Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INPATIENT HEMODIALYSIS PROCEDURE SERVICES PROVIDED BY NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

JANET REHNQUIST
Inspector General

NOVEMBER 2001
CIN: A-09-01-00080

Office of Inspector General

http://www.hhs.gov/progorg/oig/

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DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

CIN: A-09-01 -00080

November 14, 2001

Dr. Joseph Lee
Nephrology Associates Medical Group, Inc.
4361 Latham St. Suite 150
Riverside, California 92501

Dear Dr. Lee:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Inpatient Hemodialysis Procedure Services Provided by Nephrology Associates Medical Group, Inc." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-23 1, OAS reports 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. (See 45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-09-01-00080 in all correspondence relating to this report.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. David Sayen
Associate Regional Administrator
Division of Financial Management
Centers for Medicare & Medicaid Services
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San Francisco, California 941053901

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INPATIENT HEMODIALYSIS PROCEDURE SERVICES PROVIDED BY NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

JANET REHNQUIST
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NOTICES

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at http://www.hhs.gov/progorg/oig/

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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

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
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50 United Nations Plaza, Room 171
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CIN: A-09-01-00080

November 14, 2001

Dr. Joseph Lee
Nephrology Associates Medical Group, Inc.
4361 Latham Street, Suite 150
Riverside, California 92501

Dear Dr. Lee:

The purpose of this report is to provide Nephrology Associates Medical Group, Inc. (Group) with the results of our audit of inpatient hemodialysis procedure services provided to Medicare beneficiaries by the Group in Calendar Years (CY) 1998 and 1999. The objective of our audit was to determine whether hemodialysis services provided by Group physicians to beneficiaries residing in the State of California were allowable and documented in the medical records in accordance with Medicare requirements.

We reviewed a random sample of 100 hemodialysis services to determine if they met the inpatient hospital place of service and the physician's presence requirements. We found that all 100 services met the Medicare requirement for inpatient hospital place of service. However, 59 services did not meet the Medicare requirement for documenting the physician's presence during the hemodialysis procedure. As a result, we estimate that, of the $419,987 paid to the Group for hemodialysis services in CY 1998 and 1999, at least $100,788 was unallowable for Medicare reimbursement.

These overpayments occurred because the Group did not have adequate controls in place to ensure that the physician's presence requirement was met and documented before billing hemodialysis services.

We recommend the Group:

1. Refund the overpayment of $100,788 to the Medicare program, and

2. Develop policies and procedures to ensure that the physician's presence requirement is met and documented in the medical records before billing the Medicare program for hemodialysis services.

In a written response to our draft report (see APPENDIX A), the Group did not concur with our findings. Nonetheless, the Group had taken several corrective actions including a review of Medicare rules and regulations for documentation of services and an appointment of compliance officers to develop guidelines for the Group physicians to comply with Medicare rules and regulations.

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, 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 CMS.

In our audit, we reviewed physician services provided to Medicare beneficiaries with renal failure 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.

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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 A[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].

[4] Peritoneal Dialysis is a process A[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] .

The Physician's Current Procedural Terminology (CPT)[5] includes the following codes for hemodialysis 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.

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

- The place of service to be at an inpatient hospital [MCM '15062.1.D], and
- 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].

In the June 1988 Medicare Bulletin, the Carrier[6] informed physicians of the presence requirement by stating, A[w]hen a physician bills Medicare for inpatient dialysis services, that billing must reflect the fact that **the physician was physically present with the patient at some time during the course of dialysis**. Hospital records **must** document the physician's presence during the dialysis.@

The Group, located in Riverside, California was incorporated on June 3, 1996. There were nine physicians practicing under the Group in CY 1998 and 1999.

OBJECTIVE, SCOPE AND METHODOLOGY

OBJECTIVE

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

[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.

[6] Blue Shield of California was the former Carrier, which handled Medicare billings for the area where the Group was located. National Heritage Insurance Company is the current Carrier for the State of California.

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, and
- The medical record documented the physician's presence with the patient during the hemodialysis procedure.

Our review of the Group=s 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 at the Group.

Our fieldwork, which included visits to hospitals in the Riverside, California area; the Carrier; and the Group's office in Riverside, California, was performed during the period May 2001 to August 2001.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- Reviewed the Medicare criteria related to hemodialysis services,
- Interviewed appropriate CMS and Carrier officials to obtain an understanding of how the hemodialysis services should be documented in the medical records,
- Identified the universe of Medicare Part B payments for CY 1998 and 1999 for the Group using the National Claims History Files (NCHF) for California beneficiaries,
- Selected a random sample of 100 hemodialysis services based on our approved sampling plan,
- Reviewed all other services provided to beneficiaries associated with the 100 services and determined if additional Evaluation and Management (E & M)[7] services were paid to the same physician who received the payment for hemodialysis services,
- Interviewed dialysis nurses to obtain an understanding of how physicians care for patients during the hemodialysis procedure,

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

- Interviewed Group officials 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 universe.

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

FINDINGS AND RECOMMENDATIONS

The audit included a review of a random sample of 100 hemodialysis services to determine if the services met the inpatient hospital place of service and the physician's presence requirement as stated in the MCM. We found that all 100 services met the inpatient hospital place of service requirements. However, 59 services did not meet the Medicare requirement for documenting the physician's presence. For these 59 services, the Group billed and was paid for hemodialysis services even though the documentation in the medical records did not support the physician's presence during the hemodialysis procedure. As a result, we determined that, of the $7,356 Medicare payments reviewed, $2,186 was unallowable. We projected the results of the statistical sample to the population using standard statistical methods, and estimated that at least $100,788 of the $419,987 paid to the Group for CY 1998 and 1999 were ineligible for Medicare reimbursement. These overpayments occurred because the Group did not have adequate controls in place to ensure that the physician's presence requirement was met and documented before billing hemodialysis services.

PHYSICIAN PRESENCE

We determined that 59 of the 100 services reviewed did not have sufficient documentation to support the physician's presence during the hemodialysis procedure. Of the 59 services, we determined that:

- 47 services would be allowable as subsequent hospital care,

- 8 services would be allowable as initial hospital care, initial inpatient consultation, or hospital discharge day management services if not already billed, and

- 4 services should not have been billed.

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 in order to be paid for the hemodialysis service. It also states that:

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

As stated in the Methodology section, for the 59 services that lacked documentation to support the physician's presence, we consulted with the Carrier medical review staff to determine appropriate hospital visit codes.

For the 59 services that lacked documentation to support the physician's presence, we determined that 47 services would be allowable as subsequent hospital care services. Because payments for hemodialysis services are higher than those for subsequent hospital care, the Group received an overpayment, representing the difference between the payments for hemodialysis services and subsequent hospital care services. The following example illustrates the calculation of the overpayment for one service reviewed.

The physician billed a hemodialysis service (CPT 90935) and received a payment of $71.66. A review of the documentation in the medical records revealed that the physician's presence during the hemodialysis procedure was not documented. We determined that the documentation supported only a subsequent hospital care service (CPT 99231) for which the payment would have been $29.18.

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

Hemodialysis service……..	$71.66 (Paid)
Subsequent hospital care service……	29.18 (Allowed)
Unallowable ……	$42.48

For the 59 services that lacked documentation to support the physician's presence, we determined that 8 services would be allowable as initial hospital care, initial inpatient consultation, or hospital discharge day management services. However, the Group had already billed and received Medicare

payments for the appropriate service for the same day when hemodialysis services were provided. Therefore, we disallowed the total payments for hemodialysis services.

For the 59 services that lacked documentation to support the physician's presence, we determined that 4 services should not have been billed to the Medicare program. These services were billed without any documentation that the physicians had ever visited the patient on the day of service. Therefore, we disallowed the total payments for hemodialysis services.

The Group received a total overpayment of $2,186 for these 59 sample items by billing hemodialysis services when documentation did not support the physician's presence during the hemodialysis procedure services. Details on our findings are presented in APPENDIX C.

These overpayments occurred because the Group did not have adequate controls in place to ensure that the physician's presence requirement was met and documented before billing hemodialysis services.

RECOMMENDATIONS

We recommend the Group:

1. Refund the overpayment of $100,788 to the Medicare program, and

2. Develop policies and procedures to ensure that the physician's presence requirement is met and documented in the medical records before billing the Medicare program for hemodialysis services.

GROUP COMMENTS AND OIG RESPONSES

In written responses, dated October 8, 2001 and October 7, 2001, (see APPENDIX A) to our draft report, the Group indicated that it was taking the following actions:

1. Holding a meeting with the Group physicians to review Medicare guidelines for documenting their services in compliance with the Medicare rules and regulations,

2. Appointing two compliance officers to develop guidelines for the Group physicians to maintain compliance with the Medicare rules and regulations, and

3. Sharing our audit findings with the company that provides dialysis services to the Group's patients and requesting the dialysis company notify the Group physicians of hemodialysis treatment schedules so that they could be present during the procedures.

Although the Group has taken corrective actions on our recommendations, it disagreed with the findings stated in our draft report. The Group's comments are summarized below and included as APPENDIX A.

Group Comment #1

The medical group stated that the OIG's interviews with the dialysis company's nurses revealed that physicians were present over 70 percent of the time during hemodialysis procedures. Also, in 1998 and 1999 the medical group had a "hospitalist" system, which allowed one physician to care for all patients at one hospital. This designated physician did not have any responsibility outside of caring for patients at that hospital all day long. Therefore, this system would have allowed the designated physician to be available for patients during the hemodialysis procedure. The OIG should consider the dialysis nurses' oral statements and the "hospitalist" system to substantiate the services billed, thereby, reducing the number of disallowed services.

OIG Response

Although dialysis nurses, during interviews, stated that most of the medial group physicians were probably present during the hemodialysis procedure, we could not find any documentation in the medical records to support the physician's presence during the procedure. The dialysis nurses testified based on their memory, but not based on any acceptable documentation.

The "hospitalist" system existed at only two hospitals (Riverside Community Hospital and Parkview Hospital). Also, having the "hospitalist" system cannot substitute for the Medicare documentation requirement of physician's presence during the hemodialysis procedure.

The Carrier medical review staff reviewed all 59 services and the supporting medical records which included at minimum, the discharge summaries, physicians' progress notes, the dialysis nurses' treatment records, and the hospital staff nurses' notes. However, the Carrier found no support for the physicians' presence during the hemodialysis procedures. Unless the physician's presence during the hemodiaysis procedures was documented in the medical records, we could not be certain whether the physician was present. As the Carrier (National Heritage Insurance Company) informed providers in its March 1997 Medicare Part B Bulletin, "[e]ach entry [in the medical records] must be able to 'stand-alone.' In other words, it must support the fact that the level of service billed was rendered. Because the medical records did not support the services billed, we could not rely solely on the dialysis nurses' oral statements and the "hospitalist" system, which were not part of the medical records, and allow the services as billed.

Group Comment #2

The medical group indicated that the hemodialysis treatment record used by the dialysis nurses only allowed a space at the bottom of the record for physicians to sign. In addition, some dialysis nurses did not allow physicians to sign in the middle of the treatment record, where the time of a physician's visit could have been documented to support the services billed. When physicians saw patients during the hemodialysis procedure, they were forced to sign at the bottom of the treatment record. Therefore, the signature at the bottom of the hemodialysis treatment record could be a valid documentation to support the physician's presence during the hemodialysis procedure.

OIG Response

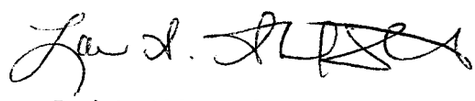
Of the 59 services disallowed, we found only 24 services with a signature at the bottom of the treatment record. The remaining 35 services did not have a signature anywhere on the treatment record.

The Carrier medical review staff stated that the signature alone at the bottom of the treatment record could not be a valid support for the physician's presence because physicians could have signed it at any time. The Carrier also stated that the content of physician's progress notes of the 59 disallowed services reflected that they appeared to have been written before or after the procedures were performed. The Carrier medical review staff allowed some services based on physician's progress notes if they appeared to be written during the hemodialysis procedures even though the signatures appeared at the bottom of the treatment record. As stated above, the March 1997 Medicare Part B Bulletin required that each entry in the medical records must be able to stand-alone. We believe that the signature alone at the bottom of the treatment record could not be a stand-alone entry to support the fact that the service billed was rendered.

In addition, it would be the billing physicians, not the dialysis nurses, who were responsible to document their presence and services in the medical records before billing Medicare. The billing physicians could have written their own progress notes documenting their services, which would have been accepted as support for the services billed to Medicare.

To facilitate identification, please refer to Common Identification Number A-09-01-00080 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

APPENDICES

Nephrology Associates Medical Group, Inc.

October 8, 2001
CIN: A-09-0 I-00080

Lori A. Ahlstrand
Office of Inspector General, Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Ms. Ahlstrand:

Nephrology Associates Medical Group has reviewed your recommendations of 9/5/01 regarding alleged "overpayment" by the Medicare program to us for provision of physician services CPT 90935 & 90937 and are disappointed in these recommendations.

By your methodology, you identified 59 of 100 records out of compliance with your guidelines for documenting physician presence during these procedures. Accordingly 59% of these procedures were down coded to a lower lever of service (payment). However, your interviews with multiple dialysis nurses documented our presence in over 70% of the procedures. This should have lowered your "adjustment" by at least 50%. Moreover your assessment does not take into account the role of Davita as the technical provider of these services. As you acknowledged, the run sheet's space for signatures is at the bottom of the page and does not provide for timing. In fact, dialysis nurses often refused to allow us to record our presence in the timed portion of the dialysis run. Furthermore, Davita is neither owned nor controlled by us. It is a national, publicly traded corporation that manages the acute dialysis services as part of a comprehensive dialysis program. As such, we have little influence over them regarding how they choose to document their care. In fact we have had multiple meetings with them to better manage this service to include better documentation procedures, adequate staffing of acute services, and paged notifications of initiation of dialysis procedures. As you may be aware, Davita like all other healthcare providers has experienced a nursing shortage, which has resulted in increased problems in scheduling timely dialysis procedures. These staffing problems of the technical provider of dialysis services made it very problematic for us to be present during these treatments at often odd hours. To improve our efficiency and presence, we described our program of "hospitalist" nephrology services (in our busiest hospitals) to you. Nonetheless this was not acknowledged in your report.

In summary Nephrology Associates Medical Group does not concur with your recommendations but does acknowledge some documentation deficiencies by us in meeting Centers for Medicaid Services (CMS) guidelines. With respect to corrective actions, we have done the following:

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850 [illegible] #D Hemet, CA 92543 (FAX) 652-3547
[illegible] Moreno Valley, CA 92555 (FAX) 485-2190
[illegible] Riverside, CA 92501 (909) 274-0888 FAX 274-9249
35243 Inland Valley #170 Wildomar, CA 92595 (909) 600-7830 FAX 600-7164

1. Met with all individual MD's and reviewed CMS guidelines for documentation and encouraged them to be compliant with these directives.

2. Shared you findings with Davita and notified them of our expectations for notification of dialysis procedures (i.e. scheduled and actual time of treatment) initiation.

3. Installed two compliance officers to develop guidelines for Nephrology Associates Medical Group to maintain compliance with MCS on all CPT coding guidelines.

Our intention and expectation is to provide high quality Nephrology care to our patients. We expect to be paid for appropriate services rendered. Clearly, we have not abused this and as such we have collectively billed a very low CPT 90937 incidence (< 1% compared to 10 – 20% nationally). Your recommendations seem to penalize us exceedingly for sloppy documentation and not recognized either the scope of this documentation problem nor our intention to bill appropriately.

Sincerely,

John A. Robertson, M.D.
Nephrology Associates Medical Group

JAR\yr

c.c. Jessica Kim

Nephrology Associates Medical Group, Inc.

October 7, 2001

Lori A. Ahlstrand
Office of Inspector General, Region IX
Office of Audit Services
50 United Nations Plaza, Room 17 1
San Francisco. CA 94 102

Dear Ms. Ahlstrand:

Thank for your recent letter. Since your visit, our group has conducted several meetings and undertaken many steps and actions aiming toward the implementation of a compliant program according to Medicare guidelines. Here is what has been done:

1. For Individual Phvsician-Re -education and emphasis, follow up with audit result, informed of the signature on the run sheet, not at the bottom.
2. Approach from Our Patient Care **Deliverv** Svstem Standpoint-

- Meeting with Acute Dialysis Coordinator and Nursing Director for communication and making of necessary change.
- A voice mail has been added to each nephrologist's pager; Dialysis Nurse will use voice mail to inform nephrologists directly when their patients are on dialysis treatment.
- Six new Acute Dialysis Nurse had been hired since June; they are done with training and are ready for Acute Program now. The addition of nurses will eliminate the delay, changing of schedule and cancellation, which has been the real problem of compliance for nephrologists.
- Two Compliance Officers had been installed and will start auditing according to OIG guideline.
- Attendance of a lecture given by a certified biller and coder, regarding coding and compliance, the information and material will disseminated to all (see Exhibit A). (Despite of recent announcement by Secretary Thorny Thomson)
- We are also reading Journal of Health Care Compliance to obtain update and expert opinion on this subject. (See Exhibit A)
- Continue to implement our Hospitalist System, which allows one physician to work only in one hospital without divided attention (relieved of his or her duty such as outpatient or dialysis round). This makes "examining the patient on dialysis" very easy, and possible; the physician is available in the hospital for patient's care all day iong.

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- Physician did re-education for the Dialysis Nurse regarding the documentation of physician's presence while he or she examines the patient during dialysis, and to allow a space for the signature. (In the past this is often rejected by the nurse based on hospital's documentation guideline)

We do want to explain the following facts, which will help you understand the infrastructure of acute dialysis team and its detailed interaction between the players in the team.

Acute Dialysis Team--- It is own and run by DaVita (a public trade company), serving 12 hospitals among 13 nephrologists (9 are in our group and 4 from other unrelated nephrologists). anytime, there are about SO hospitalized dialysis patients (see Exhibit B), there are three acute dialysis nurses on call every night among a total force of about 15 nurses. (During last three years there was constant shortage of acute nurses, much more so than in the whole health care industry because working hours and conditions). We as practicing nephrologists, have no direct influence over the administrative aspect of the team.

We are not surprised that you have found the status of under charge on 90937, only 10 cases of 90937 out of 5,646 total dialysis treatment (which is merely 0.17% only) we have charged during the last two years when compared to national average of 15-20% (from Renal Physician Association data). This reflects our very conservative and careful approach in the reimbursement approach.

Conceding that we were not able to be 100% compliant on the audit cases according to Medicare guideline according to the criteria set up by the Carrier and yourself According to Medicare rule, a nephrologist must examine the patient during dialysis treatment with documentation; our group had felt this is important all along and had implemented "hospitalist system" in 1996. Under this system, typically, one of our nephrologists stays and works at one hospital only, which is his or her job for that day or week. The intent is that he or she bears no other responsibility so as to allow he or she to be available all day in one place with undivided attention-- no need to travel, no need to visit outpatient dialysis unit or see outpatient clinical patients. The only job for him or her is to attend all hospitalized patients in one place all day long. (Exhibit B) He or she should be able to see all the in-hospital patients between 7 am to 6 pm when dialysis patients are supposed to be undergoing dialysis treatment; and if the dialysis treatments are done during these hours, given adequate nurses and enough machines, then theoretically nephrologist should be able to examine all in-hospital patients while being on dialysis treatment. But his or her ability to meet compliance unfortunately heavily depends on many other constraint factors that he or she totally has no control with, such as:

- Number of the dialysis machine available-Often inadequate machines will push the dialysis treatment delivered at unreasonable hours.

- Machine usability! its maintenance-often, a patient is to be run at certain hour. then machine broke, the run time is therefore pushed back to unknown hour.
- Dialysis nurses availability-sick time, overwork, stress and severe nursing shortage last few years too. Often not enough nurses are available for the job demanded. Rather than 8 nurses run 16 patients in two shifts, now 4 nurses run 16 patients with each one doing 4 patients, which will extend dialysis hours into midnight. Considering they are on call every three night and routinely they work through the night. Many nurses left since they were burnout.
- Others-such as dialysis treatment has to wait for other procedures including X ray, cardiac cauterizations, physical therapy, procedures, dialysis access insertion, and surgery.
- Availability of hospital bed while patient is waiting to be admitted to medical floor since Emergency Room does not allow the dialysis treatment to be done there.
- Often emergent cases arises which mandates total change of routine schedule. (Exhibit C), sometime many times a day.
- Availability of acute dialysis coordinator and his or her effectiveness as to inform and update the change of schedule to nephrology's and be available for inquiry when often, nephrologist found out change of schedule by surprise-the communication was very primitive during 1998- 1999.
- Dialysis nurse needs to remember the documentation on the chart.

When patient is not seen during dialysis treatment, patients are examined thoroughly and orders are written specifically for dialysis treatment during the day. Thus, with total availability and commitment to reasonable working hours (7am-6pm), we believe we have exercised every reasonable, prudent attempt and effort to take good care of patients and examine the patient while they are on dialysis. (In reality, dialysis treatment typically perfonned from 8am to 12 noon, then second shift starts at Ipm through 5pm. If this is what was being done, nephrologist should not have problem examining the patients during the treatment at all.). I am confident above fact can be substantiated by statement of our acute dialysis nurses, by hospital unit secretaries or acute dialysis coordinator. Therefore, the fact and evidence clearly support the conclusion that it would be unconscionable to hold that no documentation or wrong place of signature constitutes a noncompliance on nephrologist part, as to be penalized.

May I again describe and emphasize how we did the documentation routinely during 1998 thru 1999 concerning the documentation of visit when examining patient during dialysis treatment. As hospital had asked nurses to leave no space on the chart for legal concern, our Dialysis nurses therefore did not let us have our signature on the space where they entered the note, instead, we signed under their signature at the bottom of the run sheet. That was the way we had documented. We are in strong disagreement with the allegation that the signature at the bottom of the run sheet does not represent valid documentation of our involvement during patient's dialysis treatment.

This allegation by the Carrier that "signature at the bottom of the dialysis record likely reflects that nephrologist not present during dialysis treatment" may be true for nephrologists who have to see outpatient dialysis patients, in-hospital patients among many hospitals and outpatient clinic on a daily basis However our fully integrated and coordinated system discussed hereinabove represents a different spectrum. Our physician is totally available for dialysis treatment during reasonable hours, sick patients are frequently seen many times (without charging 90937)

Medicare guideline dictates that 90935 be charged when nephrologist is present during dialysis treatment with documentation. But the criteria and its detailed implementation guideline for documentation is overbroad and imprecise, if not lacking, as to constitute a standard for easy compliance; plus it lacks the expressed appreciation of the need to have total cooperation of acute dialysis nurse to document too. Besides, since documentation (signature on hemodialysis run sheet) is only a surrogate of a physician's involvement in the treatment process, I believe the purpose and intent of Medicare guideline which dictates that a physician must examine his or her patient while patient is on hemodialysis so as to be considered a standard treatment and constitutes a procedure, must not be overshadowed by the merely arbitrary, unilateral argument on where the physician's signature should be, disregarding the overwhelming demonstration of a physician's total availability or Dialysis Nurse's testimony and other objective factors. Strictly speaking, the burden of proof does not rest on us. One needs also take into consideration that the testimony by our three dialysis nurses upon your subpoena provides much more reliable surrogate of our presence during the patient's dialysis treatment.

I sincerely hope that you will share the information with Carrier, since they may not have the necessary information to allow a better and more accurate assessment of the audit result. We feel strongly that we have much better compliance than you had stated and we are very proud that we had gone through lots of effort in setting up this very reliable infrastructure for better renal health care delivery.

We found ourselves unable to agree with your conclusion of 40% compliance. Substantial evidence tends to support beyond a reasonable doubt that we have made maxima1 effort and are better than stated.

I humbly submit that you will reconsider the result of the audit based on the evidence hereinabove. A reasonable reconsideration must be contemplated since Medicare guideline is to overbroad and expressly insufficient for easy acceptance and compliance. I hope you have derived a conclusion as we do that Nephrologist Associates have created an infrastructure most feasible to be compliant with Medicare regulation, but to penalize for reason and cause that is beyond our control might appear to be deviation from Medicare's original intent and is therefore, unreasonable, and may be non- enforceable. Therefore, I thought it is more reasonable to allow 90 % compliance since 70% is what the nurse have testified, and allow us extra 20% for our maximal effort, attempt and other factors beyond our control.

I plan to call you next week and request a meeting with you and the panel in person to discuss this matter further.

Sincerely Yours,

Joseph Lee M.D., M.B.A.

ENCLOSED:

1 . EXHIBITA—

- The information obtained from magazine and lecture from certified billing and coder.

2. EXIHIBIT B—

- Acute Dialysis Run sheet compared to Nephrologist's schedule of the day. This is the evidence that Hospitalist Nephrologist only had duty in the hospital for that day.
- Many of the handwriting on the Run sheet represents changing schedule.
- Run sheet also demonstrates one nephrologist, one hospital policy.

3. EXHIBIT C---

- The log of Acute Dialysis Treatment based on Diagnosis and Emergency Status. This shows 38.4% of All Dialysis Treatment is on Emergent Basis.

OIG Note.

Exhibits A through C attached to the October 7, 2001, response letter contain information exempted by the Freedom of Information Act (See 45 CFR Part 5). Therefore, they are not included as a part of this final report. These Exhibits have been forwarded to the action official under a separate cover.

APPENDIX B

NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

STATISTICAL SAMPLING METHODOLOGY

POPULATION		SAMPLE		ERRORS	
Items:	5,646	Items:	100	Items:	59
Payments:	$419,987	Payments:	$7,356	Payments:	$2,186

PROJECTION OF SAMPLE RESULTS
At the 90 Percent Confidence Level

Point Estimate:	$123,448
Lower Limit:	$100,788
Upper Limit:	$146,107

NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

Sample Number	Billed CPT[7]	Audited CPT[8]	Paid Amount[9]	(Audited Amount"	Difference (Paid-Audited)
1	**90935**	99231	$71.66	$29.18	$42.48
2	90935	99232	$71.66	$43.89	$27.77
3	90935	99232	$76.22	$43.38	$32.84
4	90935	90935	$71.66	$71.66	$0.00
5	90935	90935	$76.22	$76.22	$0.00
6	90935	99232	$71.66	$43.89	$27.77
7	90935	90935	$71.66	$71.66	$0.00
8	90935	None	$71.66	$0.00	$71.66
9	90935	99232	$76.22	$43.38	$32.84
10	90935	99232	$71.66	$43.89	$27.77
11	90935	90935	$71.66	$71.66	$0.00
12	90935	99231	$76.22	$29.63	$46.59
13	90935	99232	$71.66	$43.89	$27.77
14	90935	99232	$71.66	$43.89	$27.77
15	90935	99232	$76.22	$43.38	$32.84
16	90935	99232	$71.66	$43.89	$27.77
17	90935	None	$71.66	$0.00	$71.66
18	90935	99233	$76.22	$60.40	$15.82
19	90935	90935	$71.66	$71.66	$0.00
20	90935	None	$76.22	$0.00	$76.22
21	90935	99233	$76.22	$60.40	$15.82
22	90935	99233	$76.22	$60.40	$15.82
23	90935	90935	$71.66	$71.66	$0.00
24	90935	99233	$71.66	$61.47	$10.19
25	90935	90935	$71.66	$71.66	$0.00
26	90935	99233	$76.22	$60.40	$15.821

[7]The term "Billed CPT" denotes the CPT code, which was originally billed by and paid to the Group,

[8]The term "Audited CPT" denotes the CPT code allowed during our audit.

[9]The term "Paid Amount" denotes the amount paid by Medicare Part B.

[10]The term "Audited Amount" denotes the amount allowed during our audit.

NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

Sample Number	Billed CPT	Audited CPT	Paid Amount	Audited Amount	Difference (Paid – Audited)
27	90935	90935	$71.66	$71.66	$0.00
28	90935	99232	$71.66	$43.89	$27.77
29	90935	None	$71.66	$0.00	$71.66
30	90935	90935	$76.22	$76.22	$0.00
31	90935	None	$76.22	$0.00	$76.22
32	90935	99233	$76.22	$60.40	$15.82
33	90935	90935	$76.22	$76.22	$0.00
34	90935	90935	$71.66	$71.66	$0.00
35	90935	99232	$71.66	$43.89	$27.77
36	90935	90935	$71.66	$71.66	$0.00
37	90935	99232	$76.22	$43.38	$32.84
38	90935	90935	$76.22	$76.22	$0.00
39	90935	None	$76.22	$0.00	$76.22
40	90935	None	$71.66	$0.00	$71.66
41	90935	99233	$76.22	$60.40	$15.82
42	90935	90935	$71.66	$71.66	$0.00
43	90935	99231	$76.22	$29.63	$46.59
44	90935	90935	$71.66	$71.66	$0.00
45	90935	99233	$76.22	$60.40	$15.82
46	90935	90935	$76.22	$76.22	$0.00
47	90935	90935	$76.22	$76.22	$0.00
48	90935	90935	$71.66	$71.66	**$0.00**
49	**90935**	**90935**	$76.22	$76.22	$0.00
50	90935	99233	$71.66	$61.47	$10.19
51	90935	99232	$71.66	$43.89	$27.77
52	90935	None	$71.66	$0.00	$71.66
53	90935	90935	$71.66	$71.66	$0.00
54	90935	99233	$71.66	$61.47	$10.19
55	90935	90935	$76.22	$76.22	$0.00
56	90935	90935	$39.78	$39.78	$0.00
57	90935	90935	$76.22	$76.22	$0.00
58	90935	None	$76.22	$0.00	$76.22
59	90935	99232	$76.22	$43.38	$32.84
60	90935	None	$71.66	$0.00	$71.66

NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

Sample Number	Billed CPT	Audited CPT	Paid Amonn t	Audited Amount	Difference (Paid – Audited)
61	90935	99232	$76.22:	$43.38:	$32.84
62	90935	90935	$76.22:	$76.22:	$0.00
63	90935	90935	$71.66;	$71.66;	$0.00
64	90935	None	$76.22	$0.00	$76.22
65	90935	99232	$76.22:	$43.38	$32.84
66	90935	90935	$76.22:	$76.22:	$0.00
67	90935	90935	$76.22:	$76.22:	$0.00
68	90935	99231	$71.66:	$29.18:	$42.48
69	90935	99231	$71.66:	$29.18:	$42.48
70	90935	99233	$76.22:	$60.401	$15.82
71	90935	99232	$76.22:	$43.38:	$32.84
72	90935	90935	$76.22:	$76.22:	$0.00
73	90935	90935	$76.22:	$76.22:	$0.00
74	90935	99232	$71.66:	$43.89:	$27.77
75	90935	90935	$71.66:	$71.66:	$0.00
76	90935	90935	$71.66:	$71.66:	$0.00
77	90935	99233	$76.22;	$60.40:	$15.82
78	90935	99231	$76.22:	$29.63:	$46.59
79	90935	None	$71.66:	$0.00:	$71.66
80	90935	90935	$65.50:	$65.50:	$0.00
81	90935	90935	$76.221	$76.22:	$0.00
82	90935	99232	$71.66:	$43.89:	$27.7 7
83	90935	99233	$71.66:	$6 1.47:	$10.19
84	90935	99231	$76.22:	$29.63:	$46.59
85	90935	99232	$71.66:	$43.89:	$27.77
86	90935	99232	$71.66:	$43.89:	$27.77
87	90935	90935	$71.66:	$71.66;	$0.00
88	90935	99231	$76.22:	$29.63:	$46.59
89	90935	99233	$71.66:	$6 1.47:	$10.19
90	90935	90935	$76.22:	$76.22:	$0.00
91	90935	99232	$76.22;	$43.38:	$32.84
92	90935	90935	$76.22:	$76.22:	$0.00
93	90935	99232	$71.66:	$43.89:	$27.77
94	90935	99232	$76.22:	$43.38:	$32.84

NEPHROLOGY ASSOCIATES MEDICAL GROUP, INC.

Sample Number	Billed CPT	Audited CPT	Paid Amount	Audited Amount	Difference (Paid-Audited)
95	90935	90935	$76.22	$76.22	$0.00
96	**90935**	**90935**	$71.66	$71.66	$0.00
97	90935	90935	$76.22	$76.22	$0.00
98	90935	90935	$71.66	$71.66	$0.00
99	90935	90935	$76.22	$76.22	$0.00
100	90935	99232	$76.22	$43.38	$32.84
Totals			**$7,355.96**	**$5,169.50**	**$2,186.46**