DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector Gener
Office of Audit Services
Region IX

Memorandum

Date: March 28,2002

From: Regional Inspector General
for Audit Services

Subject: Results of the California Statewide Audit of Inpatient Hernodialysis Procedure Services (A-09-01-00068)

To: Elizabeth Abbott
Regional Administrator, Region IX
Centers for Medicare & Medicaid Services

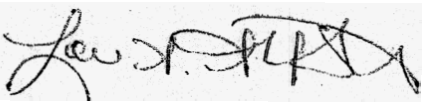
Attached are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "California Statewide Audit of Inpatient Hemodialysis Procedure Services." This audit was conducted based on an audit lead derived from the Physicians At Teaching Hospital, University of California review that we previously had performed.

For this current review, we audited a stratified sample of 500 hemodialysis procedure services to determine if each service met the inpatient hospital place of service, the physician's presence, and the medical necessity requirements. We found that 135 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. In addition, 61 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure.

Officials in your office have generally concurred with our recommendations, set forth on page 9 of the attached report, and have taken, or agreed to take, corrective action. We appreciate the cooperation given us by CMS staff in conducting this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact Gordon Fickle at (415) 437-8360.

To facilitate identification, please refer to Common Identification Number A-09-01-00068 in all correspondence relating to this report.



Lori A. Ahlstrand

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA STATEWIDE AUDIT OF INPATIENT HEMODIALYSIS PROCEDURE SERVICES

JANET REHNQUIST
Inspector General

MARCH 2002
CIN: A-09-01-00068

Office of Inspector General

http://oig.hhs.gov

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CALIFORNIA STATEWIDE AUDIT OF INPATIENT HEMODIALYSIS PROCEDURE SERVICES

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NOTICES

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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 Final determination on these matters will be made by authorized officials of the HHS divisions

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program covers physician services provided to Medicare beneficiaries requiring dialysis services, including hemodialysis and peritoneal dialysis. In our audit, we focused on hemodialysis services that were performed in an inpatient setting. Physicians bill these inpatient hemodialysis services to Medicare using either Current Procedural Terminology (CPT) 90935 or CPT 90937. The CPT 90935 represents a hemodialysis procedure with single physician evaluation, and the CPT 90937 represents a hemodialysis procedure requiring repeated evaluations.

For physicians to receive payments for inpatient hemodialysis procedure services, the Medicare Carrier Manual (MCM) requires:

The place of service must be at an inpatient hospital,

The medical record must document that the physician was physically present with the patient at some time during the course of the dialysis, and

- The medical record must document that the physician's repeated evaluation of a patient during the hemodialysis procedure was medically necessary.

OBJECTIVE

The objective of our audit was to determine whether inpatient hemodialysis procedures provided during Calendar Years (CY) 1998 and 1999 by physicians to beneficiaries residing in the State of California were allowable and documented in the medical records in accordance with Medicare requirements.

FINDINGS

We audited a stratified sample of 500 inpatient hemodialysis procedure services with 100 services per stratum, one through five. We determined that, of the 500 services, 135 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. In addition, 61 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. As a result, we are 95 percent confident that at least $3,541,886 (or 16 percent) of the $22,214,841 paid to physicians for CY 1998 and 1999 was ineligible for Medicare reimbursement.

These overpayments occurred because some physicians:

- Did not ensure that their presence during the hemodialysis procedures was documented in the medical records before billing Medicare for hemodialysis procedures, and

- Did not ensure that the medical necessity for their repeated evaluation of patients during the hemodialysis procedures was documented in the medical records before billing Medicare for hemodialysis procedures with repeated evaluations.

As a part of this statewide audit, we conducted separate audits on four medical groups (strata one through four) that received the most Medicare payments for hemodialysis procedures for CY 1998 and 1999. We issued a separate report to each of the medical groups with a recommendation to refund the projected overpayments, totaling $288,340, to the Medicare program. However, the majority of the projected overpayments found in the California statewide audit was from the fifth stratum and not recoverable based on our sampling method. As indicated in APPENDIX A, individual physicians and medical groups in the fifth stratum received an overpayment of $1,858 for the 100 inpatient hemodialysis procedures reviewed. This amount should be recovered. However, expanded separate reviews would be necessary for individual physicians and medical groups in the fifth stratum in order to recover the total projected overpayments in excess of the $1,858 found in our sample.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS):

- Develop an education and monitoring program to reinforce the billing requirements for hemodialysis procedures,

- Determine if separate reviews for individual physicians or medical groups within the fifth stratum are cost effective, and, if so, perform additional reviews to recover the projected overpayments, and

- Initiate a recovery process for the $1,858 overpayment made to individual physicians and medical groups in the fifth stratum.

CMS COMMENTS

In a written response, dated January 4, 2002, to our draft report, CMS stated that the findings in our report warranted further consideration by the California Carrier Medical Review area to validate the potential error, determine a level of concern and take appropriate administrative action. It also stated that all overpayments identified in our audit would be collected or offset as appropriate. The CMS comments are included in their entirety as an Appendix to this report.

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INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act, provides health insurance coverage to people age 65 and over, the disabled, and people with end-stage renal disease (ESRD)[1]. Administered by the Centers for Medicare & Medicaid Services (CMS)[2] within the Department of Health and Human Services (HHS), the program consists of two components - Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part B covers a multitude of medical services including physician services. The Medicare Carriers Manual (MCM), published by CMS, sets forth the billing requirements for paying physician services under Part B. Medicare claims for Part B are processed by Acarriers@ which are agents contracted by HHS.

In our audit, we reviewed physician services provided to Medicare beneficiaries requiring dialysis services. There are two types of renal dialysis, hemodialysis[3] and peritoneal dialysis[4]. Dialysis services can be provided at either an inpatient or outpatient setting. Our audit focused on inpatient hemodialysis procedure services provided by physicians.

The Physician's Current Procedural Terminology (CPT)[5] includes the following codes for inpatient hemodialysis procedure services provided on an inpatient basis:

CPT 90935 - Hemodialysis procedure with single physician evaluation, and

CPT 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription.

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[1]The term ESRD means that Astage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life@ [MCM '2230.1.A].

[2]The former name of Centers for Medicare & Medicaid Services (CMS) was Health Care Financing Administration (HCFA).

[3] Hemodialysis is a process [w]here blood is passed through an artificial kidney machine and the waste products diffuse across a man-made membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body [MCM 2230.1.B.1].

[4] Peritoneal dialysis is a process [w]here the waste products pass from the patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the bath solution (dialysate) is introduced and removed periodically [MCM 2230.1.B.2].

[5] Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The CPT book is published by the American Medical Association annually.

The Medicare payment for hemodialysis procedures are set to include payment for certain Evaluation & Management (E & M)[6] services, including subsequent hospital visits, when both services are performed on the same day by the same physician for the same beneficiary. Separate payment may be made for an initial hospital visit, an initial inpatient consultation, or a hospital discharge service when billed for the same date as an inpatient dialysis service [MCM '15350.B].

For physicians to receive payments based on inpatient dialysis procedure codes, the MCM requires:

- The place of service must be at an inpatient hospital [MCM '15062.1.D],
- The medical record must document that the physician was physically present with the patient at some time during the course of the dialysis [MCM '15062.1.C], and
- The medical record must document that the physician's repeated evaluation of the patient during the hemodialysis procedure was medically necessary [MCM '15062.1.A.1 and 15062.1.C.1].

In the September 1988 Medicare Newsletter and the June 1988 Medicare Bulletin, the Carriers[7] informed physicians of the presence requirement by stating that in order to bill inpatient dialysis procedures, physicians must visit the patient during the procedure and the medical record must document the physician's presence during the procedure. In addition, in the July 1989 Medicare Newsletter, the Southern Carrier informed physicians of the medical necessity requirement by stating, "…multiple visits on the same day must be documented to indicate the visits were at different times and were **medically necessary**." [*Emphasis Added*.]

As a part of this statewide audit, we conducted separate audits on four medical groups that received the most Medicare payments for inpatient hemodialysis procedures for CY 1998 and 1999. We issued a separate report to each of the medical groups with a recommendation to refund the overpayment to the Medicare program as follows:

Medical Group	CIN Number	Overpayment
1	A-09-01-00050	$32,568
2	A-09-01-00084	$151,566
3	A-09-01-00080	$100,788
4	A-09-01-00067	$3,418
Total		$288,340

[6] E & M services represent the classification of physicians= work. They are divided into broad categories such as office visits, hospital visits and consultations.

[7] Transamerica Occidental Life Insurance (Southern Carrier) and Blue Shield of California (Northern Carrier) were the former Carriers, which handled Medicare billings for the State of California. National Heritage Insurance Company is the current Carrier for the State of California. The Medicare Newsletter was published by the Southern Carrier and the Medicare Bulletin was published by the Northern Carrier.

OBJECTIVE, SCOPE AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether inpatient hemodialysis procedures provided by physicians to California beneficiaries during CY 1998 and 1999 were allowable and documented in the medical records in accordance with Medicare requirements.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards. Our audit was limited to determining whether:

- The place of service was an inpatient hospital,
- The medical record documented the physician's presence with the patient during the hemodialysis procedure, and
- The medical record documented the medical necessity for the physician's repeated evaluation of the patient during the hemodialysis procedure.

We obtained the population of all inpatient hemodialysis procedures that were provided to California beneficiaries and paid by Medicare for CY 1998 and 1999. From the population, we excluded procedures provided by physicians who received less than a total of $5,000 for CY 1998 and 1999. We stratified the remaining population into five strata based on the total Medicare Part B payments made to individual physicians or medical groups. Strata one through four represented the four medical groups that received the most Medicare Part B payments for CY 1998 and 1999. The fifth stratum included all other individual physicians or medical groups that received at least $5,000 for inpatient hemodialysis procedures for CY 1998 and 1999.

Our review of the four medical groups' internal control structure was limited to those controls relating to the submission of claims to Medicare. The objective of our audit did not require an understanding or assessment of the entire internal control structure of the medical groups. We did not perform any internal control reviews for individual physicians or medical groups within the fifth stratum.

Our fieldwork included visits to hospitals in the State of California, the Carrier, and the four medical groups' offices from November 2000 to September 2001.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- Reviewed the Medicare criteria related to inpatient hemodialysis procedures,
- Interviewed appropriate CMS and Carrier officials to obtain an understanding of how the hemodialysis procedures should be documented in the medical records,

- Identified the universe of Medicare Part B payments for CY 1998 and 1999 using the National Claims History Files for California beneficiaries,

- Selected a stratified sample of 500 inpatient hemodialysis procedure services based on our approved sampling plan,

- Reviewed all other services provided to beneficiaries associated with the 500 services and determined if additional E & M services were paid to the same physician who received the payment for hemodialysis procedures,

- Interviewed hospital staff and dialysis nurses to obtain an understanding of how physicians of the four medical groups care for patients during the hemodialysis procedure,

- Interviewed officials of the four medical groups to obtain an understanding of how physicians care for patients during the hemodialysis procedure,

- Collected medical records at hospitals where the services were provided and analyzed them to determine whether the services met the MCM requirements for billing Medicare Part B,

- Utilized medical review staff from the Carrier to evaluate the services which did not appear to meet the billing requirements, and

- Used a variable appraisal program to estimate the dollar impact of overpayments in the population.

Details on our statistical sampling methodology are presented in APPENDIX A.

FINDINGS AND RECOMMENDATIONS

The audit included a review of a stratified sample of 500 inpatient hemodialysis procedure services to determine if they met the inpatient hospital place of service, the physician's presence, and the medical necessity requirements as stated in the MCM. These 500 services were comprised of 393[8] services for hemodialysis procedure with single physician evaluation (CPT 90935) and 107 services for hemodialysis procedure requiring repeated evaluation (CPT 90937). See APPENDIX B for a breakdown of the 500 services by CPT codes per stratum.

We found that all 500 services met the inpatient hospital place of service requirement. However, 135 of the 500 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. For these 135 services, physicians billed and were paid for either CPT 90935 or CPT 90937 even though the documentation in the medical records did not support the physician's presence for one and/or more visits during

[8] One of these 393 services was billed as CPT 90937, but paid for as CPT 90935 by the Carrier.

the hemodialysis procedure. In addition, 61[9] of the 500 services were billed for as CPT 90937 even though they did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. Figure 1 below illustrates our findings for the 500 services.

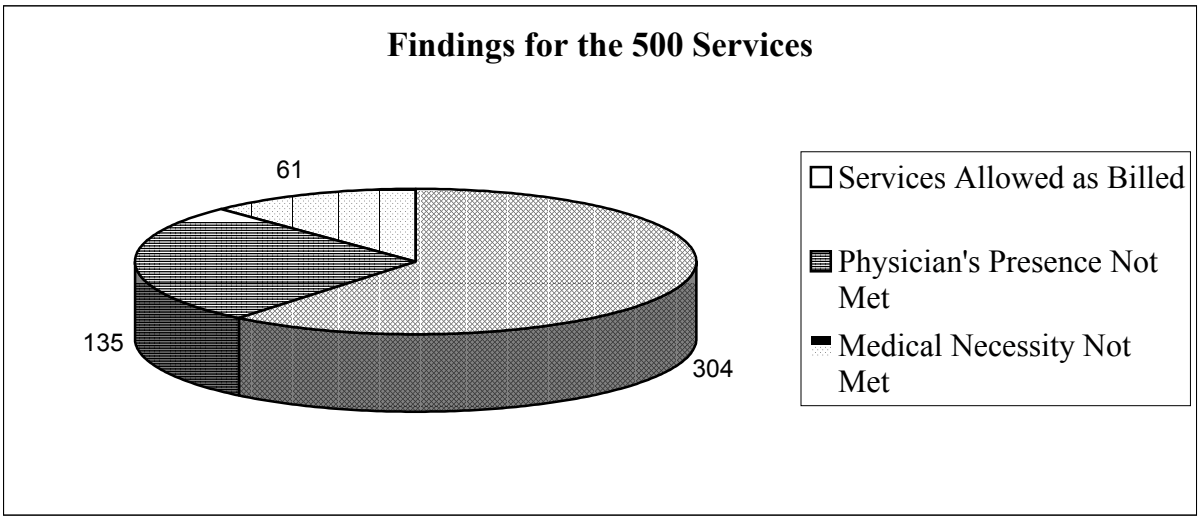

Figure 1: Findings for the 500 Services

We determined that, of the $44,705 reviewed, $9,022 was unallowable. Extrapolating the results of the statistical sample to the population using standard statistical methods, we found that the point estimate of the overpayment was $4,669,396 with an upper limit of $5,796,905 and a lower limit of $3,541,886 at the 90 percent confidence level. Therefore, we are 95 percent confident that at least $3,541,886 (or 16 percent) of the $22,214,841 paid to physicians for CY 1998 and 1999 was ineligible for Medicare reimbursement. These overpayments occurred because physicians failed to ensure that their presence during the hemodialysis procedures was documented in the medical records before billing Medicare for hemodialysis procedures. Also, physicians failed to ensure that the medical necessity for their repeated evaluation of patients during the hemodialysis procedures was documented in the medical records before billing Medicare for hemodialysis procedures with repeated evaluations. Details of our findings are presented below and in APPENDIX C.

PHYSICIAN PRESENCE

We determined that 135 of the 500 services reviewed did not have sufficient documentation to support the physician's presence during the hemodialysis procedure. In order to be paid for the hemodialysis procedure, the MCM '15062.1.C.2 requires that the physician be physically present with the patient during the hemodialysis procedure and the medical record must document the physician's presence. It also states that:

> *If the physician visits the dialysis inpatient on a dialysis day, but not <u>during</u> the dialysis treatment, do not pay the physician on the basis of a [hemodialysis]*

[9] Errors for these 61 services were found at a single medical group.

procedure code. The nature of these services is the same as physicians' services furnished to any inpatient during a hospital visit. Therefore, use the same hospital visit codes that apply to any other physicians treating hospital inpatients.

In addition, the July 1989 Medicare Newsletter issued by the Southern Carrier states that the physician's repeated evaluation of patients on the same day must be documented to indicate that the physician's evaluations were at different times.

As stated in the Methodology section of this report, for the 135 services that lacked documentation to support the physician's presence, we consulted with the Carrier medical review staff to determine if other appropriate services were supported by the documentation.

We found that:

- ***100 services would be allowable as subsequent hospital care services.***

  Because the payment for a hemodialysis procedure is higher than the one for subsequent hospital care, physicians received an overpayment of $3,121 for these 100 services. Example 1 below illustrates the calculation of the overpayment for one service reviewed.

The physician billed a service as a hemodialysis procedure with repeated evaluation (CPT 90937) and received a payment of $146.10. A review of documentation in the medical records revealed that the physician's presence during the hemodialysis procedure was not documented. The hemodialysis procedure began at 09:00 and ended at 12:00. The single physician's progress note was not timed. The dialysis and hospital staff nurses did not indicate in the medical records that the physician was present during the procedure. As a result, we determined that the documentation supported only a subsequent hospital care service (CPT 99232) for which the payment would have been $46.95.

We allowed the payment for the subsequent hospital care service. We disallowed the difference between the payment made for CPT 90937 and the payment that would have been made for subsequent hospital care service.

CPT 90937…..…….....	$146.10	(Paid)
CPT 99232…….....	46.95	(Allowed)
Unallowable	$ 99.15	

Example 1: Overpayment Calculation for a Service Billed as CPT 90937

- ***15 services, which had been billed as CPT 90937, would only be allowable as CPT 90935.***

  The documentation in the medical records supported only a single physician evaluation of patients during the hemodialysis procedures. Because the payment for CPT 90937 is higher than the one for CPT 90935, physicians received an overpayment of $870 for these 15 services.

- ***14 services would be allowable as other E & M services, i.e., initial hospital care, initial inpatient consultation, or hospital discharge day management services.***

  The documentation in the medical records supported only other E & M services. However, physicians had already billed and received Medicare payments for the other E & M services for the same day when hemodialysis services were provided. Therefore, physicians received an overpayment of $1,076 for these 14 services.

- ***6 services should not have been billed to the Medicare program.***

  These services were billed without any documentation that the physicians had visited the patient on the day of service. Therefore, physicians received an overpayment of $458 for these 6 services.

In summary, physicians received a total overpayment of $5,525 by billing 135 services as inpatient hemodialysis procedures when documentation in the medical records did not support the physician's presence during the hemodialysis procedures. Of the $5,525 overpayment, $1,858 was found in the fifth stratum (see APPENDIX A). These overpayments occurred because physicians did not ensure that their presence during the hemodialysis procedures was documented in the medical records before billing hemodialysis procedures.

MEDICAL NECESSITY

Of the 500 services reviewed, 107 services were billed and paid for as CPT 90937. Of these 107 services, 61 services did not have sufficient documentation to support the medical necessity for billing CPT 90937. All of the 61 services were found in the second stratum, a Southern California medical group.

The MCM '15062.1.A.1 and 15062.1.C.1 states that the Medicare program covers physician's services that are medically necessary. The MCM '15062.1.A.1 further states, "[t]he hospital medical record must document the services furnished and the medical reasons for them." The July 1989 Medicare Newsletter issued by the Southern Carrier states, "… multiple visits on the same day must be documented to indicate the visits were at different times and **were medically necessary**." [*Emphasis Added*.]

For the 61 services that lacked documentation to support the medical necessity, we determined that these services would be allowable as CPT 90935. Because the payment for CPT 90937 is higher than the one for CPT 90935, the medical group received an overpayment of $3,497.

As stated in the Methodology section of this report, we consulted with the Carrier medical review staff to determine whether the documentation supported the medical necessity for the physicians' repeated evaluation of patients during the hemodialysis procedures. If the documentation did not support the medical necessity for services billed for as CPT 90937, the staff determined if any other appropriate services were supported by the documentation.

The following example illustrates the process for determining medical necessity and calculating of the overpayment for one service reviewed.

The physician billed a service as CPT 90937 and received a payment of $129.30. A review of the documentation in the medical records revealed that the physician visited the patient twice during the hemodialysis procedure. His two visits were 20 minutes apart. According to the medical records, the patient was stable and tolerated the hemodialysis procedure well with no obvious problems. In consultation with the Southern Carrier, we determined that the documentation did not support the medical necessity for the physician's repeated evaluation of the patient during the hemodialysis procedure.

We allowed the payment for CPT 90935 for this service. We disallowed the difference between the payment made for CPT 90937 and the payment that would have been made for CPT 90935.

CPT 90937…..…….....	$129.30	(Paid)
CPT 90935…….....	75.38	(Allowed)
Unallowable	$ 53.92	

Example 2: Calculation of Overpayment for a Service Not Met Medical Necessity

The medical group received an overpayment of $3,497 for these 61 services by billing CPT 90937 when CPT 90935 should have been billed. These overpayments occurred because physicians failed to ensure that the medical necessity for their repeated evaluation of patients during the hemodialysis procedure was documented in the medical records before billing Medicare for hemodialysis procedures with repeated evaluation.

CONCLUSION

Our audit of a stratified sample of 500 hemodialysis services disclosed that 135 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. In addition, 61 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of a patient during the hemodialysis procedure. As a result, we determined that, of the $44,705 reviewed for CY 1998 and 1999, $9,022 was unallowable. As indicated in APPENDIX A, individual physicians and medical groups in the fifth stratum received an overpayment of $1,858 for the 100 inpatient hemodialysis procedures reviewed. This amount should be recovered.

We projected the results of the statistical sample to the population using standard statistical methods and found that the point estimate was $4,669,396 with an upper limit of $5,796,905 and a lower limit of $3,541,886 at the 90 percent confidence level. We are 95 percent confident that at least $3,541,886 (or 16 percent) of the $22,214,841 paid to physicians for CY 1998 and 1999 was ineligible for Medicare reimbursement. Details of our findings are presented in APPENDIX C.

As stated in the Background section, we recommended in separate reports that the four individual medical groups in our stratified sample refund the overpayments, totaling $288,340, to Medicare. However, the majority of the projected overpayments found in the California statewide audit was from the fifth stratum and not recoverable based on our sampling method. Expanded separate reviews would be necessary for individual physicians and medical groups in the fifth stratum in order to recover the total projected overpayments in excess of the $1,858 found in our sample.

RECOMMENDATIONS

We recommend that CMS:

- Develop an education and monitoring program to reinforce the billing requirements for hemodialysis procedures,

- Determine if separate reviews for individual physicians or medical groups within the fifth stratum are cost effective, and, if so, perform additional reviews to recover the projected overpayments, and

- Initiate a recovery process for the $1,858 overpayment made to individual physicians and medical groups in the fifth stratum.

CMS COMMENTS

In a written response, dated January 4, 2002, to our draft report, the CMS stated that the findings in our report warranted further consideration by the California Carrier Medical Review area to validate the potential error, determine a level of concern and take appropriate administrative action. It also stated that all overpayments identified in our audit would be collected or offset as appropriate. CMS comments are included in their entirety in APPENDIX D.

OIG RESPONSE

Actions proposed by CMS address the recommendations of this report.

APPENDICES

SAMPLING METHODOLOGY

A stratified random sample was used for this review. Statistical sampling information is presented below.

POPULATION

We used the population of all inpatient hemodialysis procedure services (CPT 90935 and CPT 90937) that were provided by and paid to physicians for CY 1998 and 1999 for Medicare beneficiaries residing in State of California. The population does not include the hemodialysis services provided by individual physicians or a group of physicians (medical groups) that received less than $5,000 for CY 1998 and 1999 for the hemodialysis services. The population was extracted from National Claims History Files.

SAMPLE DESIGN

We stratified the population into five strata based on the total Medicare Part B payments made to individual physicians or medical groups. We identified the top four medical groups that received the most Medicare Part B payments for CY 1998 and 1999 as the first four strata. Stratum five was identified as all other individual physicians or medical groups that received at least $5,000 for hemodialysis services for CY 1998 and 1999.

Table 1 below shows the sample design for this review.

Strata Number	Number of Individual Physicians or Medical Groups	Count of Services	Total Medicare Part B Paid Amounts
1	1	8,168	$595,148
2	1	4,111	$542,996
3	1	5,646	$419,987
4	1	4,713	$380,596
5	329	232,202	$20,276,114
Total	333	254,840	$22,214,841

Table 1: Sample Design

We selected a stratified sample of 500 services with 100 services for each stratum. After completing the reviews for the top four medical groups, we issued each of them a report, which included a recommendation of refunding the overpayment made to them for CY 1998 and 1999 to the Medicare program. These overpayments were calculated using a lower limit of standard statistical method at 90 percent confidence level. We also completed the review of 100 services for Stratum five.

RESULTS OF SAMPLE

Table 2 below shows the results of our review.

Stratum Number	Number of Services	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	8,168	100	$7,360	21	$654
2	4,111	100	$13,245	72	$4,113
3	5,646	100	$7,356	59	$2,186
4	4,713	100	$8,177	6	$211
5	232,202	100	$8,567	38	$1,858
Total	254,840	500	$44,705	196	$9,022

Table 2: Results of Review

We projected the results of the statistical sample to the population using standard statistical methods and found that the point estimate was $4,669,396 with an upper limit of $5,796,905 and a lower limit of $3,541,886 at the 90 percent confidence level. We are 95 percent confident that at least $3,541,886 (or 16 percent) of the $22,214,841 paid to physicians for CY 1998 and 1999 was ineligible for Medicare reimbursement.

Stratum	Point Estimate	Upper Limit	Lower Limit
1	$53,441	$74,313	$32,568
2	$169,080	$186,595	$151,566
3	$123,448	$146,107	$100,788
4	$9,927	$16,435	$3,418
5	$4,313,500	$5,451,089	$3,175,911
Overall	**$4,669,396**	**$5,796,905**	**$3,541,886**

Table 3: Projection of Sample Results

APPENDIX B

BREAKDOWN OF 500 SERVICES BY CPT CODES PER STRATUM

Strata	1	2	3	4	5	Total
CPT 90935	100	6	100	100	87	393
CPT 90937	0	94	0	0	13	107
Total	**100**	**100**	**100**	**100**	**100**	**500**

Descriptions of CPT Codes:

CPT 90935 - Hemodialysis procedure with single physician evaluation.

CPT 90937 - Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription.

APPENDIX C

ANALYSIS OF AUDIT FINDINGS

Audit Findings	Strata 1		2		3		4		5		Total	
	Number of Services	Amount	Number of Services	Amount	Number of Services	Amount	Number of Services	Amount	Number of Services	Amount	Number of Services	Amount
Total Services Billed	100	$ 7,360	100	$ 13,245	100	$ 7,356	100	$ 8,177	100	$ 8,567	**500**	**$ 44,705**
PHYSICIAN'S PRESENCE NOT MET:												
Services Allowed as Subsequent Hospital Care Services	18	$ 435	1	$ 36	47	$ 1,304	6	$ 211	28	$ 1,135	**100**	**$ 3,121**
Services Allowed as CPT 90935			10	$ 580					5	$ 290	**15**	**$ 870**
Services Allowed as Other E & M Services	3	$ 219			8	$ 587			3	$ 270	**14**	**$ 1,076**
Services that Should Not Have Been Billed					4	$ 295			2	$ 163	**6**	**$ 458**
MEDICAL NECESSITY NOT MET:												
Services Allowed as CPT 90935			61	$ 3,497							**61**	**$ 3,497**
Total	**21**	**$ 654**	**72**	**$ 4,113**	**59**	**$ 2,186**	**6**	**$ 211**	**38**	**$ 1,858**	**196**	**$ 9,022**

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION IX

Memorandum

FILE COPY

Date January 4, 2002

From Elizabeth C. Abbott
Regional Administrator, Region IX
Centers for Medicare and Medicaid Services (CMS)

Subject Results of the California Statewide Audit of Inpatient Hemodialysis Procedure Services (A-09-01-00068)

To Lori A. Ahlstrand
Regional Inspector General for Audit Services
DHHS/OIG/OAS

This is in response to your letter dated November 21, 2001 in which you request our written comments regarding the U.S. Department of Health and Human Services (HHS), Office of Inspector General's draft report entitled, "The California Statewide Audit of Inpatient Hemodialysis Services."

The report states that your audit focused on physicians billing inpatient hemodialysis services to Medicare in CY 1998 and 1999 using CPT 90935 – Hemodialysis procedure with single physician evaluation, and CPT 90937 – Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription. The objective of your audit was to determine whether inpatient hemodialysis procedures provided by physicians to California beneficiaries during CY 1998 and 1999 were allowable and documented in the medical records in accordance with Medicare requirements.

The report findings state that of the 500-inpatient hemodialysis procedure services sampled, 135 services did not meet the Medicare requirement for documenting the physicians' presence during the hemodialysis procedure. In addition, 61 services did not meet the Medicare requirement for documenting the medical necessity for the physician's repeated evaluation of patients during the hemodialysis procedure. As a result, you are 95 percent confident that at least $3,541,886 (or 16 percent) of the $22,214,841 paid to physicians for CY 1998 and 1999 for these services was ineligible for Medicare reimbursement.

Overpayments occurred because some physicians:

Did not ensure that their presence during the hemodialysis procedure was documented in the medical records before billing Medicare for hemodialysis procedures, and

Did not ensure that the medical necessity for their repeated evaluation of patients during the hemodialysis procedures was documented in the medical records before billing Medicare for hemodialysis procedures with repeated evaluations.

The majority of the projected overpayment, $3,175,911 of the $3,541,886 overpayment, found in the California statewide audit was not recoverable based on your sampling method. Expanded separate reviews would be necessary to recover the total projected overpayments. The actual total overpayment for the 100-inpatient hemodialysis procedures reviewed in your sample of individual physicians and medical groups in the fifth stratum was $1,858.

The audit report recommendations for CMS are as follows:

- Develop an education and monitoring program to reinforce the billing requirements for hemodialysis procedures,

- Determine if separate reviews for individual physicians or medical groups within the fifth stratum are cost effective, and, if so, perform additional reviews to recover the projected overpayments, and

  Initiate a recovery process for the $1,858 overpayment made to individual physicians and medical groups in the fifth stratum.

The principles and approaches to be used in deciding how to deploy limited resources and tools for medical review are identified in Program Instructions and are as follows.

Data analysis is an essential first step in determining whether patterns of claims submission and payment indicate potential problems. Such data analysis may include patterns within claims that suggest improper billing or payment. Data analysis may be undertaken as part of general surveillance and review of submitted claims, or in response to specific information from independent government and nongovernment agencies and other sources.

Before deploying significant medical review resources to examine claims identified as potential problems from data analysis, the contractor must take the interim step of selecting a small "probe" sample (20 – 40 claims) of potential problem claims to validate the hypothesis that such claims are being billed in error. Contractors must consider factors such as total dollar value of the problem and past history of the provider and assess the problem as a minor, moderate or significant concern and use available resources to address the problem.

After validating that claims are being billed in error, the contractor must target medical review activities at providers or services that place the Medicare trust fund at the greatest risk while ensuring the level of review remains within the scope of the budget for medical review. This ensures that medical review activities are targeted at identified problem areas. Contractors must manage their medical review workloads within the constraints of their fiscal year budgets.

When a widespread problem is identified affecting a large number of providers, the contractor may solicit medical and specialty societies to help with educational efforts, develop new/revise Local Medical Review Policies (LMRP) if needed and/or issue bulletin articles clarifying existing National Coverage Policies (NCP) and LMRPs. When a problem is limited to a small group, the contractor may focus provider education with 1:1 contact through telephone contact, letter, or meeting.

When a limited problem is identified and the level of concern is minor (low error rate with no provider history of patterns of errors or few dollars improperly paid), the mandated activities of provider education and feedback and collection of actual overpayments may be sufficient. Reevaluation may be appropriate at a later date.

When there is a moderate level of concern (low error rate but total dollars improperly paid are substantial or a moderate error rate exists), prepayment medical review should be considered. The contractor will adjust or eliminate prepayment review according to provider response to actions taken.

A major level of concern (moderate error rate despite documented educational intervention or very high error rate, mitigating circumstances considered but supports need for stringent administrative action) should prompt stringent administrative action. The contractor may consider a high level of prepayment medical review and/or a statistically valid random sample projected to the universe, payment suspension, or referral to the fraud unit. Frequent feedback and provider education will be given to assure an understanding of the billing errors. Administrative actions will be adjusted or eliminated according to provider response to actions taken.

The findings presented in the report warrant further consideration by the California Carrier Medical Review area to validate the potential error, determine a level of concern and take appropriate administrative action. Provider education and feedback must be given at all levels of concern. All overpayments identified will be collected or offset as appropriate.

Please call me at 744-3501 if you would like to discuss this matter further. Should your staff have questions or wish to discuss the medical review process further, please contact MaryEllen Bruk at 744-3550.

Lucille Maloney

for Elizabeth C. Abbott