiatrists, Empire allowed $3,732,291 and paid $2,905,205. Of the total amount claimed by optometrists, Empire allowed $409,697 and paid $320,896. Empire's payments for services billed by 86 podiatrists represented 77 percent of the paid $2,905,205, and its payments for services billed by 5 optometrists represented 94 percent of the paid $320,896. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

SCOPE OF PODIATRISTS' LICENSES

We determined that the New York State Education Department's law limited podiatrists to treatment and care planning of the foot.

Article 141, Section 7001.1 of the New York State Consolidated Education Laws limits the practice of podiatry to "...diagnosing, treating, operating, and prescribing for any disease, injury, deformity or other condition of the foot, and may include performing physical evaluations in conjunction with the provision of podiatric treatment." Although the law states that a podiatrist can perform physical evaluations in conjunction with podiatric treatment, the law specifically limits the practice of podiatry to the diagnosis and treatment of the foot. Section 7001.2 states, "The practice of podiatry shall not include treating any part of the human body other than the foot, nor treating fractures of the malleoli or cutting operations upon the malleoli." (emphasis added)

We wrote the New York State Education Department's Board for Podiatry to determine what services, if any, a podiatrist is licensed to perform in addition to foot-related services. The State Education Department responded that a podiatrist's scope is limited

to the diagnosis and treatment of illnesses and injuries related only to the feet, and that there are no exceptions to the stated scope.

Given that the State limits the scope of practice for podiatrists to services related to the foot, the Social Security Act, Section 1861(r)(3), would effectively not authorize Medicare payment for claims by podiatrists for CNF assessments. As part of a CNF assessment, a physician must be able to develop or reaffirm an existing comprehensive care plan for the patient which addresses the overall medical conditions of the patient, not just the foot.

SCOPE OF OPTOMETRISTS' LICENSES

We determined that the New York State Education Department's law limited optometrists to treatment and care planning of the eye and adjacent tissue.

Article 143, Section 7101 of the New York State Consolidated Education Laws limits the practice of optometry to "...diagnosing and treating optical deficiency, optical deformity, visual anomaly, muscular anomaly or disease of the human eye and adjacent tissue by prescribing, providing, adapting or fitting lenses, or by prescribing or providing orthoptics or vision training, or by prescribing and using drugs."

We wrote the New York State Education Department's Board for Optometry to determine what services, if any, an optometrist is licensed to perform in addition to eye-related services. The State Education Department responded that the law limits an optometrist to treating conditions of the eye, and an optometrist may not diagnose or treat other conditions that do not relate to the eye. According to the Department, an optometrist would not be qualified to perform a CNF assessment.

Given that the State limits the scope of practice for optometrists to services related to the eye and adjacent tissue, the Social Security Act, Section 1861(r)(4), would effectively not authorize Medicare payment for claims by optometrists for CNF assessments. As part of a CNF assessment, a physician must be able to develop or reaffirm an existing comprehensive care plan for the patient which addresses the overall medical conditions of the patient, not just the eye and adjacent tissue.

ANALYSIS OF MEDICARE DATA: PODIATRISTS

We determined that podiatrists submitted claims to Empire for CNF assessments totaling $4,821,810 during Calendar Years 1995 through 1998. Of the total claimed amounts, Empire allowed $3,732,291 and actually paid $2,905,205.

Further analysis of the payment data showed that CNF assessments performed by a few, 86 of the 401 podiatrists billing for CNF assessments, accounted for 77 percent of the $2,905,205 in invalid payments. The invalid payments for the 86 podiatrists averaged $26,121 per provider. In contrast, CNF assessments performed by the remaining 315 podiatrists represents payments of $658,765, or an average of $2,091 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 86 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $14,999	31	36%
$15,000 to $24,999	24	28
$25,000 to $49,999	21	24
$50,000 to $99,999	9	11
$100,000 and Over	1	1
Totals	86	100%

ANALYSIS OF MEDICARE DATA: OPTOMETRISTS

We determined that optometrists submitted claims to Empire for CNF assessments totaling $517,461 during Calendar Years 1995 through 1998. Of the total claimed amounts, Empire allowed $409,697 and actually paid $320,896.

Further analysis of the payment data showed that CNF assessments performed by a few, 5 of the 18 optometrists billing for CNF assessments, accounted for 94 percent of the $320,896 in invalid payments. The invalid payments for the 5 optometrists averaged $60,270 per provider. In contrast, CNF assessments performed by the remaining 13 optometrists represents payments of $19,546, or an average of $1,504 per

provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 5 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $49,999	3	60%
$50,000 to $99,999	1	20
$100,000 and Over	1	20
Totals	5	100%

EDITS AND INSTRUCTIONS

We found that Empire had neither issued specific guidance to New York podiatrists and optometrists nor implemented computer edits to prevent the payment of CNF assessments to New York podiatrists and optometrists.

In our discussions and correspondence with Empire representatives, they stated that it is feasible to implement edits in its New York operations, and, as a result of our inquiry on this issue, they are currently drafting guidance to providers and developing edits for their New York claims processing system. Also, Empire personnel responsible for processing New Jersey Medicare Part B claims informed us that Empire started processing the New Jersey claims in March 1999. The predecessor carrier for New Jersey had computer edits in place to prevent payments for CNF assessments to podiatrists and optometrists, which Empire has continued to enforce.

In our view, the issuance of a reminder to providers and the implementation of computer edits by Empire should virtually eliminate the inappropriate payments for CNF assessments to podiatrists and optometrists.

OTHER SERVICES

For the reasons previously cited, it is clear that podiatrists and optometrists were not entitled to payment for CNF assessments of beneficiaries in nursing homes. What is not known, however, is whether the providers may have performed other, different services and incorrectly claimed CNF assessments.

RECOMMENDATIONS

We recommend that Empire:

1. Issue a reminder to podiatrists and optometrists not to bill for any service outside of the scope of their medical licenses, such as CNF assessments, and

2. Implement computer edits to prevent payment for CNF assessments claimed by podiatrists and optometrists.

As to recovery of the improper payments that have been made, we request that Empire not seek recovery at this time. We are still evaluating the recovery issue and will advise Empire on this matter at a later time.

EMPIRE'S COMMENTS

In a written response to our draft report, Empire indicated agreement with our recommendations by initiating the following actions:

1. Notified providers in its May 2000 issue of The Medicare News Brief that it would no longer pay podiatrists and optometrists for CNF assessments, and

2. Implemented computer edits on June 1, 2000, that would exclude podiatrists and optometrists from billing the CNF assessment codes (99301-99303).

Empire commented that the billing of CNF assessment codes (99301-99303) by podiatrists and optometrists was most likely the result of a coding error, rather than the inappropriate performance of CNF assessments by providers not licensed to perform the services. It believed that podiatrists and optometrists inadvertently billed CNF assessment codes when they should have billed subsequent nursing facility care codes (99311-99313). If these providers billed the wrong code, they would still be entitled to payment for those services they actually performed.

Based on Empire's belief that podiatrists and optometrists billed the wrong code, it stated that our draft report may have overstated the invalid payments. It estimated the total invalid payments for podiatrists and optometrists to be $1,321,773 rather than $3,226,101 shown in the draft report.

Additionally, Empire commented that it was not alone in this problem and that over half of the other Medicare Part B carriers are making the same error. It stated that this appears to be a widespread carrier oversight that could have been readily corrected by a system-wide edit or correction had the issue been brought to the attention of HCFA.

Empire's comments are included in their entirety as an appendix, except we excluded detailed calculations of its estimated invalid payments.

OAS RESPONSE

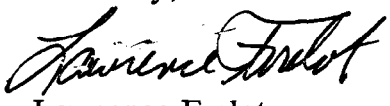
As indicated on page seven of our report, we did not determine if podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments. Without a detailed review of each provider's services, it cannot be assumed that a provider performed less expensive nursing facility visits (CPT codes 99311-99313) and inadvertently claimed higher paid CNF assessments (CPT codes 99301 - 99303).

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to common identification number (CIN) A-09-00-00090 in all correspondence relating to this report.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services' reports issued to the Department's grantees and contractors are made available to members of the press and

general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

Sincerely,



Lawrence Frelot
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Ms. Judy Berek
Regional Administrator
Health Care Financing Administration - Region II
26 Federal Plaza, Room 38-11
New York, NY 10278-0063

APPENDIX

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

MEDICARE
Part B Carrier

June 12, 2000

Mr. Lawrence Frelot
Department of Health and Human Services
Office of Inspector General
Region IX - Office of Audit Services
50 United Nations Plaza
San Francisco, CA 94102

Dear Mr. Frelot:

I am writing in response to the draft audit report regarding podiatrists and optometrists who incorrectly billed comprehensive nursing facility assessments during calendar years 1995 through 1998 to Empire Medicare Services, New York.

In our May 2000 issue of The Medicare News Brief we notified providers that we would no longer be paying optometrists and podiatrists for comprehensive nursing facility assessments. In addition, our Carrier Medical Director spoke to the executive director of the New York State Podiatric Medical Association, regarding the change and they also indicated that they agreed with the change and would notify the podiatry community. On June 1, we implemented edits that would exclude podiatrists and optometrists from billing for the comprehensive nursing facility assessment codes 99301-99303.

The billing of these services is most likely a coding error, rather than the inappropriate performance of comprehensive nursing facility assessments by providers not licensed to perform this service. The skilled nursing facilities, themselves, are a check and balance on this, as they would require an MD/DO to admit the patient and be responsible for the care of the beneficiary.

The hierarchy of evaluation and management codes is such that office and hospital visits are each divided into two families of codes, initial visits and subsequent visits (99201-99205 vs 99211-99215, and 99221-99223 vs 99231-99233). Domicilliary care codes are also similarly divided into initial and subsequent care (99321-99323 vs 99331-99333). Podiatrists and optometrists may not have realized that this logic was not extended to the nursing home visits, and that the 99301-99303 coding group is for the comprehensive nursing facility assessment service, and the 99311-99313 group is for visits to a new or established patient. The OIG does indicate that the invalid billing may be the result of a coding error, but did not pursue this possibility.

The amounts noted in the report may overstate the actual overpayments. If these providers had performed an evaluation and management service and billed the wrong code, then they would still be entitled to reimbursement for those services at the appropriate fee schedule amount. The overpayment would be the difference between the payment for the billed service and the payment for the appropriate service. Based upon the calendar year 2000 MFSDB the differences between the allowances of the correct codes and the billed codes are listed below:

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

MEDICARE
Part B Carrier

CPT CODE BILLED	ALLOWED $$	CORRECT CPT CODE	ALLOWED $$	DIFFERENCE $$
99301	$ 72.74	99311	$ 39.59	$33.15
99302	$ 94.81	99312	$ 61.16	$33.75
99303	$126.78	99313	$ 84.13	$42.65

Based upon estimates for the amount of the overpayment apportioned to each of the three codes, and the percentage change in payment by correcting the code billed (using the year 2000 fee schedule), the invalid payments for podiatrists would by reduced by 41.3% from $2,905,205 to $1,199,560 over the four-year period in question. Using the same logic for the optometrists, the invalid overpayment would be reduced by 38.1% from $320,896 to $122,214 over the four-year period. (See attached spreadsheet, Calculation All Carrier CNF.xls)*. The combined overpayment is estimated to be $1,321,773, rather than the $3,226,101 in the draft report. This data is based on approximations, but could be calculated from the actual data.

Empire Medicare Services is not alone in this problem. Over half of the Part B carriers are making the same error, including HealthNow Upstate Medicare, GHI, Trailblazers-Texas and Maryland, North Carolina, NHIC California, Maine & Massachusetts, Arkansas, Kansas Blue Cross and Blue Shield, and South Carolina. Based upon BESS data (July-Dec 1999), Empire accounts for 11.6% of these overpayments and 10.73% of the paid services. The difference between charges and services is due to which of the three services is billed, and the higher GPCIs in New York (See attached file)*. This appears to be a widespread carrier oversight, which could have been readily corrected by a system-wide edit or correction if this issue had been brought to the attention of HCFA.

If you have any questions or concerns regarding this information, please call me at (914) 248-2804.

Sincerely,

Cindy Rifkin
Coordinator
Medicare Part B Coordination

Footnote added by Office of Audit Services:

* Referenced attachments are not included in this report.

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