Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region IX

AUDIT OF MEDICARE PART B SERVICES BILLED BY INLAND PHYSICIANS' SERVICE FOR THE PERIOD JANUARY 1, 1994 THROUGH DECEMBER 31, 1996

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 recomendations 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 operating divisions.

JUNE GIBBS BROWN
Inspector General

JULY 1998
CIN: A-09-97-00062

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

JUL 16 1998

CIN: A-09-97-00062

Mr. Ed Velasco
Manager
Medicare Audit
Transamerica Occidental Life
Insurance Company
1150 South Olive, T200
Los Angeles, California 90015-2211

Dear Mr. Velasco:

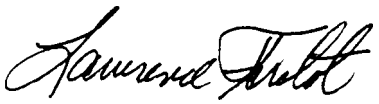
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services (OAS) report entitled 'AUDIT OF MEDICARE PART B SERVICES BILLED BY INLAND PHYSICIANS' SERVICE FOR THE PERIOD JANUARY 1, 1994 THROUGH DECEMBER 31, 1996." A copy of this report will be forwarded to the action official noted below for her 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 (Public Law 90-23), OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and 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.)

To facilitate identification, please refer to Common Identification Number A-09-97-00062 in all correspondence relating to this report.

Sincerely yours,



Lawrence Frelot
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Mrs. Alysson Blake
Associate Regional Administrator for Medicare
Health Care Financing Administration
Region IX
75 Hawthorne Street, 4th floor
San Francisco, CA 94105

EXECUTIVE SUMMARY

BACKGROUND

This audit was an outgrowth of Operation Restore Trust, a U.S. Department of Health and Human Services initiative to combat fraud, waste, and abuse in the Medicare program. The review was jointly conducted by the OIG and Transamerica Occidental Life Insurance Company (Transamerica), a Medicare carrier.

Inland Physicians' Service (IPS) is a group medical practice (a partnership of two Doctors of Osteopathy) which primarily provides services to elderly Medicare patients in nursing facilities and hospitals in the Pomona, California area.

OBJECTIVE

Our audit examined the Medicare payments (about $2 million) made to IPS by Transamerica over the 3-year period January 1, 1994 through December 31, 1996 to determine if the payments were appropriate for the services rendered.

SUMMARY OF FINDINGS

With the assistance of Transamerica's medical consultant, we reviewed a statistical sample of 100 claim lines (representing 104 services) for which IPS was reimbursed by Medicare. Our combined review disclosed that 99 of the 100 claim lines represented services which had been overpaid.

The overpayments included services which:

- Had been billed using numeric coding descriptors (i.e., procedure codes) that described services more complex than those actually performed (a condition commonly referred to as upcoding),
- Were not supported by adequate documentation in the medical records,
- Should have been paid at lower amounts because the services were rendered in different geographic areas, and
- Had been performed by physician assistants without the supervising physician present and, therefore, were subject to lower reimbursement.

Sixty-six of the 99 claim lines that were overpaid had more than one reason for the overpayments. We have included a matrix (see Appendix A) that depicts the various reasons that contributed to the overpayments for each sample item.

Based on the results of our statistical sample, we estimate that IPS was overpaid $752,256. We are 95 percent confident that the overpayment was at least $581,379.

We concluded that the overpayments occurred because the IPS physicians were apparently not familiar with the various Medicare reimbursement rules. From all appearances, they had not availed themselves of Medicare's published instructions nor had they sought the carrier's assistance in determining the proper billing requirements.

RECOMMENDATIONS

To address these problems, we recommend that Transamerica:

(1) Provide IPS with all pertinent educational materials related to Medicare rules and regulations,

(2) Require that IPS obtain additional provider numbers corresponding to the various geographic areas in which it renders services,

(3) Place IPS under prepayment review until it can demonstrate that it can properly bill for services,

(4) Conduct an audit of IPS billings for Calendar Year 1997, and

(5) Not recover the ldentified overpayment of $581,379 at this time pending further review by our office.

In response to our draft report, IPS disagreed with the audit findings. After reviewing and considering IPS comments, we concluded that our findings remain valid.

Transamerica was in agreement with the findings and recommendations.

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INTRODUCTION

Background

In May 1995, the Department of Health and Human Services began a demonstration project, known as Operation Restore Trust, to crack down on Medicare fraud, waste, and abuse associated with nursing homes, home health agencies, and durable medical equipment suppliers. This audit was an outgrowth of that demonstration project.

We looked at physicians in California who billed for services rendered to patients in nursing homes. We selected Inland Physicians' Service (IPS), a partnership created by two physicians, for this review because one of its doctors had aberrant billing patterns for nursing home visits when compared with other physicians in California.

Two doctors of osteopathic medicine formed this medical practice in August 1993. Osteopathy is a school of medicine and surgery that places special emphasis on the interrelationship of the musculoskeletal system to all other body systems. The physicians originally organized IPS as a corporation but changed it to a partnership in 1995. They primarily provide medical services: (1) to elderly patients in nursing facilities and hospitals in and around the Pomona, California area, and (2) to health maintenance organization patients in a medical office in Chino Hills, California.

At the time of our audit, the doctors employed a staff of 12, consisting of 3 physician assistants (PAs), 3 medical assistants, and 6 administrative personnel. They billed Medicare by submitting claims to Transamerica Occidental Life Insurance Company (Transamerica), a Medicare carrier, using the IPS Medicare billing name and number for services rendered to Medicare patients in nursing facilities and hospitals. A carrier is a private company, usually an existing insurance company, that contracts with the Federal Government to process and pay Medicare claims.

The doctors also billed Medicare using two other names and numbers (Inland Region Medical Group and Inland Hills Medical Group) for services provided at the medical office location. The services provided at the medical office location were billed to Blue Shield, another Medicare carrier, or National Heritage Insurance Company (NHIC), the new carrier effective December 1, 1996.

For a 3-year period, January 1, 1994 through December 31, 1996, Transamerica paid IPS $1,966,305 and Blue Shield/NHIC paid Inland Region Medical Group and Inland Hills Medical Group $48,097.

Medicare regulations require that patients residing in nursing facilities must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Medicare reimbursement can be made for one physician visit per month to the same patient in a nursing home on the presumption that such a visit is medically necessary. Further visits are reimbursable only in situations where the physician has adequately substantiated the need for more frequent visits (e.g., an episode of acute illness) to that patient.

Objectives, Scope and Methodology

We conducted our audit in accordance with generally accepted government auditing standards. Our objective was to determine if Transamerica's payment was appropriate for the services rendered.

To accomplish this objective, we reviewed a statistical sample of 100 claim lines (representing 104 services because 1 claim line was a billing for 5 separate services) from the universe of all claim lines paid by Transamerica to IPS over the 3-year period ended December 31, 1996. We did not include Medicare's payments made by Blue Shield (or NHIC) to Inland Region Medical Group and Inland Hills Medical Group in our audit scope. Appendix B presents the details of our random sampling methodology.

We obtained copies of the pertinent medical records from the patients' medical files located at the nursing facilities and hospitals. The documentation gathered included, when available: (1) patients' admission sheets, (2) history and physical examination notes, (3) physicians' progress notes, (4) physicians' orders, (5) licensed personnel progress notes, (6) lab reports, (7) consultation reports, and (8) physicians' discharge notes.

In 10 instances, we could not find adequate documentation relating to the billed services at the facilities. For these cases, we requested that IPS locate and provide us with any documentation that would support the services billed. The IPS physicians provided us with additional documentation for 5 of the 10 services.

From Transamerica and NHIC, we obtained histories of all Medicare services billed on behalf of the patients within a l-month period before and after the date of service for each selected claim

line. We also obtained copies of the original claim forms submitted by IPS.

At our request, a physician consultant at Transamerica reviewed the medical records we obtained to determine whether they supported the services billed. The consultant looked at whether the services were medically necessary and whether they were billed using the correct descriptive code.

We also interviewed the physician owners of IPS, medical nursing staff at some of the facilities, one of the PAs, and the IPS billing agent. In addition, we consulted with Transamerica and NHIC staff about Medicare's rules.

We did not test IPS internal controls over its billings of claims to Medicare because the objective of our review was accomplished through substantive testing.

Our fieldwork was performed from July 1997 to December 1997 at various nursing facilities and hospitals where the services were rendered and at the business office of IPS.

FINDINGS AND RECOMMENDATIONS

Our audit disclosed that IPS was overpaid for 99 of the 100 sampled claim lines. We estimate that the overpayment during the 3-year period ended December 31, 1996 was $752,256.

About 63 percent of this amount related to upcoded services, 20 percent to inadequately documented services, 11 percent to services performed in lower-priced geographic areas, and 6 percent to services performed by physician assistants without the supervising physician being present.

Of the 99 claim lines that were overpaid, 66 had multiple reasons for the overpayments. See Appendix A for the specific reasons that contributed to the overpayment for each of the sampled items.

It is the OIG's policy to recommend financial recovery at the lower limit of the 90 percent two-sided confidence interval, or, in this instance, $581,379. Thus, we are 95 percent confident that the overpayment was at least that amount and recommend that the $581,379 be recovered from IPS. We also have included two procedural recommendations to eliminate future overpayments. Details summarizing our sample methodology and statistical projection are contained in Appendices B and C, respectively.

Upcoded Services

Our review found that 72 of the 100 claim lines that we examined were billed using procedure codes that were higher than the services actually provided. Of these claim lines, 13 were upcoded two levels, and 59 were upcoded 1 level.

Medicare pays for nursing facility visits and hospital visits (also called evaluation and management services) based upon the coding descriptions developed by the American Medical Association (AMA) and published in its Physicians' Current Procedural Terminoloav (CPT) reference book. There are three to five levels for each evaluation and management service. The various levels encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of an illness or injury.

There are three key components in selecting the appropriate level, i.e., determining the nature and complexity of the: (1) history, (2) examination of the patient, and (3) medical decision making. There are other contributory factors (counseling, coordination of care, nature of the presenting

problem, and time) that may impact the selection of the proper level of care to bill to Medicare.

Guidance pertaining to the average time for each level of service is provided in the CPT descriptions. For example, for a low-level subsequent nursing facility visit (procedure code 99311), it says: "Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit." For a mid-level visit (99312) and high-level visit (99313), the average times are given as 25 and 35 minutes, respectively. The inclusion of time as an explicit factor in the AMA's coding descriptions is intended to assist physicians in selecting the most appropriate procedure code to bill.

The physician consultant at Transamerica found that IPS frequently upcoded its billings, both for hospital visits (43) and nursing facility visits (29). Generally, he found that the medical decision making that was documented in the medical records for most of the beneficiaries was straightforward or of low complexity. For example, in 48 of the 72 upcoded claim lines, the medical decision making, as documented, was "per orders," "per care plan," "continue care," or 'will follow."

Usually, when IPS upcoded a service, along with the low complexity decision making, either the history or the examination (or both), was less complex than that required to bill at the higher level of service. For example, sample item 30, a nursing facility visit, was billed to Medicare as a 99303, the highest level for this type of nursing facility visit. For this service, IPS received $102.63. However, based upon the documentation written by an IPS physician in the patient's medical record, Transamerica's physician consultant concluded that the service actually performed should have been billed as a 99301 (or two levels lower). Specifically, the only comment made by the IPS physician about the patient's medical history was that the patient was an 87 year old male admitted from a local hospital with a fractured right femur, and the comment about the patient's medical decision was simply to continue care. Medicare's reimbursement for a 99301 would have been $49.62; therefore, IPS was overpaid $53.01 for this claim because of upcoding (an additional $4.16 was overpaid on this claim due to the use of the wrong geographic area (see page 7 of this report)).

Sample item 29, a hospital visit billed to Medicare as a 99232, a mid-level code for this type of service, illustrates a service upcoded one level. For this service, IPS received $41.94. However, based upon the documentation written by an IPS physician in the patient's medical record, Transamerica's physician consultant concluded that the service actually performed should

have been billed using procedure code 99231 (or one level lower). For this claim, the history as written by the IPS physician was that the patient was resting and taking in fluids. The medical decision noted in the medical record was to continue the patient's care. Medicare's reimbursement for a 99231 would have been $28.47; therefore, IPS was overpaid $13.47 for this claim because of upcoding (an additional $0.12 was overpaid due to the use of the wrong geographic area).

Generally, it was IPS policy to bill monthly visits to nursing facility patients as 99312's (the 25 minute code). However, the physicians and one of the physician assistants told us that they typically spend about 15 minutes per patient when performing this type of service. These statements provide additional evidence that the services should have been billed as 99311's (the 15 minute code).

From our interviews of the physicians, it appeared to us that they were unfamiliar with the specific CPT coding descriptions. They indicated that they had not adequately researched Medicare's instructions or sought assistance from the carrier. Instead, they relied on their own experiences. For example, one IPS physician said that he used principles learned in training while working for another physician. One of these principles was that monthly visits at nursing homes were considered to be mid-level procedures.

When we pointed out the CPT requirements for each level of service, he agreed that his perception was in conflict with the CPT information.

Inadequately Documented Services

Services for 5 of the 100 claim lines that we examined were inadequately documented. Of these, four (one nursing facility visit, one hospital visit, one assist at surgery, and one care plan oversight) had no documentation to support the services billed, and one (a hospital visit) had limited documentation that was inadequate.

Federal law, specifically Title XVIII, section 1833(e) of the Social Security Act, requires that sufficient information be available to document claims. If there is inadequate documentation, Medicare's payment is not allowable.

For four of the five claim lines with no documentation, we asked the IPS physicians to provide us with any documents they had that

would support these services. They were unable to provide us with any progress notes or other direct written support.

For the fifth claim line, Transamerica's physician consultant found that the documentation did not adequately support a billable service. Sample item 72, was a mid-level hospital visit (99232) rendered on August 29, 1996 for which IPS was paid $41.62. For this beneficiary, IPS had also billed for a hospital discharge service (99238) on August 30, 1996. It was paid $48.90 for the discharge service. The only documentation directly supporting the hospital visit was a physician's progress note, written on August 29, 1996, that stated "DCS [discharge]." (This note, incidentally, did not meet the minimum information standard relating to the three key components for this procedure code; namely, the patient's medical history, examination, and the doctor's medical decision making.) The hospital's medical records, however, indicated that the patient was actually discharged on August 29. Since IPS was paid for the hospital discharge service (billed as though rendered on August 30, 1996), the hospital visit on August 29 was not allowable because the payment for the discharge service includes all patient visit services on that day.

We discussed these five claim lines with IPS physicians and found that they were unable to explain specifically why the necessary documentation may not have been prepared or how these services were billed to Medicare without adequate documentation. In one instance, the assist at surgery, we were able to determine why adequate documentation was lacking. In this case, IPS billed the service on the date it was performed (January 16, 1996) and rebilled the service as though it was rendered on January 15, 1996 when it received a copy of the surgeon's bill to Medicare. The surgeon had used the incorrect date of service (January 15, 1996). As a result, there was no documentation to support the service that IPS billed on January 15 (sample item 4). Incidently, IPS was appropriately paid for the service on January 16.

Services Performed In Lower-Priced Geographic Areas

Seventy-two of the 100 claim lines that we examined were for services performed in lower-priced geographic areas. Since payment rates vary by geographic area and IPS billed all of the 100 sample claims using the highest payment area, all 72 of the claim lines were overpaid.

On January 1, 1992, Medicare began paying for physicians' services based on a national fee schedule. The fee schedule

amount for a service is based on a formula that takes into consideration the relative value for the service, the conversion factor for the year, and a geographic adjustment factor. The geographic adjustment factor reflects the variation in prices and costs in different areas of the country.

The result of paying for services by geographic area is that a physician providing a service in one area (for example, Los Angeles County) may be paid more than if he provided the same service in another area (for example, San Bernardino County). In order to properly pay claims using the correct geographic rate, Medicare requires that providers bill according to where the services are actually rendered. In IPS situation, these locations (or geographic areas) were different than the location it used to obtain its provider (i.e., billing) number from Transamerica.

Our sample showed that IPS rendered services in four different Medicare geographic areas in southern California. Claims for two of the four areas should have been submitted to and paid by Blue Shield (or National Heritage Insurance Company after December 1, 1996), another Medicare carrier. For each of the four different areas, IPS should have obtained a different provider number. The use of different provider numbers would have allowed the carriers to pay the claims using the correct geographic adjustment factor.

Instead of obtaining different provider numbers for each of the four areas that it rendered services in, IPS obtained only one provider number that should only have been used for Los Angeles County (one of California's highest cost areas). As a result, 72 of the 100 claim lines we examined were overpaid since the payment rate for Medicare's geographic area in Los Angeles County was higher than the payment rates for the areas corresponding to where the services were actually rendered. For example, sample item 1 was a nursing facility visit rendered in a facility in San Bernardino County. For this service, IPS was paid $42.68. It should have billed Blue Shield for this service and, if so, would have been paid $38.86, or about 9 percent less.

In a letter, dated January 12, 1994, from Blue Shield to one of the IPS physicians relating to an overpayment of several claims for services in 1992 and 1993, Medicare's requirement was clearly laid out:

> "You are responsible for correct claim submission and for submitting the claims to the correct Medicare carrier. When billing Medicare for services rendered outside your office setting, you should bill the

carrier who has jurisdiction in the place that the services were rendered."

In our discussion with this IPS physician, he admitted that the instructions in the letter were clear and that he must have overlooked them, assuming that the other information in the letter was more important.

Services Performed by Physician Assistants Without the Supervising Physician Present

Eighteen of the 100 claim lines were overpaid because they involved services that had been performed by physician assistants (PAs) without a supervising physician present. Of these 18 services, 17 were provided in nursing homes, and 1 was provided in a hospital.

A PA is a skilled health care professional who, under the supervision of a physician, performs a variety of medical, diagnostic, and therapeutic services. The supervising physician may delegate to the PA most medical services and duties that are routinely performed within the normal scope of the physician's practice and which the PA is competent to perform.

Medicare pays for PA services in two ways: (1) as a service "incident to" the physician's service, requiring the physician to provide direct personal supervision, and (2) as a service where the physician need only be immediately available to the PA for consultation purposes by telephone. The "incident to" service is reimbursed at 100 percent of the physician's fee schedule amount. For the other, Medicare pays 75 percent of the applicable physician's fee schedule amount if performed in a hospital and 85 percent if performed elsewhere. In order for Medicare to pay the claim correctly, providers are instructed to include a special modifier along with the CPT code if the services are not "incident to." They are also instructed to obtain a unique number from the carrier to identify the PA who performed the service and to include this number on each claim.

The 18 services were performed by PAs without direct personal supervision by the physician and were billed without using the modifier to denote this fact. These billing errors resulted in IPS being paid 100 percent of the applicable physician schedule amount instead of 85 percent of that amount for the 17 services provided in nursing homes and 75 percent for the one service provided in a hospital.

For example, sample item 45 was a mid-level nursing home visit provided by a PA for which IPS was paid $41.29. In this instance, the supervising physician was not present **in the** facility at the time the service was rendered. Therefore, this claim should have been billed using the modifier to denote it as a PA service that was not "incident to." Using the modifier would have resulted in IPS being paid $35.09, or $6.20 less.

From our interviews of the physicians, it appeared to us that they had misinterpreted the Medicare requirements concerning PA services. One IPS physician stated that he thought that his own review (for example, 2 days later) would qualify the service as an "incident to" service since he was seeing the patient as well as reviewing what the PA had written in the medical record. He thought that he was required to see the patients after the PA had seen them and as long as he did this it would be considered **"incident** to."

Recommendations

We recommend that Transamerlca:

(1) Provide IPS with all pertinent educational materials related to Medicare rules and regulations,

(2) Require that IPS obtain additional provider numbers corresponding tc the various geographic areas in which it renders services,

(3) Place IPS under prepayment review until it can demonstrate that it can properly bill for services,

(4) Conduct an audit of IPS billings for Calendar Year 1997, and

(5) Not recover the identified overpayment of $581,379 at this time pending further review by our office.

IPS Comments

A response to our draft report was prepared by the law firm of Fulbright & Jaworski, LLP, a registered limited liability partnership, retained by IPS (see Appendix D for the response in its entirety). On behalf of IPS, Fulbright & Jaworski disagreed with the OIG audit findings. It indicated that IPS is conducting a thorough review of the 100 sampled claim lines and would provide additional information at a later date.

With regard to our recommendations, Fulbright & Jaworski stated that IPS had taken the following actions: (1) it begun billing physician assistant services using the recommended modifier, (2) it revised its internal billing form to account for services performed by physician assistants, and (3) it discussed with the appropriate Medicare carriers the issue of separate billing numbers for different geographic areas.

Fulbright & Jaworski was of the opinion that the audit sampling methodology was flawed. It included a letter from Cabot Marsh, part of a healthcare consulting firm, which concluded that the OIG's sample was nonrandom because: (1) the sample did not contain claims during the period January 1, 1994 through May 31, 1994 and (2) the sample did not have a nearly equal number of claims in each of the 3 years reviewed.

Counsel asserted that the entire medical record, rather than just the physicians' progress notes, must be reviewed when examining the support for services billed. It also stated that IPS disagreed with the OIG's conclusions that it was not familiar with the CPT coding descriptions and had not adequately researched Medicare's instructions or sought assistance from the carrier. Further, Fulbright & Jaworski disputed the OIG's determination that 72 of the 100 claim lines were billed to the wrong carrier. It maintained that a provider needed a billing number only for each pay locale in which it maintained an office.

OIG's Comments

The OIG believes that IPS response did not present new or additional evidence that would warrant changes in our findings.

It is OAS policy to allow 30 days for a written response to our draft audit reports. IPS was given 63 days to provide written comments on the draft report. We conducted an exit conference with the IPS physicians on December 16, 1997 to discuss all aspects of our audit. The Transamerica medical consultant who reviewed our sample of services attended the exit conference. At the exit conference, we provided IPS with a complete list of the 100 services that were sampled. If IPS chooses to appeal our audit findings and recommendations, it may present any additional information at that time.

Counsel's consultant, Cabot Marsh, questioned the validity of the audit statistical sample because there were no sample claims during the period January 1, 1994 through May 31, 1994 and because, it alleged, the sample did not have equal numbers of claims in each of the 3 years. The reason that the number of

claim lines in each of the 3 years was unequal is that IPS was just starting to bill Medicare in late 1993. Over the next 3 years, the number of Medicare billings gradually increased. Our sample covered all 3 years and the number of sampling units (claims lines) correlated closely to the number of claims lines billed by IPS in each year, as illustrated below:

	Universe		Sample	
Calendar Year	No. of Claim Lines	Percent	No. of Claim Lines	Percent
1994	5,946	16%	18	18%
1995	15,235	40%	39	39%
1996	16,742	44%	43	43%
Totals	37,923	100%	100	100%

Counsel for IPS argued that the entire medical record, rather than solely the physicians' progress notes, should be considered in reviewing claims for services. In all cases, this was done during the audit. The medical consultant at Transamerica was provided with pertinent and appropriate information in the medical records, including patients' admission sheets, history and physical examination notes, physicians' orders, licensed personnel progress notes, lab reports, consultation reports, and physicians' discharge notes, as discussed on page 2 of our report.

With regard to counsel's claim that IPS was familiar with CPT coding descriptions, the audit evidence would suggest otherwise. For example, one of the IPS physicians told us that instead of using the coding descriptions contained in the CPT book, he used the principles he learned in medical school training and the advice of a consultant. After we showed him the actual descriptions in the CPT book, he agreed that his monthly visits to patients in nursing homes should be coded 99311 instead of 99312.

Counsel took exception to the audit's determination that 72 of the claims were billed to the wrong carrier, arguing that a provider only needed a billing number for each pay locale in which it had an office. However, counsel's argument conflicts with the Medicare carrier's billing instructions. These instructions, as noted on page 8 of this report, require that providers bill carriers on the basis of where services were rendered, not where the provider's office was located.

Transamerica's Comments

Transamerica concurred with our audit findings and the audit statistical methodology. It also concurred with our recommendations, except for a suggested change in recommendation number 2. The suggested change was made.

APPENDICES

Reasons Contributing to the Overpayments

Sample Item	Upcoding	Inadequate Documentation	Geographic Area	PA Services
1			X	
2	X		X	
3			X	
4		X		
5	X			X
6			X	
7	X		X	
8				
9	X		X	
10	X		X	
11			X	
12	X		X	
13	X			X
14	X			
15			X	
16	X		X	
17	X			X
18	X			
19			X	
20		X		
21	X		X	
22	X			
23	X		X	
24	X		X	
25		X		
26			X	X
27	X		X	
28	X		X	
29	X		X	
30	X		X	
31	X			
32	X		X	
33	X			X
34	X		X	

Reasons Contributing to the Overpayments

Sample Item	Upcoding	Inadequate Documentation	Geographic Area	PA Services
36			X	
37	X		X	
38	X		X	
39	X		X	
40	X			
41	X		X	
42	X			
43	X			X
44	X		X	
45				X
46			X	
47	X		X	
48			X	
49				
50			X	
52	X		X	
53				
54	X		X	
55				
56	X		X	
57				
58			X	
59				
60	X		X	
61	X		X	
62		X		
63				
64	X		X	
65	X			
I 66 I	X		X	
67	X		X	
68	X		X	
69	X		X	X
70	X		X	

Reasons Contributing to the Overpayments

Sample Item	Upcoding	Inadequate Documentation	Geographic Area	PA Services
71			X	X
72		X		
73	X			X
74	X		X	
75	X			X
76	X		X	
77	X		X	
78	X			X
79			X	
80	X			
81	X		X	
82	X		X	
83	X		X	
84	X		X	
85			X	
86			X	
87	X		X	
88	X		X	
89	X			
90	X		X	
91	X		X	
92	X		X	
93			X	
94	X		X	
95			X	X
96	X			X
97			X	
98	X		X	X
99	X			X
100			X	
Totals	72	5	72	18

Sampling Methodology

Objective:

Our audit objective was to examine a statistical sample of Medicare payments made to IPS by Transamerica over the 3-year period January 1, 1994 through December 31, 1996 to determine if the payments were appropriate for the services rendered.

Population:

The population was all Medicare Part B claim lines for which IPS was paid between the period January 1, 1994 through December 31, 1996; namely 37,923 total claim lines for which IPS was paid $1,966,305.

Sampling Unit:

The sampling unit was one line on a paid Medicare Part B claim billed by IPS.

Sampling Design:

A single stage, unrestricted random sample was used.

Sample size:

Our sample size consisted of 100 claim lines.

Estimation Methodology:

Using the Variables Appraisal Program of the Office of Audit Services, we calculated the lower limit of the 90 percent two-sided confidence level using the difference estimator.

Variables Projection

The lower and upper limits of the dollar value of overpayments are shown at the 90 percent confidence level. We used our random sample of 100 claim lines out of the universe of 37,923 to project the value of the unallowable amount. The result of this projection is presented below:

Difference Value Identified in the Sample	$1,984
Point Estimate	$752,256
Lower Limit	$581,379
Upper Limit	$923,132

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May 29, 1998

BY TELECOPY AND FIRST CLASS MAIL

Mr. Jerry Hurst
Senior Auditor
Department of Health & Human Services
Office of Inspector General
Region IX
Office of Audit Services
Room 285
801 I Street
Sacramento, CA 95814

Re: Inland Physicians' Service
Identification Number A-09-97-00062
Initial Response to Draft Audit Report Dated March 27, 1998

Dear Mr. Hurst:

This firm represents Inland Physicians' Service ("IPS") in regard to the review by the Department of Health and Human Services, Region IX, Office of Inspector General ("OIG") and TransAmerica Occidental Life Insurance Company ("Transamerica") of IPS's Medicare Part B billings for the period January 1, 1994 through December 31, 1996 ("Audit Period"). This letter is in response to the OIG's draft audit report dated March 27, 1998 ("Preliminary Report"). In the Preliminary Report, the OIG states that it and Transamerica reviewed an unrestricted, random sample of 100 Medicare Part B claims IPS submitted for payment and, based on this sample, concludes that IPS was overpaid at least $581,379 for services it performed during the Audit Period. The OIG takes the position that these alleged Medicare overpayments are the result of four repeated billing errors committed by IPS:

(1) IPS "upcoded" evaluation and management services it provided to hospital patients and nursing home residents.

(2) IPS failed to include sufficient documentation in patients' medical records supporting the services performed.

(3) IPS billed the wrong carrier for certain claims.

(4) IPS billed for some services performed by physician assistants as "incident to" a physician's professional services, however, the appropriate level of physician supervision was not present.

IPS is diligently conducting a thorough review of the 100 claims identified by the OIG end intends to provide to the OIG the results of such review when complete. Due to the short tine period in which IPS had to respond to the Preliminary Report, it has not yet completed it-s substantive review. According to the Preliminary Report, it took the OIG approximately six months to perform its review of IPS billings during the Audit Period and an additional three months in which to prepare the Preliminary Report. IPS reserves the right to furnish to the OIG the results of this substantive review at a later date. In addition, we believe that a meeting should be scheduled, at least before issuance of the final OIG report, with you, the Transamerica physician consultant, Drs. * and perhaps other IPS personnel, and Frederick Robinson from this firm. We believe that such a meeting would help to resolve some of the pertinent issues. Please let me know as soon as possible whether you agree to such a meeting and, if so, what dates in the next few weeks you would be available. In the meantime, IPS has the following initial comments to the Preliminary Report.

1. IPS Has Implemented the Actions Recommended by the OIG

IPS has implemented the actions that you previously recommended to Drs. * without waiving its right to contest that failure to have complied with these actions in the Audit Period would have resulted in improper claims. In particular, IPS has taken the following actions:

a. IPS bills for physician assistant services using the recommended modifier.

b. IPS has revised its billing form for separate physician assistant visits.

c. IPS has discussed with the Medicare carriers the alleged requirement that it obtain additional Medicare billing numbers that relate to the different geographic areas in which it provides services.

* Office of Audit Services Note: It is OAS policy to exclude names of individuals in the auditee organization.

2. OIG Sampling Methodology Is Flawed

In the Preliminary Report, the OIG maintains that it conducted the audit in accordance with generally accepted government auditing standards and performed an unrestricted, random sample. See Preliminary Report, pp. 2 and Appendix B. However, IPS believes that the OIG's sampling methodology is flawed. On behalf of IPS, Cabot Marsh reviewed the Preliminary Report and reported its findings to IPS. See Attachment, letter dated May 25, 1998 from Bret S. Bissey, Vice President, Cabot Marsh. In this letter, Cabot Marsh point-s out several apparent deficiencies in the OIG's sampling methodology and concludes that "the claims identified for review during this audit were a nonprobability sample even though the OIG classified the review as a single stage, unrestricted sample." IPS intends for Cabot Marsh to perform a more thorough analysis of the OIG's sampling methodology and will provide to the OIG Cabot Marsh's final report as soon as it is available.

3. IPS Was Familiar With Medicare Requirements

IPS disagrees with the OIG's statement that IPS physicians were not familiar with Medicare reimbursement rules during the Audit Period. See Preliminary Report, p. ii. IPS physicians were knowledgeable about the Medicare requirements and attended numerous professional seminars during the Audit Period discussing these rules. IPS will provide to you evidence of attendance at these seminars, if available.

4. IPS Did Seek Guidance From the Medicare Carrier When Necessary

IPS disputes the OIG's conclusion that IPS did not seek assistance from the Medicare carrier in interpreting the Medicare billing rules in effect during the Audit Period. See Preliminary Report, p. ii. IPS was familiar with Medicare coverage and billing requirements. When uncertain about application of a particular rule, IPS personnel frequently contacted the Medicare carrier in order to seek guidance. IPS is collecting its telephone logs of these conversations with Medicare carrier analysts and intends to provide them to you as soon as possible.

5. Review of Medical Records for Medicare Coverage and Payment

We understand that the OIG takes the position that a physician's progress notes, standing on their own, must adequately document and support the medical necessity of a service and the procedure billed. We do not believe that this is correct. In reviewing whether a physician's services are adequately documented and medically

necessary, we believe the individual must review the entire medical record rather than restricting review to the physician's progress notes.

6 . Upcoded Services

At this time, IPS disputes the OIG's preliminary determination that IPS "upcoded" in 72 of the 100 sample claims. See Preliminary Report, pp. 4-6. IPS is obtaining and will review the medical record documentation relevant to these claims and intends to provide to you its findings on each claim as soon as possible. IPS does not agree with the OIG's initial conclusions that IPS: (i) was unfamiliar with the CPT coding descriptions (See Preliminary Report, p. 6); and (ii) indicated during interviews that it "had not adequately researched Medicare's instructions or sought assistance from the carrier" (See Preliminary Report, p. 6). As previously described, IPS will provide to you its telephone logs of discussions with the Medicare carrier during the Audit Period.

7. Inadequately Documented Services

At this time, IPS disagrees with the OIG's preliminary finding that it failed to adequately document services it performed in five cases during the Audit Period. See Preliminary Report, p. 6. IPS intends to furnish to you as soon as possible the results of its substantive review of these five claims.

8. Services Performed in Lower-Priced Geographic Areas

At this time, IPS disputes the OIG's initial determination that 72 of the 100 claims were billed under the incorrect Medicare billing number and to the wrong tier. See Preliminary Report, pp. 7-9. You maintain that the IPS physicians were required to obtain different Medicare billing numbers for each geographic area in which they provided services and bill the tier responsible for each such geographic area We do not understand this to be consistent with applicable Medicare requirements. We understand that a physician must obtain an individual Medicare Part B billing number for each pay locale in which he/she maintains an office. If the physician has an office in one Medicare pay locale and has a billing number for such locale, he/she may bill under this billing number for services he/she furnishes in another pay locale, assuming the physician does not maintain an office in the second pay locale. An analyst with the National Heritage Insurance Company has, on an informal basis, confirmed our understanding.

9. Services Performed by Physicians Assistants Without the Supervising Physician Present

At this time, IPS disagrees with the OIG's preliminary finding that IPS inappropriately billed 18 claims as "incident to!' a physician's professional service because the physician supervision requirement was not satisfied. IPS intends to provide to you as soon as possible the results of its substantive review of these 18 claims.

By providing you with this information at this time, IPS does not waive its right to furnish the OIG with the results of IPS's substantive review of the 100 sample claims as soon as such review is completed We appreciate your understanding in this matter. Please call me if you have any questions.

Very truly yours,

Thomas E. Dowdell

TED:pjg
Enclosure

May 25,1998

Frederick Robinson, Esquire
Fulbright & Jaworski, L.L.P.
801 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2615

Dear Attorney Robinson:

The following is Cabot Marsh's observations and professional opinions regarding the statistical validity of the OIG's sample selection of the 100 Inland Physicians Service (your client) claims in connection to the letter dated March 27, 1998 from the Department of Health and Human Services, Office of Inspector General to Inland Physicians Service.

Observations

The March 27, 1998 letter from DHHS, OIG states that "report on our review of Inland Services Physicians' Services' billings to Medicare for Part B services for the period January 1, 1994 through December 31, 1996." Upon review of the 100 claims reviewed we notice that the earliest claim reviewed was June 1, 1994. Hence, there were no claims reviewed for the months of January 1994, February 1994, March 1994, April 1994 and May 1994.

Since a three year interval is being studied during this investigation it would prudent that each year in the study would have equivalent or near equivalent claims identified for analysis. Upon review of the 100 claims reviewed we notice the following distribution; 1994 - 18 claims, 1995 - 39 claims, 1996 - 42 claims.

On page 2 of the March 1998 report it is stated " we reviewed a statistical sample of 100 claim lines (representing 104 services because 1 claim line was a billing for 5 separate services) from the universe of all claim lines paid by Transamerica to IPS over the 3-year period ended December 31, 1996." During the time period under review for Inland Physician Services there were 37,923 claim lines billed for Inland Physician Services. Hence, the review of 100 claim lines representing 104 services represents a sampling review of 1 out of every 364.64 claims or 0.27%.

On page 2 of the March 1998 report it is stated "we conducted our audit in accordance with generally accepted government auditing standards."

On Appendix B of the March 1998 report it is stated " a single stage, unrestricted random sample was used."

Professional Opinions

Cabot Marsh utilizes accepted standards regarding random sampling techniques and procedures. According to the text entitled "Basic Business Statistics - Concepts and Applications" written by Mark Berenson and David Levine they observe that "there are basically two kinds of samples: the probability sample and the nonprobability sample. The later, which is usually much simpler and cheaper to obtain, comprises a grouping of procedures such as judgment samples, quota samples and the chunk." This text goes on to state "a major drawback of the nonprobability sample is that the interviewer is given too much discretion in the process of subject selection. While this may be both efficient and economical as compared to probability sampling methods, there is no probabilistic way of estimating how representative such selected samples are. Hence it is incorrect to use such samples to make inferences to the entire population—which is the objective of sampling!"

Upon review of all of the information available on this topic, it is the opinion of Cabot Marsh that the sample selection methodology utilized in this case can be best classified as a nonprobability sample otherwise known as a chunk or convenience sample. The main disadvantage of this type of nonprobability sample is that there is no probabilistic way of interpreting how representative the particular sample is of the overall population. The only correct way in which a researcher can make statistical inferences from a sample to a population and interpret the results probabilistically is through the use of a probability sample.

According to Berenson and Levine " a probability sample is one in which the subjects of the sample are chosen based on known probabilities. In particular, the simple random sample is one in which every subject has the same chance of selection as every other subject at each successive stage of the selection process".

Again, it is the opinion of Cabot Marsh that the claims identified for review during this audit were a nonprobability sample eventhough the OIG classified the review as a single stage, unrestricted sample.

Sincerely yours,

Bret S. Bissey
Vice President

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April 22, 1998

Lawrence Frelo t
Department of Health & Human Services
Office of Audit Services
Region IX
50 United Nations Plaza
San Francisco, CA 94102

RE: CIN:A-09-97-00062

Dear Mr. Frelot:

We have reviewed the draft audit report on your review of Inland Physicians' Service (IPS) billings to Medicare.

We concur with the process followed on this review as well as with the findings reported and with the statistical methodology used to calculate the projected overpayment.

WC also concur with recommendations 1, 3, 4 and 5. I lowever, because there is no mandated requirement that the Carrier monitor or test a particular provider's knowledge of Medicare rules- WC suggest that recommendation X2 be changed to read: "Provide Inland Physicians' Service with all pertinent educational materials related to Medicare rules, regulations and establish prepayment review to monitor compliance".

Should you have any questions please call me at (213) 741-5747.

Sincerely,

Herb f-ernandez, Manager
Medicare Audit

cc. F. Velasco

Medicare Administration