Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE PART B SERVICES BILLED BY CALIFORNIA'S DEVELOPMENTAL CENTERS AND STATE HOSPITALS FOR THE PERIOD JANUARY 1, 1993 THROUGH JUNE 30, 1997

JUNE GIBBS BROWN
Inspector General

MAY 2000
A-09-98-00072

Department of Health and Human Services

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Office of Audit Services
Region IX

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JUNE GIBBS BROWN
Inspector General

May 2000
A-09-98-00072

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX
Office of Audit Services
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MAY 24 2000

CIN: A-09-98-00072

Mr. Jeff Harrison
Manager
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P.O. Box 2806
Chico, California 95927

Dear Mr. Harrison:

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 CALIFORNIA'S DEVELOPMENTAL CENTERS AND STATE HOSPITALS FOR THE PERIOD JANUARY 1, 1993 THROUGH JUNE 30, 1997." 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.

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To facilitate identification, please refer to Common Identification Number A-09-98-00072 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:

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San Francisco, CA 94105

EXECUTIVE SUMMARY

BACKGROUND

During the period of our audit, the California Department of Developmental Services (DDS) operated seven developmental centers and the Department of Mental Health (DMH) operated four State hospitals. Under a memorandum of understanding, DDS billed Medicare for medical services rendered to its and DMH's Medicare-eligible patients.

OBJECTIVE

Our audit, a joint review conducted by the OIG and a Medicare carrier–National Heritage Insurance Company (NHIC), examined the Medicare Part B payments (about $19 million) for services at the 11 State facilities over a 4 ½-year period (January 1, 1993 through June 30, 1997) to determine if the payments were appropriate for the services that were billed.

SUMMARY OF FINDINGS

With the assistance of NHIC's medical review staff, we reviewed a random, statistical sample of 100 claimed services for which DDS was paid by Medicare. Our combined review disclosed that 73 of the 100 services had been overpaid. Fifty-nine of the services were denied, and 14 were allowed but at lesser amounts. An additional five services had errors but did not result in overpayments.

The 73 overpaid services included:

- 43 for which there was no documentary evidence that the physicians had examined the patients,
- 14 which had been upcoded,
- 6 for which there was no documentation in the medical records that any services had been provided,
- 6 which were mutually exclusive of other services that had already been paid, and
- 4 which were not covered by Medicare.

Based upon our random sample, the point estimate of the overpayments was $13,046,880.

We concluded that these overpayments occurred for several reasons. Among them were staff unfamiliarity with Medicare's rules, inaccurate written instructions, lack of educational training, weak internal audits, and inadequate action plans to deal with certain known problems.

In response to our draft report, the State disagreed with our findings and conclusions. The NHIC, in its response, refuted many of the State's comments. After reviewing and considering both of their comments, we concluded that our findings remain valid.

RECOMMENDATIONS

To address these problems, we recommend that NHIC:

1. Develop with the Health Care Financing Administration's (HCFA) guidance a monitoring plan to ensure that DDS' future claims are brought into compliance with Medicare's rules, and

2. Not recover the identified overpayment at this time pending further review by the OIG.

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INTRODUCTION

BACKGROUND

California provides 24-hour services at its State-operated developmental centers and State hospitals to about 12,000 individuals who are developmentally disabled or have severe mental health problems. About 2,800 of these individuals qualify for Medicare Part B benefits, which include physicians' services and psychologists' services. The physicians and psychologists who render the medical services are, for the most part, State employees. However, some medical services are performed by doctors who are under contract with the State.

During our audit period (January 1, 1993 through June 30, 1997), California operated the following seven developmental centers and four State hospitals:

Developmental Centers	State Hospitals
Agnews	Atascadero
Camarillo (now closed)	Metropolitan
Fairview	Napa[1]
Lanterman	Patton
Porterville	
Sonoma	
Stockton (now closed)	

The developmental centers are managed by DDS and the State hospitals are managed by DMH.

Under a memorandum of understanding between the two State departments, DDS agreed to perform all cost recovery processes, including billing Medicare, Medicaid, private insurance, and other legally responsible payors. To accomplish this billing process, each facility sent computerized information to DDS headquarters on the services it provided to each individual, and then DDS prepared the appropriate billings.

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[1] Napa State Hospital is the only facility that currently serves both DDS clients and DMH clients.

Physicians and psychologists would complete coding forms to indicate the services to be billed. From these coding forms, the billing staff at the facilities would manually enter this information into a computer system for transmission to DDS headquarters in Sacramento. The computerized information would then be used to prepare billings to Medicare and other applicable payors.

Payments for medical benefits under Medicare Part B are administered by carriers, usually existing private insurance companies that contract with the Federal Government for this purpose. During our audit period, Blue Shield of California (Blue Shield) was the Medicare carrier for the developmental centers and State hospitals until December 1, 1996, at which time NHIC became the responsible carrier. In addition to processing and paying claims, carriers also make coverage determinations and provide administrative guidance to providers.

Medicare Part B payments for services at the seven developmental centers and four State hospitals during our audit period totaled about $19 million ($12.6 million for the developmental centers and $6.5 million for the State hospitals). All payments were sent to DDS, which deposited the checks and subsequently transferred to DMH its share.

OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. Our objective was to determine if Medicare's Part B payment was appropriate for the services billed (i.e., the services were necessary, supported by adequate documentation, and complied with various Medicare rules).

To accomplish this objective, we reviewed a random, statistical sample of 100 claim lines from the universe of claim lines paid by Medicare Part B to DDS over the 4 1/2-year period ended June 30, 1997. However, for three facilities (Camarillo - Skilled Nursing Facility (SNF), Lanterman - Acute, and Napa - SNF), NHIC did not provide us with claim lines with paid dates during the period January 1, 1993 through September 30, 1995. Therefore, these claim lines were not included in our universe. We also did not include any claim lines from Sonoma SNF because at the time we selected the universe, we were unaware that it had a separate provider number.

We also adjusted the total universe of claim lines by excluding those claims for which the carrier had projected overpayments that were identified in prior reviews.

All 100 of the sampled claim lines involved only one service. Appendix B presents the details of our random sampling methodology.

We did not include Medicare's Part A payments (covering generally the inpatient care) which were paid by Blue Cross of California (Blue Cross).

We obtained copies of pertinent medical records from the patients' medical files located at the various facilities. The documentation gathered included, when available and appropriate: (1) patients' admission information or "face sheets," (2) history and physical examination notes, (3) physicians' progress notes, (4) physicians' orders, (5) licensed personnel progress notes, (6) lab reports, (7) radiologists' interpretations of lab reports, (8) consultation reports, (9) psychiatrists' or psychologists' notes, and (10) other pertinent medical records or forms. If the notes were not fully readable, we obtained interpretations from the physicians who wrote the notes or from experienced staff at the facilities.

We attempted to gather the forms used by the physicians and psychologists to record the codes representing the services they rendered to beneficiaries. These coding forms were not available at the facilities for the period of our audit because they were not retained for more than 90 days after the information was entered into DDS' computer billing system.

In six instances, we could not find any documentation in the patients' medical records relating to the billed services. For five cases, we requested that DDS management staff locate and provide us with any documentation that would support the services billed. The DDS was also unable to locate additional documentation to support these five services. For the sixth service (sample item 39), we informed DDS management staff on January 19, 1999 that this service was also lacking documentation. At the time of issuance of this report, DDS had not provided us with any documentation for this service.

From NHIC, we requested and obtained, when available, histories of all Medicare services billed on behalf of the patients that were selected within about a 1-month period before and after the date of service for each selected claim line. For each randomly selected claim line, we noted the other services billed and paid for each patient. We did this to assist the medical reviewers in assessing the medical necessity for the sampled services and to identify if another mutually exclusive service may have been billed and paid. We also obtained copies of the original claim forms submitted by DDS to the Medicare carrier.

At our request, NHIC's medical reviewers examined the medical records we obtained to determine whether they supported the services billed. They looked at whether the services were medically necessary, billed using the correct descriptive codes, represented Medicare covered services, met various Medicare reimbursement rules, and whether the documentation was adequate to support the services billed.

At the facilities, we interviewed physicians, psychologists, and billing staff. We did not visit Stockton and Camarillo Developmental Centers because both had been permanently closed at the time of our fieldwork. We did not visit Patton State Hospital because it did not have any claims in our sample of 100. We also interviewed management staff at six facilities (Agnews, Fairview, Lanterman, Napa, Metropolitan, and Porterville), DDS headquarters, and DMH headquarters. The six facilities accounted for about 90 percent of our sampled claims.

We also obtained documentation of various policies, procedures, and communications pertaining to the Medicare billing process at the facilities and at DDS headquarters. In addition, we consulted with NHIC staff about Medicare's rules.

We reviewed DDS' internal controls over the processing of Part B Medicare claims for services provided at the facilities. This review included the controls in place for billing at the facilities and the DDS headquarters in Sacramento.

Our fieldwork was performed from November 1997 to January 1999 at the facilities and at the Sacramento headquarters offices of DDS and DMH.

FINDINGS AND RECOMMENDATIONS

Our audit, using statistical sampling techniques, disclosed that DDS was overpaid for 73 of the 100 sampled services. Fifty-nine of them were totally denied, and 14 were allowed but at lower reimbursement amounts than those originally paid. An additional five services had errors, but the errors did not result in overpayments to DDS.

Based on our random sample, the point estimate of the overpayments was $13,046,880 for the 4 1/2-year period ended June 30, 1997. Details summarizing our sample methodology and statistical projection are contained in Appendices B and C, respectively.

The payment errors fell into the following five categories:

- No evidence that the physicians had examined the patients (43),
- Upcoded services (14),
- No documentation (6),
- Mutually exclusive services (6), and
- Noncovered services (4).

See Appendix A for the specific reason for the overpayment and the specific facility involved for each of the sampled items.

Of the 73 services that were overpaid, 59 were billed as physician services and 14 were billed as psychiatric/psychologist services (there were 83 physician services and 17 psychiatric/psychology services in our sample).

We concluded that the billing problems were prevalent. We based this conclusion upon the interviews with the physicians and billing staff at the facilities, as well as headquarters staff, our review of the policies and procedures over billing, the overall error rate (73 percent), and the number of errors found at the individual facilities.

The errors in our sample for each facility were as follows:

	Number of Sample Items	Errors
Developmental Centers		
Agnews	15	9
Camarillo	7	7
Fairview	23	17
Lanterman	16	11
Porterville	14	11
Sonoma	1	0
Stockton	2	0
State Hospitals		
Atascadero	1	1
Metropolitan	8	7
Napa	13	10
Totals	100	73

The errors in our sample for the various years were as follows:

Year	Number of Sample Items	Errors [2]
1993	35	27
1994	21	15
1995	26	23
1996	10	7
1997	8	6
Totals	100	78

[2] The data used in this table include the five services that had errors but did not result in overpayments to DDS. No Medicare overpayments to DDS resulted from these claims because the patient's deductible exceeded Medicare's allowed amount for the service. Thus, either the patient or another payor (e.g., Medicaid) absorbed any overpayment.

We identified several reasons why there was such a high rate of overpayment errors. We found that: (1) the medical staff was not familiar with Medicare's billing requirements, (2) some written instructions to the medical staff did not agree with Medicare's rules and regulations, (3) the medical and billing staffs had not received adequate training relating to Medicare's billing requirements, (4) internal audits of the Medicare billings were deficient, and (5) inadequate action plans were implemented to deal with the known problems.

NO EVIDENCE THAT PHYSICIANS EXAMINED THE PATIENTS

Forty-three of the 100 services that we examined had no documentary evidence in the medical record that the physician had examined the patient for the service that was billed. As a result, all 43 of the services were denied. Forty of the denied services were physician services and three were psychiatric/psychology services. An additional 2 services (sample items 6 and 11) had similar errors, but they did not result in overpayments.

In order to be a reimbursable Part B service, Medicare requires that the patient must be examined:

> "A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc." (Medicare Carriers Manual, section 2020A)

In each of these 43 instances, the physician's (or psychologist's) progress note or other documentation did not contain evidence that the doctor had, in fact, examined the patient (i.e., the note did not have information pertaining to what was observed when the patient was examined).

For example, in sample item 29 the note reads (as interpreted by the staff at Fairview Developmental Center):

> "Monthly medical note
> Weight maintenance: weight 104 (90-100) pounds
> Epilepsy: last seizure 8/28/92
> Chronic constipation: decreased bowel movements treated with

medications, diet
Nonspecific vaginal discharge: treated with douche
Spasticity: utilizes safety device
Contractures: utilizes hand rolls
Seborrheic scalp dermatitis: seborrhea treated with shampoo"

From this description, the medical reviewer concluded that the physician had not documented an examination of the patient--no face-to-face time spent with the patient. Instead, to the reviewer the note appeared to be a recap of the patient's care plan, not a visit with the patient. From the medical record, it was not possible to determine if an actual encounter with the patient did or did not occur.

In 9 of the 43 instances, the only notation in the patient's medical record was a physician's note ordering a prescription (sample items 45, 49, 57, 58, 61, 66, and 70), ordering a lab test (sample item 18), or reviewing lab results (sample item 51). In 5 instances (sample items 5, 26, 28, 34, and 78), the only support was a physician's note to document that the patient's medications had been reviewed and extended, if necessary. These 14 services are not separately payable by Medicare. They are reimbursable only when performed as an integral part of a complete evaluation and management service, which involves documenting the patient's history, examination, and the medical decision. Carriers have been instructed not to separately pay for services which are essentially pre- or post- work of other physician services.

Medical record documentation is used to record pertinent facts, findings, and observations about an individual's health history, including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. It should be complete and legible.

The documentation of each patient encounter should include:

- Reason for the encounter;
- Physical examination findings;
- Assessment, clinical impression, or diagnosis;
- Plan for care;

- Date; and

- Identity of the observer.

Proper documentation in the medical record is vital for a number of reasons. The primary purpose of medical documentation is to ensure that patient treatment is recorded for quality of care and continuity of treatment. Reimbursement and legal issues are considered secondary. Federal regulations impose certain documentation requirements on all hospitals participating in Medicare. For example, concerning medical records, 42 Code of Federal Regulations (CFR) 482.24 (c) states[3] that:

> "The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

In addition, 42 CFR 483.40(b)(2) requires[3] that physicians performing services in nursing facilities must:

> "Write, sign, and date progress notes at each visit...."

Without sufficient documentation that records an examination of the patient, then either the facilities have billed Medicare for activities that may not have been performed (i.e., did not involve an actual face-to-face encounter with the patient) or their medical record keeping was inadequate, either of which may negatively impact on patient quality of care and continuity of treatment.

UPCODED SERVICES

Our review found that 14 of the 100 examined services were billed using numeric coding descriptors (i.e., procedure codes) that described services more complex than those actually provided (a condition commonly referred to as upcoding). One was a psychiatric/psychology service and 13 were physician services. Two additional services (sample items 36 and 56) were upcoded but did not result in overpayments.

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[3] This regulation was in effect during the entire period of our audit.

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 and published in its Physicians' Current Procedural Terminology[4] (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.

The extent of the history and examination is dependent upon the nature of the patient's problem and the physician's clinical judgement. There are four levels of history and examination, ranging from limited to comprehensive. The various levels of medical decision making (straightforward, low complexity, moderate complexity, and high complexity) refer to the complexity of establishing a diagnosis, extent of data to be reviewed, and the risk of complications and/or morbidity or mortality. The CPT reference book specifies the various levels, discusses the instructions for selecting the appropriate level, and provides examples for each type of service.

Generally, NHIC's medical reviewers found that the upcoded services involved medical problems that were minimally complex and required medical decisions by the physicians that were straightforward or of low complexity, instead of more complex problems and decisions that would have warranted the use of higher codes.

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

For example, sample item 7 was billed as a 99312 (a mid-level nursing facility visit), and DDS was paid $30.22. For this service, the physician examined the patient's ears for infection. The medical decision, as documented in the physicians' progress notes and physicians' orders, was to treat the infection with medications. The medical reviewer concluded that the examination and medical decision was straightforward or of low complexity and should have been billed as a 99311, the lowest complexity nursing facility service. Medicare's reimbursement for a 99311 would have been $26.10, or $4.12 less than was actually paid for this service.

Two of the upcoded services (sample items 63 and 72) were billed using CPT codes for an incorrect place of service. For example, sample item 63 was billed as a 99232, a code used to report a subsequent hospital visit. However, this service was actually performed in an outpatient clinic. Because this service was billed with an inpatient code instead of an outpatient code, DDS was paid $37.86, or $18.64 more than it should have been paid. Except for these two services, all the upcoded services were upcoded only one level. The medical reviewers concluded, based on their review of the medical documentation, that none of the services should have been paid at higher levels than billed.

NO DOCUMENTATION

In six instances, we could not find any documentation in the patients' medical records to support the services billed. All six were psychiatric/psychology services.

Federal regulations specify that as a basis for Medicare payment:

> "The provider...must furnish...to the carrier sufficient information to determine whether payment is due and the amount of payment." (42 CFR 424.5(a)(6)) [5]

These six services did not meet this requirement.

We provided DDS headquarters staff with all the documentation that we had copied from five of the patients' medical records and asked them to research the files again to ensure that we had not missed any appropriate documentation. They too were unable to locate documentation that pertained to the services billed. In addition, we notified them that sample item 39 was denied because no documentation on the

[5] This regulation was in effect during the entire period of our audit.

service date could be found. All six of these services were denied by NHIC's medical reviewers. The services were for pharmacologic management (two claims), group medical psychotherapy (three claims), and a psychiatric diagnostic interview (one claim).

MUTUALLY EXCLUSIVE SERVICES

In six instances, the sampled service was denied because another mutually exclusive service had been paid for the same patient on the same day. A mutually exclusive service is a procedure that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed by the same provider on the same patient. Codes representing such services or procedures cannot both be reimbursed.

By definition, certain CPT codes, such as those for subsequent nursing facility services (99311, 99312, and 99313) and inpatient hospital services (99221, 99222, 99223, 99231, 99232, and 99233), represent all evaluation and management care to a given patient for the entire day. For example, the description from the Physicians' Current Procedural Terminology for code 99312 is:

> "Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires...." (emphasis added)[6]

Our sample revealed the following mutually exclusive services:

Sample Number	Patient	Facility	Date	Sample Service	Other Service
1	A	Fairview	11/19/93	99313	99311
44	B	Camarillo	11/18/93	99232	99233
55	C	Fairview	12/28/93	99312	99313
60	D	Napa	8/23/93	99233	99232

[6] This description was consistent from 1993 through 1997.

Sample Number	Patient	Facility	Date	Sample Service	Other Service
68	E	Metropolitan	8/27/95	90801[7]	99232
80	F	Fairview	7/11/94	99312	99311

Medicare allows an exception to the above rule when two rendering physicians with different specialities see the patient for a problem related to their given speciality. However, this condition was not present in the services we reviewed. Therefore, all six of the sample items were denied because another mutually exclusive service had already been paid.

NONCOVERED SERVICES

Our review found that four services which had been billed and paid were for noncovered Medicare services. An additional service (sample item 27) had a similar problem but did not result in an overpayment.

For 2 of the 4 (sample items 40 and 69), the only documentation found in the patients' medical records were notational entries dealing with administrative matters. In sample item 40, the physician changed the code identifying one of the patient's medical problems because it had originally been miscoded. For this simple annotation in the medical record, DDS had billed Medicare for an evaluation and management service.

In sample item 69, a note was placed in the medical record that the patient had been approved for a limited "grounds" card (giving him access around the grounds of the facility with less supervision). The NHIC reviewer found that there was no documentation in the medical record indicating that the patient had been examined by the physician for this purpose. For this notational entry in the patient's medical record, DDS had billed Medicare for a psychiatric therapy service.

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[7] A psychiatric diagnostic interview (90801) was billed, but the service documented in the medical record more accurately reflected a subsequent hospital visit. The medical reviewer concluded that the physician's note did not support payment for a psychiatric diagnostic interview.

These two notational entries in the medical records do not constitute reimbursable Medicare services.

Sample item 91 (billed as a group medical psychotherapy service) was also denied as a noncovered service. The documentation in the medical record consisted of a 90-day treatment team meeting. It was attended by a psychologist, a social worker, rehabilitation specialist, registered nurse, and the patient; was supervised by a physician; and lasted about an hour. The purpose of the team meeting was to discuss the patient's condition and to develop the treatment goals.

The medical reviewer concluded that there was no evidence of face-to-face time with the patient for the purpose of an examination. This type of meeting, even when supervised by a physician, is considered to be part of the patient's overall care (a responsibility of the facility) and does not qualify as a Part B service.

The fourth service (sample item 4, billed as psychological testing with interpretation and a report) was denied because the patient was severely mentally retarded (i.e., he had an I.Q. in the range of 20-34). According to Medicare policy, psychological services (including testing) for patients with this level of mental retardation are not covered unless there is an indication of suicidal ideation or destructive aggression. The medical record did not indicate that the patient had these indications.

THE MEDICARE BILLING PROCESS

We found that there were several reasons why the overpayments occurred. The reasons we identified include, among others, that:

- Physicians, psychologists, and facility billing staffs were not conversant with Medicare billing rules,

- Some of the facilities' billing instructions to the physicians were not in accordance with Medicare's requirements for reimbursement,

- At two facilities, the billing office staff routinely assigned mid-level codes to all monthly evaluation and management services without input from the physicians,

- The physicians, psychologists, and billing staff had not received adequate educational training about Medicare's rules,

- Internal audits of the Medicare billings (when performed) were not comprehensive (i.e., they did not include looking at whether claims submitted to Medicare complied with Federal requirements),

- When problems were found, corrective actions were not always taken, and

- Computer edits were not utilized to eliminate the billing of mutually exclusive services.

Familiarity with Medicare's Rules

In our interviews with physicians, psychologists, and billing staff at the facilities, we noted that they were not familiar with some of Medicare's rules. For example, many thought that simply an order for a prescription or a complete review of all existing medication orders for a patient could be billed to Medicare as an evaluation and management service. Many also said that they included a separate evaluation and management code each time they saw a patient on a given day.

In addition, some physicians told us they were unaware that Medicare required an examination of the patient in order for the service to be a reimbursable service or that they were not aware of Medicare's restrictions on billing mutually exclusive services for the same patient on the same day.

We asked the physicians how they determined which billing code to use for an evaluation and management service. Generally, they said that they primarily relied on the time spent performing the service. While this is one factor that may play a part when selecting the proper code to use, the CPT instructions require that instead of using time as a key component, physicians should rely on the degree of complexity involved in the history, exam, and medical decision making for the service they provide to a patient. (A brief description of how to select the proper code for an evaluation and management service is presented on page 10 of this report.)

Written Instructions

We found that the facilities had written instructions which sometimes conflicted with Medicare's rules and may have contributed to the errors noted in our sampled claims.

For example, at Lanterman the instructions to physicians called for increasing the level of coding each time that the patient was seen on the same day. This instruction appeared on the sheets that they used for daily recording of the billing information:

> "To document multiple physician services to the same resident:
>
> a. For the same diagnosis by the same physician: move the X to the next higher service level column each time the client is seen again during the same day."

The instruction automatically called for a progressively higher code based upon seeing the patient multiple times on the same day. Because this instruction does not take into account the nature and complexity of the (1) history, (2) examination of the patient, (3) medical decision making, and (4) any other contributory factors that might impact the selection of the appropriate level of care to bill to Medicare, it may result in an upcoded service.

At Fairview, we found another instruction that may have encouraged the use of unwarranted higher codes because it called for specific codes for most visits. The instruction to the physicians was:

> "Use 99312 and 99313 for the majority of visits. Avoid using 99311 except for sedation orders."

At Agnews and Sonoma, the sheets used for recording required monthly visits did not provide for the physicians to select the appropriate level of code for the service rendered. Instead, the physicians merely indicated on the form that the patients were seen. The billing office personnel, without reviewing the medical notes written by the doctors, always assigned the mid-level code, 99312. This coding, therefore, was done without regard to what level of service may actually have been performed by the physicians or the completeness of the notes in the medical record.

We found other instructions at Agnews which conflicted with Medicare's requirements for a reimbursable service. For instance, we noted these examples

mentioned as billable services:[8]

> "Any time the physician has a discussion with staff about the client's condition."
>
> "Telephone calls to the family."
>
> "Orders for PPD [purified protein derivative] skin test...."
>
> "Attendance at ID [interdisciplinary] Team meetings & Bioethic committee meetings."

We believe that written instructions to physicians and billing staff should conform with Medicare rules. If any instructions are meant to be applicable only to other payors, they should be appropriately labeled.

Educational Training

We found that educational training about Medicare's rules was lacking. Medical staff, as well as the administrative billing staff, at the facilities told us that they had not had training specifically related to Medicare's reimbursement rules, documentation standards, and the proper selection of CPT codes. The only information that they said they were given regarding Medicare billing related to administrative billing information provided by DDS headquarters.

Although DDS' headquarters manual listed training as one of that office's responsibilities (see page 20 of this report), the headquarters staff said that their training efforts were limited to administrative matters of the billing process and did not include instructions to the medical staff on how they should document progress notes, how to select the various levels of procedure codes, or specifics about various Medicare reimbursement rules.

The facilities had not used the services of the Medicare carrier to become knowledgeable about Medicare billing requirements. One of the services provided by a Medicare carrier is to educate the provider community. Another service provided by the carrier is to publish educational material, such as Medicare

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[8] These instructions were dated April 1994 and were still being used at the time of our audit.

Bulletins and Special Notices. These materials are mailed to the official address of record for each provider. In the case of the DDS and DMH facilities, the bulletins were mailed to the DDS headquarters office in Sacramento. The headquarters office said that they had forwarded each one of them to the appropriate facility. However, we found that the facilities did not maintain a library of these bulletins.

If the medical and billing staffs had received more educational information about Medicare's rules and program guidance, many of the problems disclosed by our audit may not have occurred.

Internal Audits of Medicare Billings

We examined the internal audits (referred to by DDS as "fee for service audits") conducted at the six facilities that had the most claims (about 90 percent) in our sample and those done by the DDS headquarters staff. In summary, we found that:

- Two facilities (Lanterman and Napa) had not performed any reviews of their Medicare billings during our 4 ½-year audit period.

- Two facilities (Fairview and Porterville) performed reviews, but the reviews did not include looking at whether the services that were billed were supported by adequate documentation.

- Two facilities (Metropolitan and Agnews) looked at and found undocumented services but did not take any kind of action on them.

- The reviews done by DDS headquarters staff also found undocumented services but refunds to Medicare were not made.

- None of the four facilities that did reviews (Fairview, Porterville, Metropolitan, and Agnews) nor DDS headquarters included determining if the services were properly coded or met other Medicare reimbursement rules.

- None of the two facilities that found undocumented services (Metropolitan and Agnews) nor DDS headquarters used the information from the reviews to develop action plans for improvement.

Staffs at Lanterman and Napa said that they had not conducted such reviews during our 4 ½-year audit period.

At Fairview and Porterville, two of the four facilities that had written procedures for such reviews, the reviews did not examine whether adequate documentation was present to support the services that were billed. Instead, the reviews were devoted only to identifying services that had not been previously billed to Medicare. The reviews that were conducted consisted of comparing the medical records to the services that had been previously billed to Medicare. According to staff, when the reviews found services that had not been billed, then additional Medicare billings were prepared.

The other two facilities that had written procedures for such reviews (Metropolitan and Agnews), in addition to finding unbilled services, looked for services that had been billed but that were not supported by documentation in the medical records. These two facilities billed Medicare for the newly discovered services, but they did not submit adjustments to Medicare to correct the previous payments in those instances where they determined that documentation was lacking. The written policies describing how to conduct the reviews at these two facilities did not address what to do with services that were found not to have any documentation.

The DDS headquarters staff also conducted "fee for service audits" about once per year at each facility. During the course of these reviews, they prepared new Medicare billings when they found unbilled services. However, they also found services that had been billed but which lacked documentation to support them. When we asked headquarters staff what they had done to refund Medicare's payment for these services, they said that they had offset the undocumented services against services that they found that were not billed. We asked for any documentation to support that they had made this offset when preparing the new billings, but we were told that they had none.

None of the reviews performed by the four facilities that did them nor those done by DDS headquarters staff included looking at whether the services had been billed at the appropriate level (i.e., whether the documentation in the medical record supported the level of service actually billed).

The headquarters policy and procedures required comprehensive reviews. Headquarters staff were responsible for providing direction and advice to the

facilities regarding capturing and reporting physician services with respect to:

"a. Procedure, diagnosis, and physician identification reporting.
b. Covered services (CPT)....
c. Non-covered services edits and systems blocks.
d. Reporting and level-of-services audits.
e. Monitor patient eligibility....
f. Provide training to facility, as necessary.
g. Audit for compliance, errors, and omissions."
(Client Financial Services Branch Manual, section 7078, emphasis added)

However, the reviewers did not look at whether the services billed were properly coded, consisted only of Medicare covered services, and met Medicare reimbursement rules. Instead, we found that the purpose of the reviews was essentially to identify additional Medicare billings.

And lastly, concerning the reviews at Metropolitan and Agnews and those conducted by the DDS headquarters staff that identified billed services that were not supported by documentation, the DDS headquarters staff told us that they properly informed staff at the facilities on numerous occasions that undocumented services were a problem. Yet, there was little evidence that the facilities took action to correct the problem, and it persisted. It is apparent that stronger action, such as involvement by upper management, was needed to bring about changes.

Internal audits can be an effective tool to ensure compliance with Medicare's rules. At a minimum, these reviews should include determining whether adequate documentation exists to support the services that were billed, examining the level of coding, and reviewing any written procedures or instructions that may have caused improper claims. Any services that are identified which are not supported by documentation in the medical records should be treated as overpayments, and, at a minimum, appropriate amounts should be promptly returned.

In addition, the results of these reviews should be used by the facilities' management staff to take whatever steps are necessary to prevent past problems from reoccurring.

Action Plans

Action plans to correct Medicare billing problems were not always implemented. For example, Blue Shield, the Medicare carrier at the time, conducted a statistical sample review of claims at Agnews Developmental Center that disclosed many of the same problems we identified in our audit. The sample consisted of 30 beneficiaries randomly chosen with services rendered between December 1, 1994 and December 31, 1995. For these 30 patients, DDS had billed a total of 83 claims.

The final report was sent to DDS headquarters in October 1996 and to the facility at Agnews in November 1996. It disclosed that numerous claims were denied because:

- No face-to-face encounter with the patient was documented in the medical record,
- Evaluation and management services were billed when the only services documented were reviews of lab results,
- Mutually exclusive services were billed, and
- Telephone calls were billed when they were the only services documented in the medical records.

We asked managers at the six facilities that we visited (those six had about 90 percent of our sampled claims), including Agnews, if they were aware of the findings in this audit. None of them could recall that this information had ever been made known to them. Staff at Agnews were also not aware of any corrective actions that were subsequently taken to make improvements. The DDS headquarters staff had forwarded the carrier's audit report to Agnews, but they said they had not shared the report with any of the other facilities.

Even though there were known problems with duplicative services[9] and mutually exclusive services being billed, no attempt was made to develop computer edits to identify and delete these services before they were billed to Medicare.

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[9] Although DDS billed for some duplicate services as well as mutually exclusive services, our audit did not find that duplicate services were paid by the carrier.

In addition, a "fee for service audit" conducted by DDS headquarters at Porterville Developmental Center in March 1997 disclosed that 24 percent of the services sampled were not supported by evidence of a physician's progress note. Even though this problem was known to exist, we found that no action was undertaken by the facility to correct the problem.

Staff at the facilities that were responsible for ensuring that the "fee for service audits" were conducted could not recall that any action plans had ever been implemented as a result of these reviews.

Effective August 1995, all facilities ceased billing for psychology services that were rendered by psychologists because of disclosed documentation problems and problems with lack of appropriate identification numbers for the psychologists who provided the services.

Although the facilities were aware of the problems with billing for psychology services, no one we interviewed at the facilities indicated that they knew of other problems related to: (1) a lack of evidence showing that the patient was examined, (2) upcoding, (3) mutually exclusive services, or (4) noncovered services. Therefore, no attempts were undertaken to make corrections in these areas.

We believe that prompt corrective action should be taken whenever billing problems are identified, including determining whether the problems noted at one facility may be occurring at other facilities and taking corrective actions at those facilities as well.

RECOVERY OF OVERPAYMENTS FOR CERTAIN UPCODED SERVICES

Eight of the 14 upcoded services we found were paid prior to August 1995. As such, the carrier would not have sought overpayments at the time. Prior to August 1995, Blue Shield, then the carrier for DDS' Part B claims, did not seek recovery of overpayments from providers for upcoded evaluation and management services based on instructions from HCFA (it did seek recovery for other issues, such as no evidence of physician examination of patient, etc.). Carrier staff explained that they did not seek overpayments on upcoding because HCFA advised carriers not to do so pending further clarification on the description of the various levels of evaluation and management services.

The question of whether there is a legal basis for recovering overpayments relating to upcoding of evaluation and management services rendered prior to August 1995 was addressed by the U.S. General Accounting Office (GAO) in a report entitled MEDICARE: Concerns With Physicians at Teaching Hospitals (PATH) Audits (GAO/HEHS-98-174, dated July 23, 1998). In that report, the GAO concluded that the OIG had the legal basis for applying this coding criteria.

The report stated that:

> "Furthermore, although detailed guidance for documenting evaluation and management codes--the codes physicians use to bill Medicare for certain services--was not effective until 1996, the definitions of these codes and instructions for their use have been available since the codes were implemented in 1992 and provided the standard for the PATH initiative.
>
> * * * * *
>
> "The 1992 CPT provided definitions or explanations of the various levels of evaluation and management services; ultimately, more clarity was provided by the publication of guidelines, effective August 1995, on how to use and interpret the codes in order to document services.
>
> "Notwithstanding the subsequent publication of clarifying guidance, from 1992 to 1995, Medicare required physicians to code their services in order to receive reimbursement, and the CPTs for 1992 through 1995 provided definitions for determining the appropriateness of such coding."

In addition, the report said:

> "Despite the concerns raised by representatives of the academic medical community, HHS OIG has legal authority to apply the physician presence and coding criteria it is using in the PATH initiative....Similarly, despite recognition that evaluation and management coding guidance needed clarification, physicians have always been required to bill only for services performed and to comply with billing guidance in effect at the time." (emphasis added)

For our review, NHIC's medical reviewers applied the CPT definitions and guidance appropriate at the time the services were rendered. Therefore, the OIG believes it is appropriate to seek overpayments for such upcoded evaluation and management services.

RECOMMENDATIONS

To address these problems, we recommend that NHIC:

1. Develop with HCFA's guidance a monitoring plan to ensure that DDS' future claims are brought into compliance with Medicare's rules, and

2. Not recover the identified overpayment at this time pending further review by the OIG.

THE STATE'S COMMENTS

A response to our draft report was jointly prepared by DDS and DMH (see Appendix D for the response in its entirety). The two departments disagreed with our findings and conclusions. They stated that the audit sample design was flawed, the data produced by the sample was misleading and inaccurate, and as a result, our conclusions were not valid. They also said that they were provided with confusing and conflicting instructions regarding documentation and billing requirements by Blue Shield, the prior Medicare carrier. In addition, they disagreed with our conclusions about the possible causes which led to the errors we noted.

Concerning the audit sample design, they were of the opinion that since we had not included all claims that had been billed when we determined the audit universe, then the sample process was biased. They contended that a sample size of 100, randomly chosen, was not sufficient to draw reasonable inferences about the physicians' and psychologists' treatment, documentation, and billing practices.

They asserted that because the sample involved claims from two different departments, with different types of facilities, each having different types of patients, then the data could not be used to reach conclusions about the prevalence of errors.

In addition, they maintained that the report did not provide the basis on which the overpayment of $13,046,880 was calculated and, as a result, its accuracy and validity could not be confirmed nor denied.

Concerning the conflicting instructions and interpretations provided by the prior carrier, they stated that the medical record documentation that the medical reviewers treated as insufficient to support evidence that the patients had been examined, had been regularly approved as acceptable by Blue Shield. Two examples of medical notes that were treated as acceptable in the Agnews audit were provided as evidence of this situation. They also provided a recent letter from a staff person in NHIC's Educational Outreach unit as evidence that NHIC's policy does not require an actual examination of the patient. In addition, they contended that two medical notes for claims billed as nursing facility visits and denied by our audit contained adequate support for billing a medication management service.

They also explained that two of the services determined to be upcoded by NHIC's medical reviewers were actually underpaid because the audit had not given credit for any payment from Medicare Part A (for the technical component) that the State would have been entitled to if the claims had been properly billed to Blue Cross, the Medicare Part A intermediary. For three of the claims for which they could not find supporting documentation (three services performed by psychologists), they were of the opinion that it was not appropriate to spread the errors over the entire universe since they had stopped billing services performed by psychologists effective August 1995.

For the six claims found to be unallowable as mutually exclusive of other services, they said that the audit had not given credit for the one correct service that was billed in each case. In addition, for the one service found to be noncovered because the patient was profoundly mentally retarded, they asserted that the policy was not in effect until June 1998 and, therefore, the sample service rendered in 1995 should not be considered as unallowable.

And finally, concerning the audit's conclusions regarding the possible causes for the unallowable claims, they also did not concur. Even though they outlined improvements they recently made in training, policies and procedures, billing forms, and their "fee for service audits," they maintained that they could not ascertain the validity of our conclusions about what the physicians told us regarding their lack of knowledge of Medicare's rules and lack of training relating to Medicare because they did not know specifically how many and which physicians gave us the information. They also were of the opinion that the examples of improper instructions cited in the audit report were exceptions rather than the rule. In addition, they stated that the departments were not contractually required to

monitor physician and psychologist billings to determine if the billings met Medicare requirements.

THE NHIC'S COMMENTS

In a response to our draft report (see Appendix E), NHIC disagreed with several comments in the State's response. It stated that DDS and DMH had taken information out of context to support their contention that the former carrier had used different interpretations of Medicare's rules.

Concerning the one sampled claim which Blue Shield examined in 1992 at the request of HCFA, NHIC stated that the purpose of the review was to assess whether the service in question was supported. It was not intended to be a blanket approval for documentation requirements.

Concerning the two sampled services for which the State claimed that it was underpaid, NHIC disagreed and believed that the State was confusing Part B services with Part A services. The NHIC also noted that it was not aware that DDS had made a voluntary refund to the Medicare program for past billings when it discovered that its services by psychologists were not allowable.

Regarding the psychological testing for the severely mentally retarded patient, the carrier commented that it was incomprehensible that the staff psychologists and psychiatrists were unaware that profoundly retarded beneficiaries could not benefit from psychological intervention. As such, the psychological services were not a covered benefit of the Medicare program.

THE OIG'S COMMENTS

The OIG believes that the State's response did not present evidence that would warrant changes in our findings. We did make changes to the report to delete any reference to error rates at individual facilities and in different years.

Regarding DDS' and DMH's contention that the sample design was flawed, we believe that our methodology was appropriate in this instance. Statistically, a simple random sample of 100 was adequate in this audit for determining the extent of inappropriate billings. We used a random number generator to select the sample items from the universe of all claims available to us at the time the selection was made. We had no control over which items were selected. The projection of the

sample was limited to the universe from which the sample was drawn and is statistically valid.

Even though differences in the types of facilities and their patients may have existed between the facilities, they had no effect on the overall error rate. We believe that the answers provided to us in our interviews with staff at the facilities, as well as headquarters, our review of the policies and procedures, the number of errors at the individual facilities, and the overall error rate (73 percent) showed that our conclusions were valid, particularly in that the billing problems were prevalent.

Regarding whether sufficient information was included in our audit report to show how the total overpayment was calculated, we did present all necessary information in the appendices to determine the total projected overpayment and its statistical reliability.

The DDS and DMH asserted that different instructions and interpretations were provided by the two carriers and stated that they relied in good faith on these instructions and interpretations in submitting their claims. However, we did not find that to be the case. First, the two departments did not provide any specific instructions from the carriers that they had relied upon. Second, we found that the interpretations and actions by Blue Shield were remarkably consistent with those of NHIC.

For example, the Agnews audit, performed by Blue Shield, resulted in a claim denial rate of 50 percent. Many of the claims denied were for the same reasons as those in this audit, including no examination of the patients and services supported only by notes indicating a review of the patient's medications. The DDS' and DMH's claim that their physicians and psychologists relied on a select few services that were accepted by Blue Shield in the Agnews report is not credible, given that DDS and DMH did not share the report with other facilities. Furthermore, the physicians we interviewed were not even aware of the Agnews audit results.

In another example, Blue Shield, investigating a complaint by a patient's relative of services billed in September 1992 but not rendered, determined that payment should be denied because the patient was on visiting leave from the facility for 3 days and that the supporting documentation in the medical record stated only that "...the monthly medications were reviewed and renewed today." That conclusion by Blue Shield was consistent with NHIC's conclusions for this audit–namely, that review and renewal of medications by itself is not a payable Medicare service.

In another instance, DDS appealed Blue Shield's denial of several services for a patient in June 1994 where the progress notes lacked any indication that the services involved any personal contact with the patient. Two representatives from DDS' Client Financial Services Branch attended the July 1996 hearing and presented testimony. Despite their arguments, the hearing officer upheld Blue Shield's determinations and stated in her report, dated October 30, 1996, that:

> "It is not reasonable for Medicare to allow payment for services billed that were not actually performed, such as individual psychotherapy with a patient that was not even personally seen by the physician. Most of the entries into [the patient's] medical records indicate that the physicians would discuss the patient's daily behavior with the hospital staff, then adjust his medications accordingly. This does not represent one to one personal contact with the patient."

These three examples, among many, demonstrate that Blue Shield's interpretations of Medicare's rules were consistent with those of NHIC's.

Concerning the letter from an Educational Outreach employee of NHIC, dated April 20, 1999, we note that the letter responds to an oral question that was posed to the employee and the question itself was not included in the State's response. The NHIC employee's response did not state that evaluation and management services were payable by Medicare when those services did not involve an examination of the patients. Any inference to this effect on the part of the State would be in error.

Further evidence that NHIC's interpretations were consistent with those of Blue Shield's is the fact that the majority of the medical reviewers who reviewed the sample items in this audit had also worked as reviewers for Blue Shield. They used the same appropriate Medicare criteria as in past reviews.

With regard to the two claims that the State contended were actually underpaid, the DDS and DMH have used flawed logic by applying Part A reimbursement rules to a Part B claim. The two claims have been correctly priced as Part B services.

Concerning the statistical treatment of the three psychology services for which the State could not locate any supporting documentation, the projection of the errors to the entire universe is the only statistically valid application. To project these three errors to only a portion of the universe would result in an improper statistical inference.

For the six claims that we found that were mutually exclusive of other services, the State was paid for the other claimed service of the pair. In each of the six instances, only one service of the pair was denied (the sample item), even if the documentation for the unquestioned service was not sufficient to support its payment.

Regarding the service for psychological testing of a patient with known severe mental retardation, the claim was properly denied. One of Medicare's most basic principles is that services must be reasonable and necessary. By law, services that are not reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member are excluded from coverage.

The two State departments did not concur with our conclusions about the causes for the unallowable claims. However, they supplied little information to refute our conclusions.

Regarding DDS' and DMH's statement that the two departments were not required to ensure that the physicians/psychologists billed correctly, we note that the professional staff at the facilities were State employees or consultants. Therefore, we believe that the DDS' headquarters office, agreeing to oversee the billing process for the facilities which included submitting the claims and receiving payment from Medicare, has a responsibility to ensure that the bills submitted comply with Medicare rules. It should create an organizational culture that seeks to prevent conduct that does not conform to the program's laws and regulations. It should also ensure that it has strong internal controls over the entire billing process.

APPENDICES

Types of Overpayment Errors by Facility

DEVELOPMENTAL CENTERS

Sample item	Facility	PE	ND	MU	NC	UP	OK
2	Agnews	X					
13	Agnews	X					
15	Agnews	X					
25	Agnews						X
40	Agnews				X		
45	Agnews	X					
53	Agnews						X
65	Agnews	X					
75	Agnews	X					
76	Agnews	X					
78	Agnews	X					
82	Agnews						X
83	Agnews						X
98	Agnews						X
100	Agnews						X
Subtotals for Agnews		**8**	**0**	**0**	**1**	**0**	**6**
19	Camarillo		X				
23	Camarillo		X				
26	Camarillo	X					
37	Camarillo	X					
44	Camarillo			X			
54	Camarillo	X					
72	Camarillo					X	
Subtotals for Camarillo		**3**	**2**	**1**	**0**	**1**	**0**
8	Lanterman						X
17	Lanterman	X					
18	Lanterman	X					
21	Lanterman					X	
39	Lanterman		X				
46	Lanterman						X
47	Lanterman	X					
48	Lanterman						X
50	Lanterman	X					
51	Lanterman	X					
56	Lanterman						(NE)
57	Lanterman	X					
71	Lanterman	X					
77	Lanterman	X					
79	Lanterman	X					
90	Lanterman						X
Subtotals for Lanterman		**9**	**1**	**0**	**0**	**1**	**5**

LEGEND

PE= No evidence that patient was examined
ND= No documentation
MU= Mutually exclusive
NC= Noncovered
UP= Upcoded
OK= claim was ok
(NE)= error, but no effect on payment

Types of Overpayment Errors by Facility

Sample item	Facility	PE	ND	MU	NC	UP	OK
1	Fairview			X			
4	Fairview				X		
7	Fairview					X	
12	Fairview					X	
14	Fairview					X	
16	Fairview						X
24	Fairview	X					
27	Fairview						(NE)
29	Fairview	X					
42	Fairview						X
52	Fairview	X					
55	Fairview			X			
58	Fairview	X					
66	Fairview	X					
70	Fairview	X					
74	Fairview						X
80	Fairview			X			
86	Fairview					X	
94	Fairview						X
95	Fairview						X
96	Fairview					X	
97	Fairview					X	
99	Fairview	X					
Subtotals for Fairview		**7**	**0**	**3**	**1**	**6**	**6**
5	Porterville	X					
9	Porterville	X					
20	Porterville						X
22	Porterville						X
30	Porterville	X					
33	Porterville					X	
34	Porterville	X					
43	Porterville	X					
73	Porterville						X
81	Porterville	X					
84	Porterville	X					
85	Porterville	X					
88	Porterville	X					
93	Porterville	X					
Subtotals for Porterville		**10**	**0**	**0**	**0**	**1**	**3**

LEGEND

PE= No evidence that patient was examined
ND= No documentation
MU= Mutually exclusive
NC= Noncovered
UP= Upcoded
OK= claim was ok
(NE)= error, but no effect on payment

Types of Overpayment Errors by Facility

Sample item	Facility	PE	ND	MU	NC	UP	OK
36	Sonoma						(NE)
Subtotals for Sonoma		**0**	**0**	**0**	**0**	**0**	**1**
32	Stockton						X
87	Stockton						X
Subtotals for Stockton		**0**	**0**	**0**	**0**	**0**	**2**
Subtotals for All Developmental Centers		**37**	**3**	**4**	**2**	**9**	**23**
	STATE HOSPITALS						
63	Atascadero					X	
Subtotals for Atascadero		**0**	**0**	**0**	**0**	**1**	**0**
3	Metropolitan	X					
38	Metropolitan					X	
41	Metropolitan					X	
59	Metropolitan	X					
64	Metropolitan		X				
68	Metropolitan			X			
89	Metropolitan						X
91	Metropolitan				X		
Subtotals for Metropolitan		**2**	**1**	**1**	**1**	**2**	**1**
6	Napa						(NE)
10	Napa		X				
11	Napa						(NE)
28	Napa	X					
31	Napa						X
35	Napa	X					
49	Napa	X					
60	Napa			X			
61	Napa	X					
62	Napa		X				
67	Napa					X	
69	Napa				X		
92	Napa					X	
Subtotals for Napa		**4**	**2**	**1**	**1**	**2**	**3**
Subtotals for All State Hospitals		**6**	**3**	**2**	**2**	**5**	**4**
Totals for All Facilities		**43**	**6**	**6**	**4**	**14**	**27**

LEGEND

PE= No evidence that patient was examined
ND= No documentation
MU= Mutually exclusive
NC= Noncovered
UP= Upcoded
OK= claim was ok as paid
(NE)= error, but no effect on payment

Sampling Methodology

Objective:

Our audit objective was to examine a statistical sample of Medicare payments made to DDS by NHIC over the 4 1/2-year period January 1, 1993 through June 30, 1997 to determine if the payments were appropriate for the services that were billed.

Population:

The population was all Medicare Part B claim lines with dates of service for which the carrier had processed a Medicare allowed amount from the period January 1, 1993 to June 30, 1997. (The Medicare allowed amount is Medicare's approved charge before the patient's deductible and coinsurance are applied.) NHIC did not provide us with claim lines for the following facilities with paid dates during the period January 1, 1993 through September 30, 1995: (1) Camarillo - SNF, (2) Lanterman - Acute, and (3) Napa - SNF. Therefore, these claim lines were not included in our universe. We adjusted all claim lines in the universe by excluding any claims which the carrier had projected overpayments that were identified in prior reviews. The resulting claim lines totaled 612,636, and DDS was paid $19,024,205 for these claim lines.

Sampling Unit:

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

Sampling Design:

A single stage, unrestricted random sample was used.

Sample size:

Our sample size consisted of 100 claim lines. For each of the 100 claim lines, there was only one service billed.

Estimation Methodology:

Using the Variables Appraisal Program of the Office of Audit Services (RATS-STATS), we calculated the 90 percent two-sided confidence interval 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 612,636 to project the value of the unallowable amount. The result of this projection is presented below:

Difference Value Identified in the Sample	$2,130
Point Estimate	$13,046,880
Lower Limit	$11,265,584
Upper Limit	$14,828,176

Point Estimate by Type of Facility

Point Estimate - DDS Facilities	$9,228,687
Point Estimate - DMH Facilities	$3,818,193
Total of Point Estimate by Type of Facility	$13,046,880

Point Estimate by Type of Error

Point Estimate - No Examination of the Patient	$8,445,555
Point Estimate - Mutually Exclusive	$1,737,313
Point Estimate - Upcoded	$1,183,184
Point Estimate - No Documentation	$1,027,084
Point Estimate - Noncovered	$653,744
Total of Point Estimate by Type of Error	$13,046,880

STATE OF CALIFORNIA–HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF DEVELOPMENTAL SERVICES
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May 26, 1999

Mr. Lawrence Frelot
Regional Inspector General for
Audit Services
Office of the Inspector General
50 United Nations Plaza
San Francisco, CA 94102

Dear Mr. Frelot:

OFFICE OF THE INSPECTOR GENERAL'S DRAFT AUDIT REPORT
(CIN: A-09-98-00072)

The Departments of Developmental Services (DDS) and Mental Health (DMH) staff have reviewed a copy of the draft audit report prepared by the Office of the Inspector General (OIG) entitled "Audit of Medicare Part B Services Billed by California's Developmental Centers and State Hospitals for the Period January 1, 1993 through June 30, 1997." DDS and DMH believe that OIG's report contains useful information that will be of assistance to both departments as they plan for the future.

Since the audit covered both developmental centers operated by DDS and state hospitals operated by DMH, the comments are included in a single joint response which will provide specific comments to OIG's findings and recommendations and discuss how DDS and DMH have each addressed the issues. DDS and DMH appreciate the opportunity to respond and understand that these comments will be included in the final report when issued.

If you have any questions, please contact Patsy Nelson, Manager of DDS's Financial Management Services, at (916) 654-3377 or Nick Burgeson, Chief of DMH's Program Policy and Fiscal Support, at (916) 654-3600.

Sincerely,

for Paul D. Carleton
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Enclosure

"Building Partnerships, Supporting Choices"

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**Departments of
Developmental Services' and Mental Health's
Joint Response to the Draft Audit Report of the
Office of the Inspector General
For The Period January 1, 1993, Through June 30, 1997**

I. OVERVIEW

The comments contained herein are in response to the Office of the Inspector General's (OIG) draft audit report (CIN: A-09-98-00072) provided to the Departments of Developmental Services (DDS) and Mental Health (DMH) for their review and comment. The draft audit report is based on OIG's review of a sample of 100 claim lines from a selected group of 612,636 claim lines billed by California's developmental centers (DC) and state hospitals (SH) during the four and one-half year period covered by this audit January 1, 1993, through June 30, 1997. The total amount paid on the 612,636 claim lines for Part B services billed by individual physician and psychologist Medicare contract providers was about $19 million. OIG's conclusion is that Medicare overpaid DDS and DMH in the amount of $13,046,880.

In addition to this financial conclusion, OIG's auditors state many other conclusions and make a number of assertions of fact. DDS and DMH have fully evaluated the observations and comments presented in the draft audit report. This joint response by DDS and DMH acknowledges the audit findings and specifies the findings and conclusions the departments do not concur with in OIG's draft audit report.

OIG's auditors identified five problem categories listed on page 5 of the draft audit report under FINDINGS. The 100 claims reviewed by OIG centered around these five issues:

- No Evidence Physician Examined Patients
- Upcoded Services
- No Documentation
- Mutually Exclusive Services
- Noncovered Services

In the health care industry across the United States during the period covered by this audit, DDS and DMH note that the most common reasons for disallowances and overpayments included these same five problem areas. It should not have been surprising to OIG's auditors that the DCs and SHs would have problems in these areas just as other Medicare providers and health organizations were experiencing difficulties in these same areas.

DDS and DMH wish to point out that after the audit was completed but before the draft audit report was issued, DDS and DMH staff met with OIG's auditors to discuss the findings that would be included in the draft audit report. As a result of these meetings, both DDS and DMH sent letters to the senior auditor laying out some of the issues that were relevant to OIG's findings. There is no evidence in the draft audit report that the additional information was considered. DDS and DMH believe the comments are still valid and have included the letters as Exhibit A to this response. Some of the comments in this response are taken from those letters and their attachments in relation to the areas where concerns have been expressed.

DDS and DMH disagree and object to the following findings and actions of OIG:

A. Sample Method (use of the audit data in the sampling methodology, i.e. sample size, universe selection, etc.)

B. Difference Between DDS and DMH (significant differences were not recognized by OIG)

C. Conclusion that Problems are System Wide (sample does not allow for reasonable comparative inferences between facilities, programs, or individual providers)

D. Conclusion There was Little Improvement Over Period of Audit (data is inadequate for the purpose of determining if problems improved or grew worse with passage of time) *

E. Data Does Not Support Conclusions (use of a system wide projection of the error rate to the universe)

F. Change in Medicare Carrier (conflicting instructions and interpretations from two different Medicare carriers)

DDS and DMH believe the audit design was flawed and that a different audit methodology should have been used to conduct OIG's audit. Errors in the design resulted in sample biases that then produced misleading and inaccurate data. OIG's auditors relied on erroneous data in reaching their conclusions regarding the extent of Medicare billing errors by physicians and psychologists in the DCs and SHs and the amount Medicare overpaid during the period covered by the audit. Further explanation of these disagreements are included in detail in Section II. PROBLEMS OF AUDIT DESIGN AND USE OF DATA.

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In addition to concerns about the adequacy and validity of the audit process, DDS and DMH believe the tone and focus of the draft audit report does not reflect a balanced or objective view of the circumstances in place during the period covered by the audit. The data in this response will demonstrate that confusing and conflicting instructions regarding documentation and billing requirements were given to DDS and DMH by Blue Shield of California (BSC), the Medicare carrier during 47 of the 54 months covered by this audit. This is particularly important since problem claims identified in the audit relate to errors in these areas.

In asserting OIG's legal authority to recover overpayments in spite of HCFA's failure to provide needed clarification, the auditors acknowledge (see pages 22 and 23 of the draft audit report) that one of the reasons documentation and billing errors were occurring was because of confusing and/or conflicting instructions from HCFA and its Medicare carriers. During the period covered by the audit, Medicare providers in DCs and SHs relied in good faith on the instructions and behavior of HCFA's agent, BSC, regarding the adequacy and acceptability of certain documentation practices. With all due respect to General Accounting Office's legal opinion on the matter, neither the Medicare beneficiaries, these contract providers, nor DDS and DMH should suffer any detrimental consequences as a result of such good faith reliance. *

This response also comments on the specific findings in relation to the 73 problem claims. Both DDS and DMH believe the evidence provided in this response will demonstrate that in a number of cases, the specific disallowance should not have been taken and the error level is lower than that reported in the draft audit report. The comments contained in this response regarding the use of data developed from this audit and the conclusions drawn from that information are not intended in any way to minimize the need to improve monitoring systems and performance. As a matter of fact, a number of positive changes have been made in the billing process since the period covered by the audit. Additional improvements have been implemented as a result of OIG's auditor's comments and suggestions, and still others have been initiated since receipt of the draft audit report. These improvements are discussed in some detail throughout the remainder of this response.

DDS and DMH are committed to ensuring that the claims submitted to the Medicare program accurately reflect medically necessary and eligible services provided to Medicare beneficiaries. Both DDS and DMH welcome closer working relationships with the Health Care Financing Administration (HCFA), the Medicare fiscal intermediary, and the current Medicare carrier, National Heritage Insurance Company (NHIC), as we all strive for improved patient care as well as regulatory compliance.

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II. PROBLEMS OF AUDIT DESIGN AND USE OF DATA

The design of the audit sampling methodology used in this audit was flawed. As a result the conclusions drawn from the findings are inaccurate and misleading and cannot be relied upon as a basis for making generalizations about the percentage of overpaid claims in the identified audit universe (612,636 claim lines) or the amount of any overpayment to be recovered from DDS or DMH.

A. Sample Method

There was a total of about 800,000 claim lines submitted for payment during the four and one-half years covered by the audit. On page 2 of the draft audit report, the auditors indicate they decided to exclude some claim lines from the audit sample. The excluded claim lines were those for which the Medicare carrier had projected overpayments in prior reviews. Also excluded were all claim lines from January 1, 1993, through September 30, 1995, from two DMH Skilled Nursing Facility (SNF) units (one at Napa SH and the other at Camarillo SH/DC) and DDS acute units at Lanterman DC. These claim lines were not included because NHIC did not provide the auditors with any claim lines with paid dates during the 1993 to 1995 time period. We have discovered that the audit does not include any claim lines from the SNF units at Sonoma DC. From the total 800,000 claim lines submitted for payment, 612,636 claim lines were selected by the auditors for review. These decisions had the effect of reducing the scope of the audit universe by about 187,364 claim lines or 23 percent.

Making these changes in the sample size and scope also modified the characteristics of the universe that was sampled. In this case the changes disproportionately reduced the number of SNF and acute claims and biased the sample process in the direction of a smaller sample universe that contained a different mix of programs, services and Medicare providers. The auditors then reviewed 100 claim lines selected on the basis of a single stage, unrestricted sample of the revised audit universe of 612,636. During the four and one-half years covered by the audit there were 768 individual Medicare providers in DDS and DMH contributing to the 612,636 claim lines. On the average they each billed about 800 claim lines. The 100 claim line random sample included the records of only 69 (9 percent) of the 768 providers. For most providers only one claim line was included in the audit. In a few cases, 2 to 7 claim lines of a provider were examined. For 699 (91 percent) providers, no claim lines were selected or examined in the random sample. Reviewing one record per provider, or even 7 claim lines per provider, is just not a sufficient sample on which to draw a reasonable

inference about the provider's treatment, documentation and billing practices. This sampling method certainly does not support generalized inferences about the documentation and coding compliance of the 768 providers working in 11 different facilities.

Another example of the flawed sample process is that 23 claims lines of the 100 sample claim lines were selected at Fairview DC and that 1 physician provider at Fairview DC had 7 claim lines reviewed. Fairview DC represented 23 percent of the total sample and the single physician provider at Fairview DC represents 7 percent of the total sample. Although Fairview DC employed 16 physicians providing Medicare billable services, 7 of the 23 claim lines selected were billed by 1 physician. This physician's claim lines represented 30 percent of the claim lines reviewed at Fairview DC and the auditors state that all 7 of the claims were erroneously paid. Of the 23 claim lines reviewed at Fairview DC, the auditors identified 17 as containing errors. The 1 physician's claim lines represent 41 percent of Fairview DC's errors and 7 percent of the entire system's errors. This small sample is just not adequate to conclude that this is representative of the other documentation efforts of the other 16 Fairview DC physicians.

The audit clearly looked only at the total claims in the selected universe of claims (612,636) without considering the implications of potential provider, program, facility, or departmental differences in documentation and billing practices. Since the random sample method assumes there are no significant differences in the sample universe, the data developed by this audit method cannot then be used to draw conclusions about the differences or distinctions of the parts of the universe. This audit uses a single stage, unrestricted design. Had the auditors used a stratified, multistage design as discussed on page 2 in Inspector General Brown's testimony before the House of Representatives on March 26, 1999 (Exhibit B), DDS and DMH believe the resulting information would have been both more accurate and more helpful to OIG, DDS, and DMH. *

B. Differences Between DDS and DMH

There are a number of significant differences between DDS and DMH as well as differences between the individual DCs and SHs. As acknowledged in the last paragraph on page 1 of the draft audit report, the Client Financial Services (CFS) unit within DDS serves as a clearinghouse for billing purposes for the DCs and provides this same function for DMH's SHs under a joint Memorandum of Understanding. DDS serves as a clearinghouse for all billing activities including those related to Medicare for both departments.

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CFS serves as an administrative entity that accepts paper or electronic transactions from a total of seven DCs owned and operated by DDS and four SHs owned and operated by DMH. CFS also performs high level edits and value added processing and then electronically (via magnetic tape) routes the information to the Medicare carrier for reimbursement.

The single stage, unrestricted sampling method used in this audit treated both departments as a single homogeneous provider of service. In fact, in almost all respects the two departments function independently and serve distinctly different clientele. Each facility is independently licensed pursuant to applicable California health facility licensing regulations (Title 22, California Code of Regulations). Each has its own unique Medicare and Medi-Cal provider agreement and number, and each facility has its own governing body and medical staff organization. During the period covered by the audit there were 11 facilities (7 DCs and 4 SHs). They serve different client/patient populations (DD vs. MD). There are about four times as many Medicare providers (physicians and psychologists) in DMH's SHs than there are in DDS's DCs. Yet another variable not addressed by the sampling method used in this audit was that the number of Medicare eligible clients, as a percentage of the facility's overall population, differed from one facility to another and at the same facility from one year to another during the period covered by the audit.

Using a single stage, unrestricted audit design methodology that combines DDS and DMH into a single universe resulted in a review of 78 DDS claim lines, but only 22 DMH claim lines. Assuming there are substantive differences between the two departments, this proportional distribution of claims reviewed could easily affect (positively or negatively) either department's disallowance rate and payback requirement. The comparison of the two departments and the conclusions reached as a result of that comparison are impaired by the fact that 7 DDS vs. 3 DMH facilities were sampled and the sample sizes at DDS facilities were generally larger then those at DMH facilities. Using the data generated by this audit to conclude that the problems found are pervasive and equally present in all parts of the providers, programs, facility, or department would be incorrect. The data cannot be used as a valid basis for reaching any conclusions about the prevalence of documentation errors or coding errors.

The differences described above, differences that could easily bias the data sampling process and invalidate the conclusions, were not recognized or addressed in the design of this audit. If a stratified, multistage audit design had been employed giving consideration of these differences, DDS and DMH

believe the overall percentage of disallowed claims and associated overpayments would have been substantially less than the level found in the audit.

C. Conclusion that Problems are System Wide

Page 5 of the draft audit report states that, "Except for the three facilities that had a very small number of claims in our sample, we noted no significant differences in error rates or the type of problems amongst all the facilities. Thus the problems appeared to be system wide." This statement is incorrect and is not consistent with the facts presented. *

The sample 100 claim lines reviewed in the audit were selected randomly from the universe of 612,636 claim lines without reference to department, facility, program or Medicare provider. This random selection process resulted in Patton SH being excluded entirely from the 100 claim line sample. As the table at the top of page 6 of the draft audit report demonstrates, the random sample yielded only 1 claim line to review at Sonoma DC and Atascadero SH and 2 claim lines for review at Stockton DC.

DDS and DMH do not believe the auditors inferred, nor did they intend for the readers of their report to infer, that because the single claim line reviewed at Atascadero SH was disallowed, that 100 percent of the claim lines submitted from Atascadero SH should be disallowed. It is just as unlikely that they intended the reader to conclude that because the 1 claim line reviewed at Sonoma DC and the 2 reviewed at Stockton DC did not contain errors that no claim lines submitted by providers at these two facilities would have any errors. DDS and DMH believe it should be evident to everyone that these small samples were only to be a representative sample of the entire universe being examined of the 612,636 claim line universe. The 100 claim lines identified in the audit sample were never intended to be used to make inferences about the individual facility from which they were drawn or to be used as the basis for comparing one facility to another (e.g., Atascadero SH to Sonoma DC or Stockton DC).

Again referring to the table at the top of page 6 of the draft audit report, DDS and DMH note that the differences in error rates among the seven other facilities ranges from 60 percent to 100 percent a spread of 40 percent which would be considered significant by most people. It is just not possible to make reasonable comparative inferences between facilities, programs or individual providers based on the 100 claim line sample data. The number of sample items relating to any one facility is too small to yield a reasonable *

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result. For example, is it not likely that 100 percent of all claim lines submitted by Medicare providers at Camarillo DC are in error? The answer is clearly no, that is not possible. The fact is that the correct error rate for each facility cannot be determined from the data. First of all the sample was not selected or collected to answer that question. Second, the sample size for each facility is far two small to provide any reliable information about any specific facility's error rate.

The following table further demonstrates how efforts to use the data from this audit to reach conclusions about the system wide compliance can be misleading. Stockton DC and Sonoma DC, with more than 1,000 Medicare beneficiaries had zero error rates. Camarillo SH/DC and Atascadero DC, with approximately 500 Medicare beneficiaries, had an alleged 100 percent error rate. The following table compares the approximate number of paid claim lines by DC and SH with the number of claims sampled and claims determined to be in error.

DC	Approximate Number of Paid Claim Lines	Number Sampled	Errors	Error Rate
Sonoma	95,000	1	0	0
Stockton	15,000	2	0	0
Camarillo (DD)	17,500	0	0	0
SH				
Camarillo (MD)	35,000	7	7	100 %
Atascadero	13,000	1	1	100 %

Of course, the sampling method used in the audit did not intend to compare or contrast the various components of DDS's or DMH's systems. Its only function was to assess the number of claim lines in the 100 claim line sample that were overpaid.

D. Conclusion There was Little Improvement Over Period of Audit

There is simply no credible evidence in the 100 claim line data to support the conclusion that there was no improvement in compliance over time or that management did nothing to correct billing problems. On the bottom of page 6 of the draft audit report a table presents the percent of error rates for the years covered by the audit. As DDS and DMH have already pointed out, OIG employed a simple random sampling technique. This sampling method was *

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not intended to provide any comparative information regarding error rates for the various years included in the audit. The data is completely inadequate for the purpose of determining if the problems identified improved or grew worse with the passage of time. The sample size is also insufficient to determine if there were any changes in error rates at one institution or another over time. Also, since the sample size was different between the years and between the facilities in each year, the percent of errors each year shown in the table on page 6 of the draft report is meaningless and misleading. The data does not support any particular conclusion as to whether improvement in billing/documentation practices improved or declined from the beginning to the end of the period covered by the audit. *

E. Data Does Not Support Conclusions

DDS and DMH believe that the data generated by this audit does not support the conclusions reached by the auditors or the $13 million recoupment that is proposed. The specific calculation for estimating the $13 million was not included as part of the draft audit report; however, DDS and DMH requested and received additional information which detailed the methodology and actual calculations used by OIG to determine the $13 million overpayment.

DDS's and DMH's review of this information showed that OIG's auditors simply calculated the actual cost of disallowance and the cost difference for any overpayment/underpayment for each of the 73 records questioned by the auditors. The auditors then used this dollar amount ($2,129.63) to determine the average differences for the total 100 claims reviewed ($2,129.63 divided by 100 equals $21.30 for an average per claim) and applied that average to the total claim lines ($21.30 x 612,636) and determined that the overpayment was $13,046,880. The data included in the draft audit report simply does not provide the foundation on which this conclusion is based and therefore its accuracy and validity cannot be confirmed or denied.

The sample data that relates to each DC and SH is not adequate to conclude that there is any relationship at all between the compliance rate for one facility and the compliance rate for another. The 100 claim lines identified in the audit sample were never intended to be used to make inferences about the individual facilities from which they were drawn or to be used as the basis for comparing one facility to another. *

F. Change in Medicare Carrier

Another area of concern is the conflicting instructions and interpretations of the Medicare regulations used during the billing period, January 1, 1993,

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through June 30, 1997, and those used to conduct the audit in 1998. During the billing period there were two separate Medicare carriers, BSC and NHIC, each with different interpretations of the regulations in reference to acceptable documentation for billable services. During the majority of this time, 47 of the 54 months, BSC was the Medicare carrier. BSC allowed payments for a monthly physician progress note on the client's condition. This note did not require that the client necessarily be examined by the physician (Medicare Carrier Manual Section 15062). DDS and DMH recently asked for a reinterpretation of this section. ** ', Educational Outreach with NHIC, in her letter to ** , dated April 20, 1999, responds to this question. Her current interpretation continues to support the billing for these services (Exhibit C). Indeed, NHIC is still allowing payment of these claim lines. In addition, during the BSC period our instructions were that psychologists could bill for psychological testing for individuals with an IQ below 50. Payment for these services has been disallowed in the draft audit report.

The individual contract providers in the DCs and SHs have relied in good faith on the instructions and behaviors of BSC and NHIC. ** provided an all day training for key staff from all DCs and SHs in January 1999. DMH held an education program on psychiatric documentation and billing practices for May 26, 1999. It is important that DDS and DMH, and the Medicare providers in DCs and SHs, be able to have confidence in the representations made by HCFA's agents, in this case, NHIC. This confidence is destroyed if OIG can retrospectively disavow actions of the carrier or instructions and training provided by the carrier to contract providers.

III. EXAMINATION OF SPECIFIC AUDIT FINDINGS

The single stage, unrestricted sample method employed by the auditors was used to select a random sample of 100 claims lines from a universe of 612,636 claim lines. OIG's auditors, with assistance from the medical reviewers of NHIC, reviewed the 100 clinical records associated with the 100 claim lines and concluded that DDS and DMH have been overpaid for 73 of the 100 claim lines. A total of 59 of the claims were denied and 14 were allowed but at a lesser amount. Based on this information the auditors have extended this error rate and the associated overpayment to the entire 612,636 universe of claim lines and assert that DDS and DMH were overpaid in the amount of $13,036,880. DDS and DMH have already stated the reasons for objecting to this approach. This section will address the specific problem claims.

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OIG's draft audit report found claiming errors in the following areas:

- No Evidence Physician Examined Patients (43 claiming errors)
- Upcoded Services (14 claiming errors)
- No Documentation (6 claiming errors)
- Mutually Exclusive Services (6 claiming errors)
- Noncovered Services (4 claiming errors)

Staff of both DDS and DMH have examined the full clinical records of all 73 problem claims including the supporting documentation, and the results of this review leads both departments to disagree with OIG's findings. The comments provided below outline the specific areas of disagreement and reference supporting documentation where appropriate.

A. Review of Individual Findings

1. No Evidence Physician Examined Patients (pages 7-9 of the draft audit report)

The draft audit report identifies 43 claims that were disallowed in this category. DDS and DMH have reviewed the full clinical record of each of these claims and have concluded that 16 of the 43 charts had documentation of a monthly physician's progress note of the resident/patient health problems and status (see OIG's auditor files, Sample Claim Numbers 2, 5, 17, 24, 26, 29, 30, 47, 52, 71, 76, 77, 79, 84, 88, 99). DDS and DMH relied on BSC's verbal instructions and regular approval of this type of documentation as agreement and acceptance of these notes as adequate documentation to support the bills submitted. The practice of BSC during the period covered by the audit was to approve notes of these types and DDS and DMH relied in good faith on the carrier's representations when submitting claims for these services.

** ., Medical Review Manager in the San Francisco BSC Office, in a letter dated April 14, 1992, requested a sample progress note from ** , at Agnews DC. A copy of her letter and the progress note submitted for her review is provided for reference as Exhibit D. BSC's audit of Agnews DC (Exhibit E) dated October 4, 1996, reviewed and approved a number of progress notes almost identical to those disallowed in OIG's draft audit report. Based on the approval of these progress notes and BSC's continued

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approval of similar progress notes, DDS and DMH relied on these approvals as an indication of the acceptability of this documentation and code selection (99312).

** , Education Outreach, NHIC, in her letter of April 20, 1999, to ** , DDS (Exhibit C), ** indicates that the term observation means to her "that the physician 'looks over' the patient's care to determine if there are any changes in the patient's condition. The patient's condition is usually nonacute and therefore doesn't require frequent visits from the physician. Medicare guidelines allow for one nursing home visit per month for this 'observation' visit." ** interpretation appears consistent with BSC's historical and regular approval of these types of monthly progress notes in which the provider "looks over" the patient's care, but may not have a face-to-face encounter with the patient.

These notes are consistent with other notes regularly approved by BSC during the period covered by the audit. Based upon DDS's and DMH's review and the evidence included in Exhibits C, D and E, it is clear that the documentation supporting these 16 claim lines was consistent with BSC's instructions and interpretations during the period covered by the audit. It is DDS's and DMH's position that all 16 of these claims should be approved. It would be unfair to apply a new standard retroactively to claims submitted and approved during the period covered by the audit.

Additionally, DDS's and DMH's review identified three more charts in this category that had documentation present to support billing for medication management (please see auditor's files, Sample Numbers 3, 43, 81). In two cases (43 and 81), the physician evaluated the residents' medication used for psychiatric/behavioral conditions, and made decisions regarding the management of the medication and modification of the treatment plan. In the Sample Number 3, the physician reviewed and renewed orders, made decisions related to revised orders for medication, made decisions related to appropriate laboratory and diagnostic tests, and approved the treatment plan. These notes appear to be consistent with the interpretation cited on page 7 of the draft audit report which states, in part, "...a service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment."

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2. Upcoded Services (pages 9 - 11 of the draft audit report)

DDS's and DMH's review of the 14 claim lines found that Sample Numbers 63 and 72 were actually underpaid. The overpayment reflected in the draft audit report for these two claims should be removed, and the amount error rate and associated dollars deleted from the auditor's calculations for repayment purposes.

Medicare Part B clinical services (outpatient) are made up of a professional component and a technical component. The Medicare carrier pays the professional component and the intermediary pays the technical component. BSC paid $37.86 per claim for code 99232 (ward) and they should have paid $19.22 per claim, as the professional component portion for each claim coded 99212 (outpatient). Blue Cross should have paid $27.22 for each claim as the technical component portion. Medicare Part B should have paid $46.44 for each claim rather then the $37.86 actually paid. The services created an underpayment not an overpayment from Medicare.

3. No Documentation (pages 11 and 12 of the draft audit report)

DDS's and DMH's review of the six claim lines found that two clients reviewed from Camarillo SH/DC and one from Lanterman DC were billed for services provided by psychologists. DDS and DMH knew in July 1995 there was a problem with psychologist billings. The problem was the same problem as OIG's auditor findings indicated, which was no documentation. In October, 1995 all psychologists billings were terminated and a block was placed in the system so that Medicare would not be billed, until such time, as (a) documentation problems were resolved and (b) psychologist applied for and received their own PIN number from the Medicare carrier. Since no psychologist billings were submitted during the last two years of the audit, it is not appropriate to spread the error factor identified to their services over the total universe. Also, the total number of paid claims for Camarillo SH/DC, for whatever reason, does not include all services billed for the time period of the audit. Of the total services for Camarillo SH/DC, 6,451 of the 9,376 (68 percent) were for psychologist services. In view of the known problems with psychologists billing, your sample does not accurately reflect billings for services provided at Camarillo SH/DC.

4. Mutually Exclusive Services (pages 12 and 13 of the draft audit report)

   The findings to disallow these services came from additional services outside the 100 sample. No adjustment was made for the correct services; however six errors were charged. (See page 4 of this response, Section II. PROBLEMS OF AUDIT DESIGN AND USE OF DATA, Section A. Sample Method).

5. Noncovered Services (pages 13 and 14 of the draft audit report)

   DDS's and DMH's review found that Sample Number 4 was a psychology service provided to a mentally retarded client. DDS and DMH were not aware that profound mentally retarded beneficiaries were not entitled to psychologist services until they read it in the Carriers Bulletin dated June 1998. When billings first started for psychologist services, neither HCFA nor BSC informed DDS or DMH of this restriction. Therefore, DDS and DMH can only conclude that the policy was not in effect prior to the carriers publication but was retroactively applied to the claim.

In addition to the specific findings mentioned in this section, DDS and DMH disagree with the remaining findings as previously stated in Section II. PROBLEMS OF AUDIT DESIGN AND USE OF DATA, DDS and DMH and object to the use of the audit data in the sampling methodology, i.e., sample size, universe selection, etc.; conflicting instructions and interpretations from two different Medicare carriers; and the system wide projection of the error rate to the universe.

B. Medicare Billing Process.

The draft audit report asserts a number of cause and effect relationships related to the reasons for possible overpayment of Medicare services by DDS and DMH, including staff's unfamiliarity with Medicare regulations and billing procedures, lack of adequate written policy and procedures, insufficient use of the Medicare carrier to become more familiar with the Medicare billing process and a lack of training on qualitative recordings.

The management of DDS and DMH had reviewed the system established for billing Medicare Part B services. DDS's and DMH's assessment found that there were policies and procedures in place during the period of the audit to direct both administrative and clinical staff on appropriate documentation and billing of Medicare services. As indicated earlier in this response, DDS and

DMH have made significant revisions to the Medicare documentation and billing systems, including the development of a new training curriculum, draft revised policies and procedures for "Fee for Service Billing" and revisions to the billing forms. These changes will be discussed in more detail under Section IV. DESCRIPTION OF COMPLIANCE PLAN.

OIG's auditor comments on DDS's and DMH's management of Medicare Part B service program has prompted DDS and DMH to take a critical look at their systems for managing clinical and billing services including documentation issues. However, there are several assertions that are made in the draft audit report that DDS and DMH do not concur.

1. Familiarity with Medicare's Rules (pages 15-16) and Educational Training (pages 17-18 in the draft audit report)

   The draft audit report stated that "some" physicians, psychologist and billing staff were not familiar with Medicare rules. However, the draft audit report did not quantify this term nor give any additional information that DDS and DMH could follow-up to ascertain the validity of these observations. It would have been helpful to know which specific physicians, psychologist, and/or billing personnel were not familiar with Medicare's rules, billing codes or restrictions on billing mutually exclusive services for the same patient on the same day.

   Some staff may have indicated they were not familiar with Medicare rules. However, training and individual assistance has been provided to staff on an ongoing basis by the Medical Director and Medical Record staff in the DCs and SHs. DDS CFS staff has also provided training for facility staff at DDS and DMH annually and as appropriate. As new codes were added, revised billing CPT code descriptions sheets were provided to staff with key information incorporated into the forms. Physicians and psychologists were trained in these new codes and other procedural changes. In spite of these training efforts, there may be a few physicians and other staff who have not totally understood all of the aspects of the billing and documentation requirements or need a refresher course in the Medicare requirements. Others may have taken your questions literally without fully appreciating the scope of documentation related to this evaluation, observation and decision making process to support the client/patient services and assigning CPT Codes.

The draft audit report also indicated that when physicians were asked "...how they determined which billing code to use for an evaluation and management service... (page 15)", they generally answered that they primarily relied on the time spent performing the service. DDS and DMH have provided physicians and psychologist with changes to the Medicare requirements, revised work sheets, and bulletins which have descriptions of the code requirements. DDS and DMH specifically reviewed their particular coding procedures and believe that the billing code is reliable. DDS and DMH physicians use the same " Physicians' Current Procedural Terminology" system as all other physicians across the United States, namely the CPT 4 Standard Edition published by the American Medical Association.

Most DCs and SHs have had some documentation of training and discussions related to adequacy of documentation. The staff interviewed by OIG auditors may not be reflective of the actions taken by DDS and DMH concerning training of staff in Medicare billing procedures and corrective action to improve systems.

2. Written Instructions (pages 15 - 17 of the draft audit report)

The draft audit report states "... we found that the facilities had written instructions which sometimes conflicted with Medicare's rules and may have contributed to the errors ....". The draft audit report identifies two such written instructions. While there may have been some written instructions that were unclear, these instructions were meant as guidelines only. The medical decision making and complexity of the evaluation and documentation still remains the physician's responsibility. There was no intent to provide guidelines that were inconsistent with Medicare rules. DDS and DMH contend that OIG's examples are the exception rather the rule for written instructions distributed by the departments. DDS and DMH have always operated under what was perceived to be the correct policy as determined by the Medicare carrier at the time.

3. Internal Audits of Medicare Billings (page 18-20 of the draft audit report)

DDS and DMH do not concur with the observations described on pages 18 through 20 of the draft audit report regarding internal audits of Medicare billings. In this area, OIG asserts that DDS and DMH did not conduct internal audits of Medicare billings. CFS and facilities did conduct administrative internal audits during the audit period from 1993 through June 1997 to conform with Title XXII and other state law

requirements. These internal audits dealt with issues of beneficiary (patient) liability reduction and Medi-Cal payer of last resort issues. The CFS Manual, Section 7078, provides the administrative guidance for identification of compliance errors/omissions and a reporting process. CFS completes annual reviews of all DCs and SHs. These reviews did not look for compliance issues involved with Medicare except incidently toward Social Security Act 1858 (g) (4). Medicare carriers, not DDS and DMH, are contractually required to monitor physician billings for the purposes described by OIG.

IV. DESCRIPTION OF COMPLIANCE PROGRAM

DDS and DMH have directed considerable staff time and energy in critiquing OIG's draft audit report and the current compliance system. A task force was established in November, 1998 to review the system design, management reporting, quality control and accountability, educational training, compliance with state and federal regulations and auditing and billing processes. The goal is to ensure a comprehensive compliance program that meets the criteria established by HCFA, the NHIC, and DDS and DMH facility personnel.

A. Training

1. Since OIG's audit, and before, DDS and DMH have been working on strengthening training of staff in Medicare billing procedures, improvement in written instructions, and audit more for compliance issues.

2. The results of the audit were carefully weighed, the HCFA's web site for Evaluation and Management codes and guidelines were printed, reviewed, and are being distributed to all of the medical staff of the DCs and SHs. DDS held a meeting with all Medical Directors from the five DCs. At this meeting, a presentation was provided on physician accuracy and adequacy of billing services and supporting documentation guidelines. The documentation guidelines that provides direction for quantity and quality of documentation has been updated and distributed to all DC medical staff for their review and comments.

3. A meeting was held with practicing physicians representing all DCs to review the Medicare audit findings and the training materials that have been developed, and to obtain input related to their need to meet on a regular basis related to Medicare requirements. As a result of that

meeting, the training materials have been modified and additional information has been gathered for use at each of the DCs.

4. The training plan and materials were developed to be carried out at each of the DCs, which includes a specific ready reference to the Evaluation and Management Documentation grid. Training for all DC physicians will be scheduled in the near future. The revised training curriculum has been shared with DMH's medical record consultant for possible modification to meet the unique needs of the DMH population, billing processes and personnel training needs. DMH's evaluation will be completed by July 1, 1999.

5. DDS and DMH management have begun a program to ensure that interpretations and instructions of NHIC are available to the providers. This program will also ensure that any interpretations and instructions received from BSC, the prior Medicare carrier, that appear to be conflicting with NHIC communications will be replaced with the correct instructions. DDS and DMH will establish a "documentation binder" at both facility and headquarters to track HCFA bulletins and newsletters to be used as a reference source for questions relating to the appropriate payment of Medicare Part B services.

B. Administrative Policies and Procedures

Based on CFS's review at the facilities, adjustments were made to billings. When a claim is identified without corresponding progress notes, a refund is issued directly to the carrier. DMH has implemented a process that requires medical records staff to verify documentation prior to entering the fee for service into the billing system. A training packet for Medical Records auditors was developed. In May 1998, a program modification was implemented that identified and removes duplicate billings from the billing tape. As mentioned above, refunds for nondocumented claims are now being made to the carrier instead of offsetting against documented but nonbilled services.

Other corrective measures have been taken over the years. The Cost Reporting System (DDS's automated billing system) was modified to prevent, or block, certain services from being billed to Medicare. As stated previously, psychologist billings were blocked because of documentation problems. In addition, CFS's administrative audit procedures have been restructured to identify billings with missing documentation, duplicate billings, and wrong CPT 4 codes.

DDS and DMH have reviewed the administrative policies and procedures and are in the process of updating them as part of management's commitment to maintaining compliance with state and federal regulations. These policies and procedures have also been shared with DMH for assessment of applicability to their system. This assessment will be completed by July 1, 1999.

DDS and DMH are in the process of determining how the services of the Medicare carrier, NHIC can be integrated into their auditing and training plans. NHIC has provided a one-day training session for representatives from all DC/SH facilities. NHIC will be presenting a training session at Metropolitan SH and the training tapes will be reviewed and utilized for both DDS and DMH facilities. It is DDS's and DMH's expectation that NHIC will effectively discharge their contractual responsibility to provide training and documentation review.

DDS and DMH senior management have reviewed and evaluated internal reports on documentation and coding practices in the facilities and the mechanisms by which Medicare claims are generated and processed. Where indicated, corrective action plans are being developed and implemented to ensure that Medicare billing requirements are met. Managers throughout the departments and DCs and SHs are expected to incorporate effective compliance practices and monitoring mechanisms into their management processes. DDS and DMH will work closely with NHIC to assure that questions regarding documentation, coding, and billing practices are responded to quickly and authoritatively. NHIC will also be asked to provide regular training to the hundreds of Medicare providers employed at DCs and SHs. DDS and DMH managers will conduct regular internal audits to ensure that compliance remains consistently high and that documentation, coding, and billing errors are corrected promptly.

C. Billing Requirements

Audit tools are being reviewed and revised to include both quantitative and qualitative evaluation of compliance with billing requirements. Suggested items and formats will be provided to the Medical Staff of DDS and DMH facilities for inclusion in their overall quality assurance program.

D. Performance Outcomes

DMH senior management staff have conducted management audits of all SHs to determine compliance with Medicare requirements. These reviews

have resulted in improved policy and procedures and more compliance training programs. DDS will conduct similar audits after the compliance plan is revised and implemented.

V. LIST OF EXHIBITS

A. December 18, 1998 letter to Jerry Hurst, Senior Auditor, DHHS, OIG from Ken Buono, Chief of Financial Services Branch, Department of Developmental Services

January 7, 1999 letter to Jerry Hurst, Senior Auditor, DHHS, OIG, from John Rodriguez, Deputy Director, Department of Mental Health

B. March 26, 1999 testimony of Inspector General June Gibbs Brown's testimony before the House of Representatives on "Fiscal Year 1998 Financial Statement Audit"

C. April 20, 1999 letter to ** , Department of Developmental Services from ** , NHIC Educational Outreach regarding the definition of the term "observation".

D. April 14, 1992 letter from ** , Medical Review Manager of Blue Shield to Agnews requesting sample progress note and a copy of the progress note provided

E. Data from BSC's audit of Agnews Developmental Center

** Office of Audit Services Note: It is OAS policy to exclude administratively confidential information from reports (including names of individuals and beneficiary numbers).

EXHIBIT A

STATE OF CALIFORNIA–HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF DEVELOPMENTAL SERVICES
1600 NINTH STREET
CRAMENTO, CA 95814
) 654-2054 (For the Hearing Impaired)
(916) 654-3378

December 18, 1998

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

Dear Mr. Hurst:

Thank you for taking the time to meet with us on November 19, 1998, to discuss your findings of the Medicare Audit. It is our understanding that your office sampled 100 claims out of 620,000 paid claims of physicians' billings for the period of 1993-96. It is also our understanding that this sample covered both developmental centers operated by the Department of Developmental Services (DDS) and state hospitals operated by the Department of Mental Health (DMH). Staff noted that a portion of the 100 claims sampled included psychologist billings which both Departments have discontinued billing of since August 1995. Although we have not seen your report, you made it clear to us that your findings pointed out that the problems noted were not specific to any facility or physician, but really indicated system-wide issues. Finally, it was our understanding that the problems were centered around five issues: 1) no documentation in the file to support billings (found in 6 records out of the 100 records sampled); 2) insufficient documentation to support billings; 3) billing for noncovered services; 4) double billings (this may also be called mutually exclusive billings and relates to multiple visits to a client by a physician in one day); and, 5) incorrect billing codes reported by physicians. This would also include those instances where up coding (using a higher level service code when the actual service was at a lower level) was identified.

We would very much appreciate it if your report was sorted, first by department, and then by facility under the respective department. It is our belief that there will be some issues specific to the type of clientele served. Having the report sorted as requested would make it a better management tool.

Both DDS and DMH take these issues very seriously, await receipt of your report, and, hope to work in partnership with your office in seeking solutions. In the meantime, we offer this memorandum to explain why we think there might be differences between what was and what is expected. We are also including a binder with copies of records that you might not have been given previously. The documents in the binder will correspond to the bold face headings of each

section in this memorandum. As your staff reported to us prior to the audit, it was your intent to review procedures and controls (not inappropriate billings) and, therefore, hope that your report focusses on how our physician and medical record procedures can be strengthened.

Change in Carriers

In January 1997, National Heritage Insurance Company (NHIC) replaced Blue Shield of California (BSC) as the Medicare carrier. The review covered claims that were paid for physician services performed during the time BSC was the carrier. The main reason that we note this change was that the departments were operating under BSC instructions and interpretation of regulations. We believe that their requirements for appropriate billing criteria differ from those now in place and believe that the review applied the new criteria to a time period in which we relied on BSC.

BSC had visited our facilities and allowed payment of claims that are now considered inappropriate. For example, BSC had accepted telephone orders, brief notes for monthly nursing facility visits, up coding for patients with profound retardation or severe psychotic problems, and other less specific documentation of treatment as evidence of physician billings. When the coding was changed in 1992, BSC sampled one physician to determine if correct coding was being used. The documentation submitted to them consisted of the brief monthly nursing note discussed above. We never received any feedback that this information was not acceptable; however, it is our understanding that NHIC will not accept this now. We do not point this out to be defensive, but in an effort to better put in perspective that applying the new criteria to a time period covered by BSC would discover problems due to inconsistent information from the carrier at that time.

A Difference with a Distinction

It is our opinion that BSC, whether right or wrong, recognized a difference between the types of reporting needs for persons receiving services in a state hospital or developmental center over those receiving services at Kaiser, Mercy, Sutter, or a similar general acute facility. As a patient in a general acute facility, the facility and the physician know enough to perform whatever procedure is necessary to correct the ailment the person was admitted for. The procedure is done, the person is put in recovery, hopefully all went well, and a day or two later is discharged. The physician's progress notes, etc., have to be sufficient enough to substantiate receiving the services and the facility's expectation of receiving payment.

On the other hand, when a person enters a developmental center, that person has already undergone extensive prescreening and comes to the facility with a full social, behavioral, physical, medical, psychological, etc., history which become a permanent part of the client's

medical record chart. Then that person becomes a resident of the facility, is assigned a physician, and care and treatment begins. A relationship begins to build because it is a long-term commitment. Even if the physician is not on the unit to visit the particular client, he/she is aware of the condition just by virtue of having been on the unit during the day. Because of this sustained relationship and prior full documentation, BSC was more lenient in the facilities documentation requirements. Again, we are not pointing this out to make excuses or to ask for special consideration. We offer it merely to put things into their proper perspective.

Department Reviews

In fiscal year 1987-88, Client Financial Services (CFS) began to investigate why the facilities were under reporting physician billings to Medicare. Over the next fiscal year, CFS, working in conjunction with the program divisions and the facilities, developed audit procedures. Beginning in 1990 and continuing today, over 104 audits have been conducted by CFS. Over the years, results of these reviews have been discussed with the program divisions of both Departments, executive directors, medical directors, and records management staff of the facilities. The results of these audits also formed the basis of training conducted by CFS.

Department Training

To some degree, the audits conducted were also considered training. That is, CFS would conduct exit conferences, point out deficiencies, and discuss things the facility could do to correct the noted deficiencies. Since 1987, CFS has conducted training sessions with physicians, psychologists, and medical records' staff. Since 1990, there have been 17 meetings with psychologists and 19 with the physicians. These meetings covered such topics as California Procedural Terminology 4 (CPT 4) code changes, BSC, NHIC, HCFA published documentation requirements, written and oral instructions from the carrier, and instructions for completing PIN application forms.

Adjustments to Billings

Based on CFS' review at the facilities, adjustments were made to the billings. While you may not agree with the methodology used to adjust the billings, it was always our intent to make sure the billings were as accurate as possible. We believe current procedures are more in line with what you would like to see, and will provide for a more documented audit trail. When we identify any paid claims without corresponding progress notes, we now issue a refund directly to the carrier.

Agnews' Review

In our November meeting, you brought out a concern that the Agnews audit findings were not brought to the attention of Agnews staff nor were they shared with other state operated facilities. As you can see by the attached information, the audit findings were sent directly to the facility. That information which had been sent to CFS was shared with Agnews and resolved. The findings were discussed with the medical director, and we issued a refund check to cover the denied claims identified by the audit. While we did not share the actual Agnews report with other facilities, we did discuss the findings, as they related, with all other facilities.

Coordination with Program Divisions/Facilities

On July 1, 1984, the State was required to change from a per-diem-billing system to a fee for services. This was a significant difference in the billing program, and required a substantial amount of adjustment in the program and the way of doing business. As a part of the audit/review of the facilities, CFS conducts exit interviews with Medical Records, the Medical/Clinical Director, and the Executive Director when available. Follow-up written reports are now sent to the facilities and to appropriate headquarters' staff. Changes in billing codes and procedures are coordinated with the Medical Directors and Medical Records of each facility. In addition, in those areas where CFS does not exercise authority to make changes, it reports its findings to the appropriate program staff or division of the respective department. NHIC (BSC) claim audits and requests for information are sent directly to the facility for review and response. Most often the information is remitted directly to the carrier.

Corrective Action Already Taken

As a result of our audits, reviews, discussions with the carrier and in anticipation of your report, we have made some changes to insure compliance with program requirements. DMH has implemented a process that requires medical records staff to verify documentation prior to entering the fee for service into the billing system. A training packet for Medical Records auditors was developed. In May 1998, a program modification was implemented that identifies and removes duplicate billings from our billing tape. As mentioned above, refunds for nondocumentated claims are now being made to the carrier, instead of just offsetting against documented but nonbilled services. We will continue to ensure written audit reports are shared with the Executive Directors and Medical Directors in the facilities and to higher level management in the respective headquarters program or division office. In addition, our letter of transmittal of the finding will request a specific plan of corrective action by the facility.

Other corrective measures have been taken over the years. The Cost Reporting System (the departments' automated billing system) was modified to prevent, or block, certain services

from being billed to Medicare. In 1995 Psychologist billings were blocked because of documentation problems. These services are still blocked for developmental centers. DMH facility billings were reinstated when the Chief of Psychologist Services affirmed that documentation was adequate. Blocks have been put in the billing system to insure that certain codes are not being billed. CFS' audit procedures have been restructured to identify billing with missing documentation, duplicate billings, and wrong CPT 4 codes; in addition to, the usual missed billings which had primarily been our focus.

Finally, as we have stated earlier both departments take this very seriously. We have independently solicited training from NHIC. They have agreed to establish their first training session in Pomona in mid January 1999. We have also established a joint task group, including staff from both departments to review the current process for improvement and to ensure all NHIC requirements are met before billing is made to the Medicare program.

Thank you for the opportunity to provide you with additional information prior to the release of your report. We hope this better explains our desire to improve physician billings. If you should have any questions, please contact Bill Niemeyer at (916) 654-2422.

Sincerely,

Ken Buono
Chief of Financial Services Branch

Attachment
c: Clifford Allenby
Douglas Arnold
Paul Carleton
Douglas Van Meter
Stephen Mayberg
John Rodriguez

CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2413

January 7, 1999

Jerry Hurst, CPA
Senior Auditor
Office of Audit Services
Office of the Inspector General
U.S. Department of Health and Human Services
801 I Street, Room 285
Sacramento, CA 95814-2510

Dear Mr. Hurst:

We would like to extend our sincere thanks to you for taking the time to discuss your findings from the Medicare Audit prior to the release of your draft report. The time frame for your audit, as we understand it, was for the period of 1993 through 1996, and it included both physicians' and psychologists' billings. You clearly indicated that the Audit pointed out problems that were not individual practitioner, discipline, or state hospital specific, but instead system wide issues.

In response to your request, we would like to take this opportunity to outline our previous efforts to address the audit. We would appreciate your review of this information not only as it is related to your audit findings, but also as to where and how we can make changes to achieve more effective results. Enclosed for your review is documentation of each hospital's activities during the past four years in relation to the subject areas listed below. As you correctly point out, these are not new issues. Indeed, the state mental hospitals have made a very substantial effort to address the issues surrounding the Fee For Service billing process.

DUTY SPECIFIC ORIENTATION BY PROCTOR

Each of the state hospitals conducts new employee orientation that requires mandatory fulfillment of training modules during the initial weeks of employment. The state hospitals are responsible for training new physician and psychologist employees in understanding the need for and the completion of the Fee For Service Form. This training is accomplished through a proctoring procedure and is part of the orientation process. Each new physician or psychologist is required to complete this training.

PHYSICIAN MONTHLY MEETING COMMUNICATIONS

The Medical Staff of each state hospital hold regular monthly meetings to discuss current items of business, in-service training, educational workshops or seminars and changes in documentation requirements. As part of this regular meeting process each state hospital medical staff, when necessary, discuss current status of Fee For Service procedure, forms and coding requirements.

PSYCHOLOGY MONTHLY MEETING COMMUNICATIONS

The Chief of Psychology at each state hospital is responsible for holding regular monthly meetings to keep members of the Psychology Department abreast of current items of business, treatment trends, in-service training, workshops or seminars and changes in documentation requirements. Discussions and in-service training for Fee For Service Forms and related documentation are conducted when necessary.

MEDICAL STAFF COMMITTEE MEETINGS

The Medical Staff at each of the state hospitals conducts various monthly meetings to address the business and treatment needs of their hospital. Identified Fee For Service problems are brought, for review and recommendation, to the committee responsible for supporting oversight of financial reimbursement.

FEE FOR SERVICE FORM REVISIONS

The Medical Staffs and Psychology Departments assisted by the Medical Record Department have revised the Fee For Service Form after extensive input from members of each discipline. The focus of the revisions was to enhance the ease of use and provide training in the completion of the form.

MEDICAL RECORD DEPARTMENT FFS TRAININGS

The Medical Record Department at each DMH state hospital is responsible for assisting physicians and psychologists in learning changes in documentation requirements and Fee For Service Form changes. As noted in the supporting documents, many sessions were held at each of the hospitals during the stated time period. Some of the training was completed on a one to one basis, between physicians and Medical Record Department staff. This training is an ongoing responsibility of the Medical Record Department and is furnished on a regular schedule and when requested by a physician or psychologist.

MEDICAL RECORD DEPARTMENT CPT-4 TRAINING

The Medical Record Department at each state hospital is responsible to keep abreast of the current CPT-4 changes, additions and deletions. Staff members are sent to workshops to glean the latest information regarding CPT-4 coding and current issues.

FEE FOR SERVICE AUDITS

The keystone of our efforts has been the Fee For Service Audits. At the request of executive staff at each state hospital, audits were conducted by the Medical Record Department to track compliance with the Fee For Service procedures. Some hospitals provided monthly reports, semi-annual or annual reports. Some of the audits were focused by codes, practitioner or completion dates. Other audits were conducted to track incomplete FFS forms or missing FFS forms. This tracking tool will continue to be utilized with vigor and audit criteria will be refined as needed.

COST RECOVERY SYSTEM MONTHLY REPORTS

To better track Medicare services provided and billed, changes have been made in the monthly MEDICARE FEE FOR SERVICE AUDIT REPORT provided to the hospitals each month. Our intention is to continue to improve automated reporting mechanisms so that important data is presented in more useful and understandable formats. The Department of Mental Health has received approval to develop a master billing system that will substantially improve the billing process. The system will be designed to check to ensure that clinical notes have been written before billings are processed. When completed the new system is expected to dramatically reduce documentation and billing errors.

Hopefully, after your review of our outline and supporting documentation you can appreciate that efforts have been made on all DMH fronts. Nevertheless, while we may disagree with specific findings and disallowances recommended by your office, we are open to a continuing dialogue and look forward to any comments or suggestions you may have to assist us with elevating our success rate.

Thank you for this opportunity to provide additional information. If you have any questions or comments, please contact Nicholas Burgeson, (916) 654-3600, Sharon Winsberg, (714) 993-9121, or me at any time.

Sincerely,

JOHN RODRIGUEZ
Deputy Director

Enclosures

C: Stephen W. Mayberg, Ph.D.
Nicholas R. Burgeson
Executive Directors - DMH State Hospitals
Ken Bono - Department of Developmental Services

EXHIBIT B

FY1998
Financial Statement Audit
Health Care Financing Administration (HCFA)

Testimony of
June Gibbs Brown
Inspector General

Hearing Before:
House Committee on Government Reform,
Government Management, Information and
Technology Subcommittee

March 26, 1999

Office of Inspector General
Department of Health and Human Services

June Gibbs Brown
Inspector General
Department of Health and Human Services

Good morning, Mr. Chairman. I am June Gibbs Brown, Inspector General of the Department of Health and Human Services, and I am pleased to report to you on our audits of Fiscal Year (FY) 1998 Medicare fee-for-service payments and the Health Care Financing Administration (HCFA) financial statements. With me today is Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities.

The Office of Inspector General (OIG) recently issued its third annual estimate of the extent of fee-for-service payments that did not comply with laws and regulations. As part of our analysis, we profiled all 3 years' results and identified specific trends, where appropriate, by the major types of errors found over the 3 years and the types of health care providers whose claims were erroneous. As required by the Government Management Reform Act of 1994, we also issued our third comprehensive financial statement audit of HCFA. The purpose of financial statements is to provide a complete picture of agencies' financial operations, including what they own (assets), what they owe (liabilities), and how they spend taxpayer dollars. The purpose of our audit was to independently evaluate the statements.

My statement today will focus first on the notable reduction in Medicare payment errors we have found and the problem areas where further effort is needed. Then I will briefly highlight the significant findings of our financial statement audit.

Before I begin, I would like to acknowledge the cooperation and support we received from the Department, HCFA, and the General Accounting Office (GAO). HCFA's assistance in making available medical review staff at the Medicare contractors and the peer review organizations (PRO) was invaluable in reviewing benefit payments. Also, I want to point out that we worked closely with GAO, which is responsible for auditing the consolidated financial statements of the Federal Government. The Department is one of the most significant agencies included in these Governmentwide statements.

MEDICARE PAYMENT ERRORS

Overview

The HCFA is the largest single purchaser of health care in the world. With expenditures of approximately $310 billion, assets of $181 billion, and liabilities of $40 billion, HCFA is also the largest component of the Department. Medicare and Medicaid outlays represent 34.2 cents of every dollar of health care spent in the United States in 1998. In view of Medicare's 39 million beneficiaries, 860 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the Medicare program is inherently at high risk for payment errors.

Like other insurers, Medicare makes payments based on a standard claim form. Providers typically bill Medicare using standard procedure codes without submitting detailed supporting medical records.

However, Medicare regulations specifically require providers to retain supporting documentation and to make it available upon request.

As part of our first audit of HCFA's financial statements for FY 1996, we began reviewing claim expenditures and supporting medical records. We did this because of the high risk of Medicare payment errors, the huge dollar impact on the financial statements (e.g., $176.1 billion in FY 1998 fee-for-service claims), and our statutory requirement to report on compliance with laws and regulations. This year, for the first time, we issued the results of our claim testing separately from the financial statement audit report.

Our primary objective was to determine whether Medicare benefit payments were made in accordance with Title XVIII of the Social Security Act (Medicare) and implementing regulations. Specifically, we examined whether services were (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

Sampling Methodology

To accomplish our objective, we used a stratified, multistage sample design. The first stage consisted of a selection of 12 contractor quarters during FY 1998 (10 from the first, second, and third quarters and 2 from the fourth quarter). The selection of the contractor quarters was based on probabilities proportional to the FY 1997 Medicare fee-for-service benefit payments. The second stage consisted of a stratified random sample of 50 beneficiaries from each contractor quarter. The resulting sample of 600 beneficiaries produced 5,540 claims valued at $5.6 million for review.

For each selected beneficiary during the 3-month period, we reviewed all claims processed for payment. We first contacted each provider in our sample by letter requesting copies of all medical records supporting services billed. In the event that we did not receive a response, we made numerous follow-up contacts by letter, telephone calls, and/or onsite visits. Then medical review personnel from HCFA's Medicare contractors (fiscal intermediaries and carriers) and PROs assessed the medical records to determine whether the services billed were reasonable, medically necessary, adequately documented, and coded in accordance with Medicare reimbursement rules and regulations.

Concurrent with the medical reviews, we made additional detailed claim reviews, focusing on previously identified improper billing practices, to determine whether (1) the contractor paid, recorded, and reported the claim correctly; (2) the beneficiary and the provider met all Medicare eligibility requirements; (3) the contractor did not make duplicate payments or payments for which another primary insurer should have been responsible (Medicare secondary payer); and (4) all services were subjected to applicable deductible and co-insurance amounts and were priced in accordance with Medicare payment regulations.

Sample Results

Through detailed medical and audit review of a statistical selection of 600 beneficiaries nationwide with 5,540 fee-for-service claims processed for payment during FY 1998, we found that 915 claims did not comply with Medicare laws and regulations. **By projecting these sample results, we estimated that FY 1998 net improper payments totaled about $12.6 billion nationwide, or about 7.1 percent of total Medicare fee-for-service benefit payments.** This is the mid-point of the estimated range, at the 95 percent confidence level, of $7.8 billion to $17.4 billion, or 4.4 percent to 9.9 percent.

Medical review personnel detected 90 percent of the improper payments in our sample. When these claims were submitted for payment to Medicare contractors, they contained no visible errors. It should be noted that the HCFA contractors' claim processing controls were generally adequate for (1) ensuring beneficiary and provider Medicare eligibility, (2) pricing claims based on information submitted, and (3) ensuring the services as billed were allowable under Medicare rules and regulations. However, these controls were not effective in detecting the types of errors we found.

As in past years, the improper payments could range from inadvertent mistakes to outright fraud and abuse. We cannot quantify what portion of the error rate is attributable to fraud. We have, however, quantified the estimated provider billings for services that were insufficiently documented, medically unnecessary, incorrectly coded, or noncovered. These were the major error categories noted over the last 3 years.

Reduction in Error Rate

This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion--a 45 percent drop. While we do not have empirical evidence supporting a specific causal relationship between the error rate decline and corrective actions, we attribute the decline to several factors:

- The Medicare Integrity Program, under HCFA's direction, provides resources to expand contractor safeguard activities, including increased medical reviews, audits, and provider education. For instance, HCFA directed its contractors to conduct extensive prepayment reviews of certain types of physician claims that we had identified as vulnerable to improper payments.

- Fraud and abuse initiatives have had a significant impact. Operation Restore Trust placed greater emphasis on more in-depth reviews of home health claims. Also, the Health Insurance Portability and Accountability Act has provided both HCFA and OIG with a stable funding source for Medicare payment safeguards and fraud and abuse activities for the next several years. Through the Health Care Fraud and Abuse Control Program, a nationwide effort was established to coordinate Federal, State, and local law enforcement activities on health care fraud. Other critical efforts include industry guidance, corporate integrity agreements with providers that settle allegations of fraud, beneficiary education, and pursuit of legislative changes.

- Virtually all major provider groups, including physicians, inpatient and outpatient services, and home health agencies, had significant error reductions since FY 1996. The provider community has been working aggressively with HCFA to ensure proper billings for services rendered, thereby ensuring compliance with Medicare program reimbursement rules.

- Finally, HCFA and OIG outreach efforts and HCFA's corrective actions were pivotal in reducing documentation errors.

Chart 1 demonstrates the reduction in improper payments by major error categories: documentation, medical necessity, coding, and noncovered services. While the drop in documentation errors is especially encouraging, errors due to the lack of medical necessity and incorrect coding remain matters of concern.

Significant Drop in Documentation Errors

Documentation errors dropped from $10.8 billion in FY 1996 to $2.1 billion in FY 1998. These errors represented the most pervasive problems in our samples for both FYs 1996 and 1997, despite Medicare regulation, 42 CFR 482.24(c), which specifically requires providers to maintain medical records that contain sufficient documentation to justify diagnoses, admissions, treatments, and continued care.

We believe that documentation has improved primarily because of:

- *HCFA and OIG outreach efforts.* With the release of our FY 1996 report, OIG and HCFA together briefed providers on the audit results and Medicare documentation requirements. For example, HCFA hosted informational meetings with major professional organizations representing various physician specialties, the home health care industry, skilled nursing facilities, hospitals, and other providers.

- *Implementation of HCFA's corrective action plan.* Since our FY 1996 audit, HCFA has developed and initiated several corrective actions designed to reduce Medicare payment errors. For example, in FY 1998, HCFA asked its contractors to perform prepayment reviews on selected claims for evaluation and management codes. In addition, HCFA asked contractors to increase their overall level of claims review (pre-pay and post-pay), including the review of supporting documentation. The HCFA dedicated approximately $14 million to increase the level of claims review in accordance with its corrective action plan. An additional $10 million was focused on medical reviews and audits of a provider group with aberrant billing practices.

For FY 1998, as seen in chart 2, the overall category of documentation includes two components: (1) insufficient documentation for medical experts to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided. In FY 1997, we included an additional component to identify situations in which providers were under investigation and the OIG could not obtain medical records to support billed services. Because we could not test the validity of these claims, we considered them invalid for determining whether total fee-for-service expenditures were fairly presented. In contrast, working with our Office of

Investigations and the Department of Justice to satisfy legal concerns, we obtained all medical records on FY 1998 claims under investigation.

Some examples of continuing documentation problems follow:

- **Physician.** Medicare paid a physician $871 for 40 hospital visits. The medical records, however, supported only 18 visits. Therefore, payment of $479 for the 22 visits without supporting documentation was denied.

- **Home health.** A home health agency was paid $64 for skilled nursing visits. Because the medical records contained no documentation to support the provision of services, the medical reviewers denied payment.

Thus, for these errors, the medical review staff could not determine whether services billed were actually provided to the Medicare beneficiaries or the extent of services performed. It should be noted that HCFA subsequently upheld almost 99 percent of prior-year overpayments and recovered approximately 94 percent.

Medically Unnecessary Services

The lack of medical necessity was the highest error category this year and the second highest for both FYs 1996 and 1997. As noted in chart 3, these types of errors in inpatient prospective payment system (PPS) hospital claims have been significant in all 3 years (FY 1996 - about $3.3 billion of the total $8.5 billion; FY 1997 - about $2.3 billion of the total $7.5 billion; and FY 1998 - about $2.8 billion of the total $7 billion).

In the case of outpatient services, we noted a major shift of errors this year from the documentation category to medically unnecessary services. For example, in FY 1996, errors in outpatient claims totaled an estimated $2.8 billion, of which $2.3 billion was attributable to documentation concerns. For FY 1998, errors in outpatient claims totaled $1.7 billion, of which $1.2 billion was for medically unnecessary services.

This error category covers situations where the medical records contained sufficient documentation to allow the medical review staff to make an informed decision that the medical services or products received were not medically necessary. **As in past years, the Medicare contractor or PRO medical staff made decisions on medical necessity using Medicare reimbursement rules and regulations.** They followed their normal claim review procedures to determine whether the medical records supported the claims, as illustrated in the examples below:

- **Hospital inpatient.** A beneficiary was admitted to an acute care hospital for a trachea resection surgical procedure. The beneficiary was discharged without having the procedure. and the hospital was paid $15,625. The beneficiary was subsequently readmitted to the same hospital, and the procedure was performed during the second admission. Based on a review of the medical records, the PRO concluded that the procedure should have been completed during the initial hospital stay and that the beneficiary was prematurely discharged at that

time. As a result, the second admission was determined not medically necessary and the total payment of $21,284 for that admission was denied.

- **Community mental health center.** A community mental health center was paid $21,421 for a beneficiary who received services under the partial hospitalization program. This program is designed to treat patients who exhibit severe or disabling problems related to acute psychiatric/psychological conditions. The medical reviewers determined that the beneficiary had already achieved sufficient stabilization and did not meet the definition of one who would otherwise require in-patient services. The services provided were therefore medically unnecessary, and the entire payment was denied.

- **Skilled nursing facility.** A skilled nursing facility was paid $10,428 for a 51-day skilled nursing stay. However, the patient's medical records documented that the patient received only maintenance-level (nonskilled) nursing home care, such as routine occupational therapy and the continuation of routine medication. Because Medicare does not reimburse for nonskilled services, the entire payment was denied.

Incorrect Coding

Incorrect coding is the second highest error category this year, representing $2.3 billion, or almost 18 percent, of the total improper payments. As illustrated in chart 4, physician and inpatient PPS claims accounted for over 80 percent of the coding errors in FYs 1996, 1997, and 1998.

The medical industry uses a standard coding system to bill Medicare for services provided. For most of the coding errors, the medical review staff determined that the documentation submitted by providers supported a lower reimbursement code. However, we did find a few instances of downcoding which we offset against identified upcoding situations.

Some examples of incorrect coding follow:

- **Hospital.** A hospital was paid $33,380 for performing a partial thyroidectomy to remove part of the patient's thyroid gland. Based on the medical records, the surgical procedure actually performed was a less complex partial parathyroidectomy to remove small glands and tissues located near the thyroid gland. The PRO's correction of the procedure code produced a lesser valued diagnosis-related group (DRG) of $19,695, resulting in denial of $13,685 of the payment.

- **Physician.** A physician was paid $103 for an initial patient consultation which required a comprehensive history, a comprehensive examination, and medical decisionmaking of moderate complexity. However, the medical review staff determined that the provider's documentation supported a less complex, expanded problem-focused history, expanded problem-focused examination, and straightforward medical decisionmaking. As a result, $46 of the payment was denied.

- **Physician.** A physician was paid $108 for a hospital visit which included a detailed interval history, a detailed examination, and medical decisionmaking of high complexity. The medical

review staff determined that the level of service actually provided supported a lower level procedure code of focused interval history and decisionmaking of moderate complexity. Because the provider should have billed a lower level of care, $30 of the payment was denied.

Noncovered/Unallowable Services

Errors due to noncovered or unallowable services have consistently constituted the smallest error category. For the last 2 years, the majority of errors in this category were attributable to physician and outpatient claims.

Unallowable services are defined as those that Medicare will not reimburse because the services do not meet Medicare reimbursement rules and regulations. For example:

- **Outpatient.** An outpatient provider was paid $56 for laboratory work which, according to the medical records, was part of a routine physical examination. Since Medicare does not cover such examinations, the payment was denied.

- **Physician.** A physician was paid a total of $34 for two claims for treating a beneficiary. Medical review follow-up determined that the treatment involved bioelectric medicine. Since this procedure is considered experimental and is not covered by Medicare, the total payment was denied.

Conclusions and Recommendations

We are most encouraged that actions on the part of the Administration, the Congress, and the provider community have contributed to a reduction in payment errors--and particularly that providers are doing a better job in documenting services to Medicare beneficiaries. But we caution that diligence is needed to sustain the apparent downward trend. In short, our audit results for the 3-year period clearly demonstrate that the Medicare program remains inherently vulnerable to improper and unnecessary benefit payments. We still have an unacceptable $12.6 billion estimated loss from the Government's coffer, and the FY 1998 improper payments relating to medically unnecessary services ($7 billion) and improperly coded services ($2.3 billion) are of significant concern.

Additionally, a number of issues could negatively affect future error rates:

- *Substantial Year 2000 initiatives.* More than 100 claim processing systems are being renovated/changed to comply with millennium requirements.

- *Instability of Medicare contractors.* The HCFA has experienced a record number of contractor terminations and consolidations.

- *Legislative requirements.* Additional requirements resulting from the Balanced Budget Act of 1997 must be implemented and enforced.

To ensure progress in reducing past problems while keeping abreast of continuing changes in the health care area and adequately safeguarding the Medicare Trust Fund, we recommended, among other things, that HCFA:

- enhance prepayment and postpayment controls by updating computer systems and related software technology to better detect improper Medicare payments and

- continue to direct that the Medicare contractors and PROs expand provider training to (1) further emphasize the need to maintain medical records containing sufficient documentation, as well as to use proper procedure codes when billing Medicare, and (2) identify high-risk areas and reinstate selected surveillance initiatives, such as hospital readmission reviews and DRG coding reviews.

We believe these types of reviews are critical to reducing improper Medicare payments and ensuring continued provider integrity.

The HCFA generally concurred with these recommendations. We expect that HCFA's testimony today will address the specific corrective actions being taken.

FINANCIAL STATEMENT AUDIT

We are pleased to report that HCFA has continued to successfully resolve many previously identified financial accounting problems. For example, substantial progress was made in improving Medicare and Medicaid accounts payable estimates, as well as estimates of potential improper payments included in cost reports of institutional providers. However, our opinion on the FY 1998 financial statements remains qualified. In accounting terms, a qualification indicates that we still found insufficient documentation to conclude on the fair presentation of all amounts reported.

Medicare Accounts Receivable

Most significantly, Medicare accounts receivable (i.e., what providers owe to HCFA) were not adequately supported. The OIG previously reported that Medicare contractors did not have adequate internal controls over these receivables. Specifically, they used various ad hoc spreadsheets and periodic financial reports in lieu of entry and tracking in a more formal accounting structure, such as dual-entry recordkeeping and having subsidiary accounting records for each provider. The contractors reported over $22.9 billion of Medicare accounts receivable activity during FY 1998, resulting in a reported gross accounts receivable of approximately $5.8 billion and net accounts receivable of $3.3 billion, which represents approximately 90 percent of the $3.6 billion of total Medicare accounts receivable at yearend.

We found deficiencies in nearly all facets of Medicare accounts receivable activity at the 12 contractors in our sample. Some contractors were unable to support the beginning balances, others reported incorrect activity, including collections, and finally others were unable to reconcile their reported ending balances to subsidiary records. We also found that substantial amounts of receivables had been settled with insurance companies but were still presented as outstanding accounts

receivable. As a result of these problems, we could not determine whether the Medicare contractors' accounts receivable balances and activities were fairly presented.

Material Weaknesses

Material weaknesses are serious deficiencies in internal controls that could lead to material misstatements of amounts reported in the financial statements in subsequent years unless corrective actions are taken.

The FY 1998 report on internal controls notes three material weaknesses:

1. As discussed above, significant improvements are needed in Medicare contractors' development, collection, and reporting of accounts receivable.

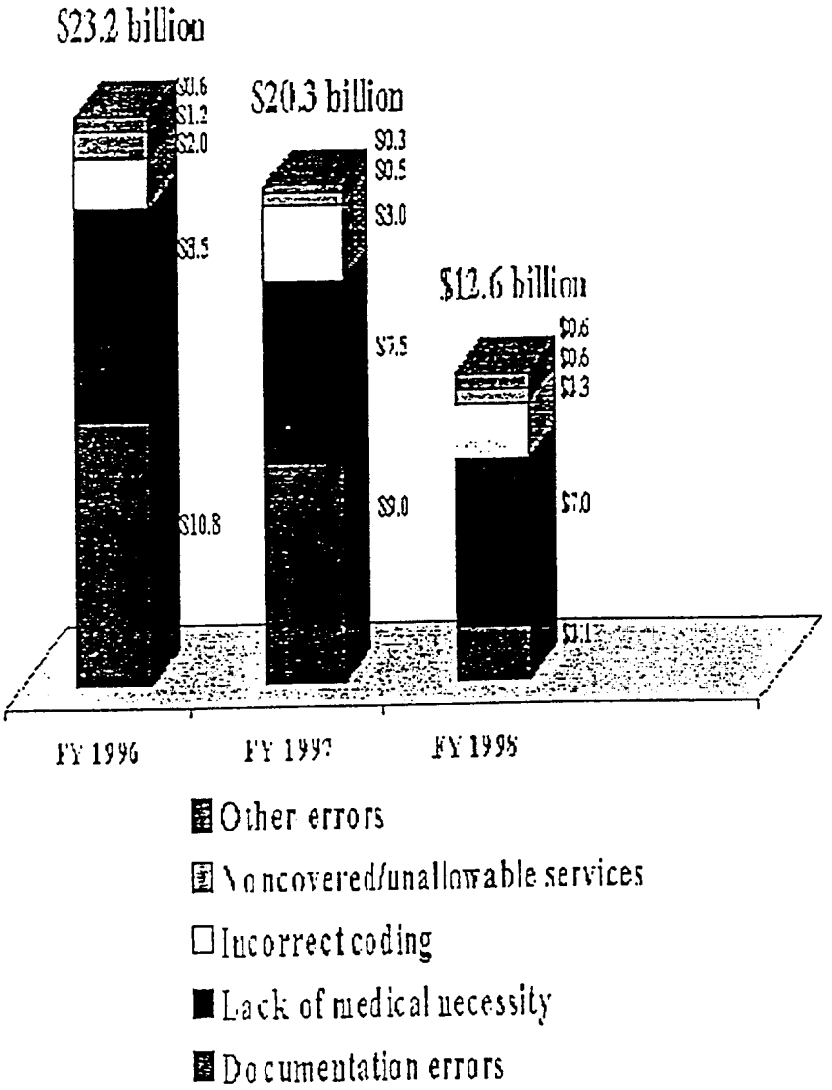
2. Financial reporting remains a material weakness because Medicare contractors have not adequately reconciled expenditures reported to HCFA. Also, the process for preparing financial statements is manually intensive.

3. The HCFA central office and Medicare contractors continue to have material weaknesses in electronic data processing controls relating to security access and application development and change controls.

****

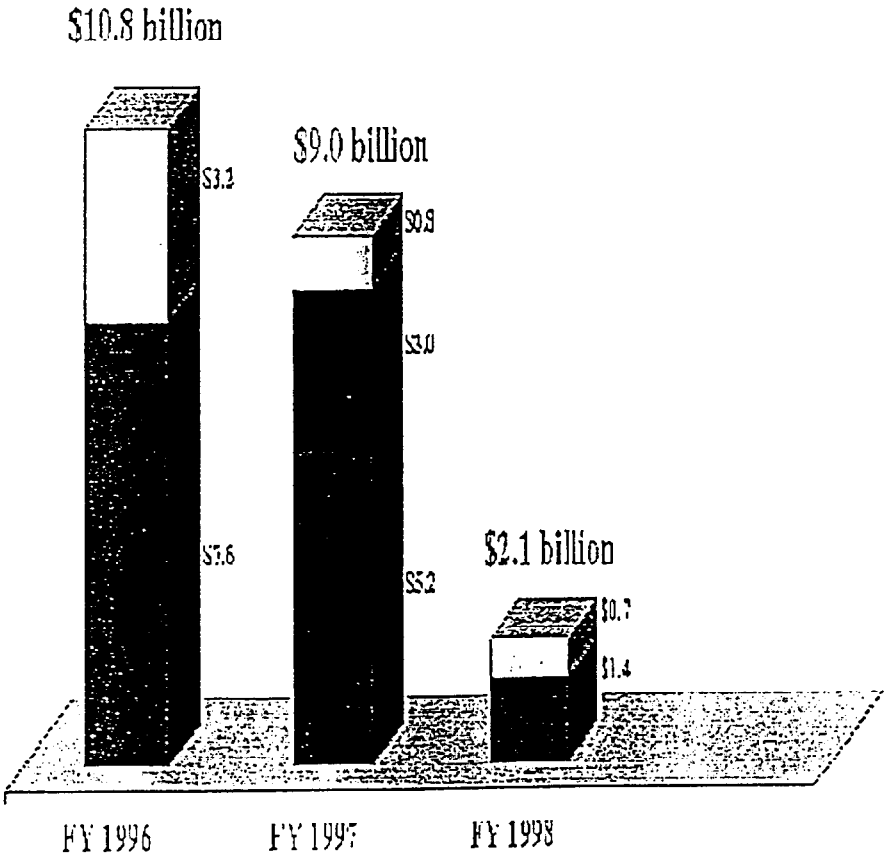
I appreciate the opportunity to appear before you today and to share our reports with you, and I will be happy to answer any questions you may have.

Estimated Improper Payments by Type of Error
(Dollars in Billions)



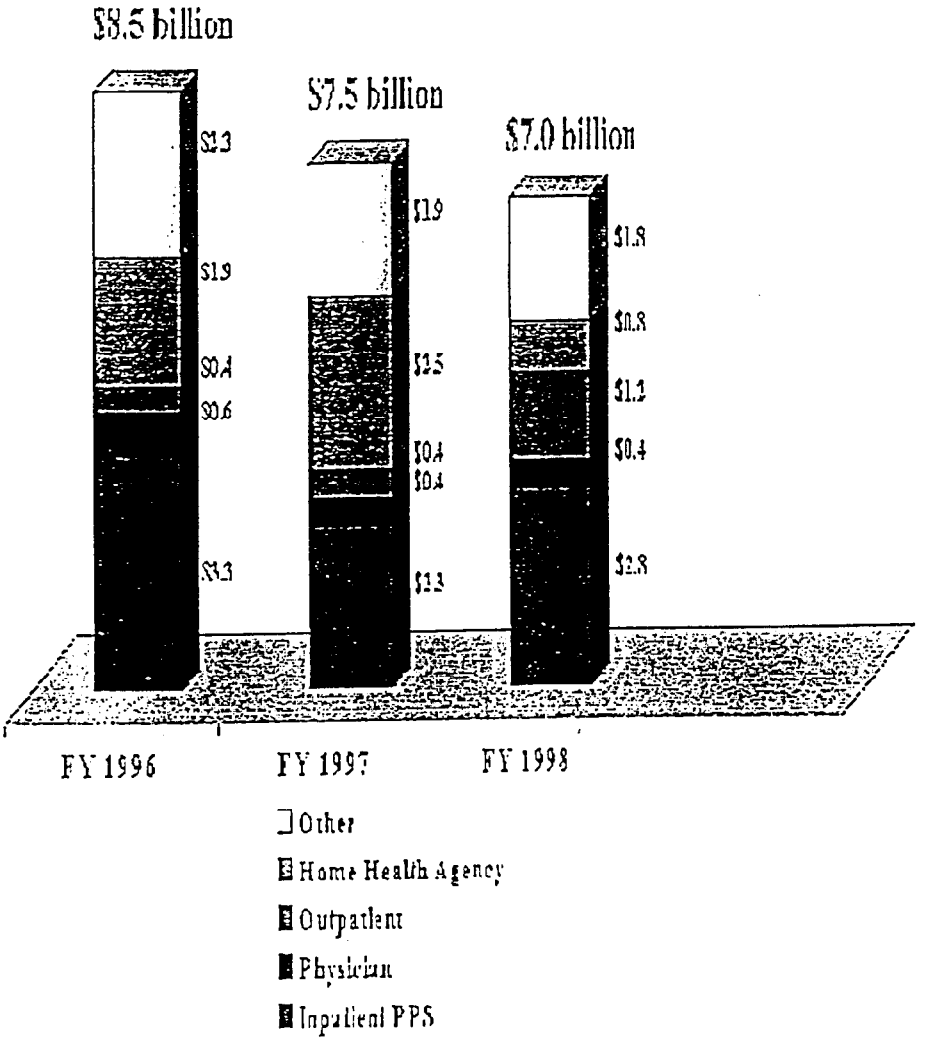
Documentation by Error Category
(Dollars in Billions)

2



Errors Due to Lack of Medical Necessity by Provider Types (Dollars in Billions)

3



Errors Due to Incorrect Coding by Provider Types
(Dollars in Billions)

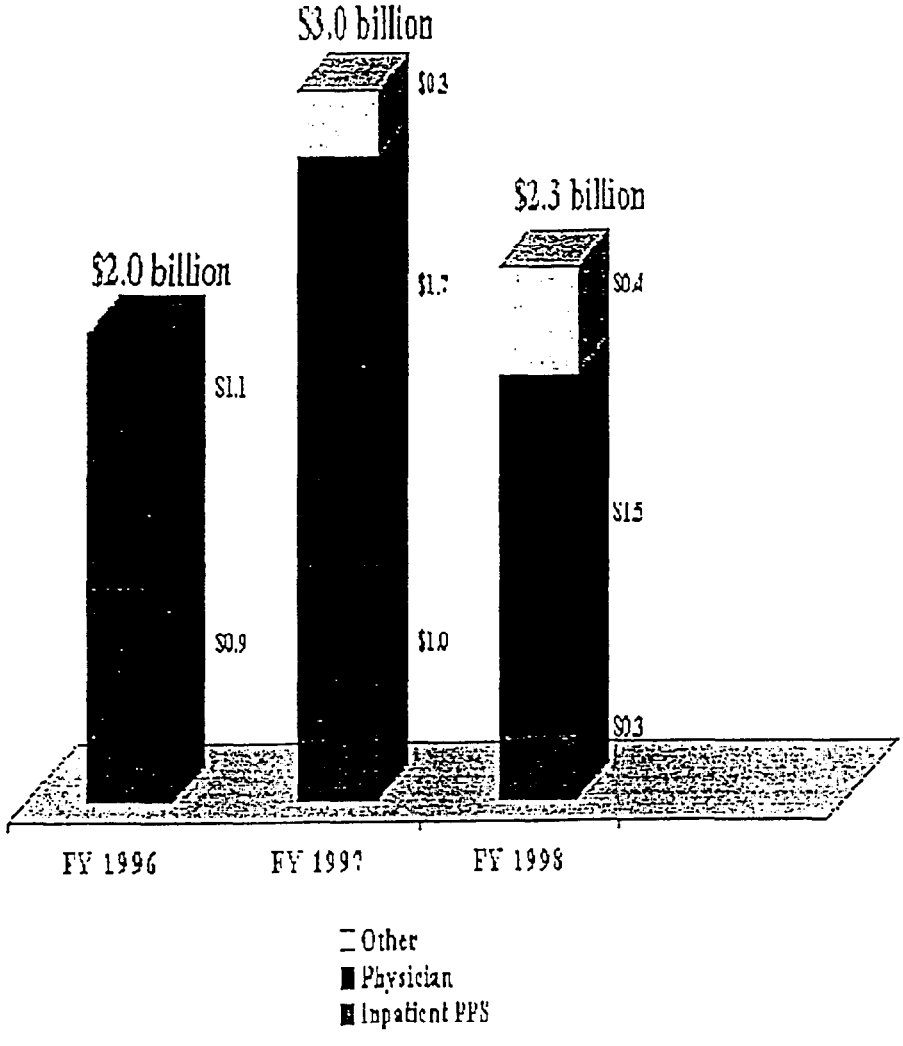


EXHIBIT C

HCFA
Health Care Financing Administration

MEDICARE
PART B CARRIER
Phone: (530) 896-7011

NHIC Educational Outreach

April 20, 1999

**
Department of Developmental Services
1600 9th Street MS 2-3
Sacramento, CA 95814

Dear Mr. ** :

Here is the information you requested about documentation guidelines. I have included the information found in the Medicare Bulletin September 1997, volume 6, plus the psychotherapy documentation guidelines found in Medicare Bulletin June 1998, Issue 4.

I have searched for a definition on "observation" for you, but cannot come up with anything definitive within Medicare regulations and guidelines. I do, however, include some examples that I found that demonstrate "observation". In your example in "Visits to Nursing Home Patients", observation, to me, means that the physician "looks over" the patient's care to determine if there are any changes in the patient's condition. The patient 's condition is usually non-acute and therefore doesn't require frequent visits from the physician. Medicare guidelines allow for one nursing home visit per month for this "observation" visit.

I hope this information helps. Please contact me if you have any questions. I can be reached at (530) 634-7521.

Yours truly,

**
Educational Outreach

**
Enclosure

NHIC
Educational Outreach
National Heritage Insurance Company
620 J St., Marysville, California 95901
A HCFA CONTRACTED CARRIER

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EXHIBIT D

MEDICARE

Mail Address: Medicare, P.O. Box 7013, San Francisco, CA 94120-7013

April 14, 1992

**
3500 Zanker Avenue
San Jose, CA 95134

Dear Dr. ** :

As you are probably aware, on January 1 Medicare carriers implemented a new method for determining payments for physician services. The new method uses a fee schedule constructed from a resource-based relative value scale (RBRVS). The implementation of the fee schedule and other associated payment policies is referred to as Physician Payment Reform (PPR).

Historically, physicians who perform a large number of procedures have been paid at a higher level than physicians who provide a proportionately larger number of evaluation and management services such as visits. PPR has addressed this historic difference by assigning higher values to evaluation and management (E and M) services in relation to the values assigned to procedures than the former payment system. New E and M service codes have been developed which more accurately describe the amount of effort and time that physicians use to perform these services. The new codes have been published in the American Medical Association's 1992 edition of Physicians' Current Procedural Terminology.

The Health Care Financing Administration (HCFA) wishes to evaluate how appropriately the new E and M codes are being used. If the HCFA is able to establish that the new codes are being used correctly, it may be possible for carriers to significantly reduce the amount of prepayment review of claims for visits and consultations that they perform.

To evaluate appropriate use of the new codes, carriers are required to request medical records for a small random sample of claims for visits each week so that they can review the documentation to determine whether the visit codes have been used correctly. The types of services reviewed include office, hospital, and emergency room visits, and consultations.

Our review of these claims is intended to provide the HCFA and the physician community with information about the use of the new codes. All physicians who submit the requested documentation will receive an assessment of their coding accuracy. Should we determine that codes were not used correctly, we will inform the performing physician of what the appropriate code would have been.

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April 14, 1992
Page 2.

The selection of your claim for review is a random event. We will not attempt to recover an overpayment and will take no other action concerning the claim reviewed. Furthermore, the result of our review will have no impact on your future interactions with the Medicare program.

We have selected the following claim for review:

Name: **
HIC No. **
Procedure Code(s): 99312
Date of Service: 02/20/92

Please provide us with the nursing facility visit notes documenting the nature of the visit. We would appreciate receiving your documentation by April 28, 1992. We will advise you of the results of our review.

Should you have any questions, you may contact ** . In addition, ** M.D., our Medical Director, would be pleased to discuss questions or concerns that you may have. ** may be reached at ** . Thank you for your cooperation.

Sincerely,

**
Medical Review Manager

::pr
c:091

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INSTRUCTIONS: Initial note to each condition shall contain all SOAP components, Subsequent notes shall include only those components requiring updating.
SOAP Components: S = Subjective O = Objective A = Assessment P = Plan

Date	Time	No.	All entries shall be signed with name and title.
[illegible]		O	Orders reviewed [illegible] [illegible]
		[illegible]	[illegible] Constipation controlled
O/A			[illegible] [illegible] Resident seen today
			[illegible] doing well **
20/92		O	Orders reviewed & renewed [illegible]
O/A			[illegible] Constipation [illegible]
P			[illegible] [illegible] (fine [illegible]) [illegible]
			[illegible] [illegible] [illegible]
			Resident seen today & is doing well **
[illegible]			[illegible] [illegible] inflammation
			[illegible] Typical antifungal [illegible]
4/3			C/O headache? at dinner time **
140			Had Tylenol 650 mg
			[illegible] x1 post dinner
			PE Looks well, alert, active, good color,
			co-operative, lively, has his usual
**			response to stimulation.
			Heart /
			CV / OK
			Abd - soft, no tender, no organomegaly,
			no guarding or rigidity, peristalsis + or normal.
			HEENT - OK, (throat cannot be seen properly)
			[illegible] Emesis x1 ? cause.
			Plan observe

PHYSICIANS' PROGRESS NOTES

**

Confidential Client/Patient Information
See W & I Code, Sections 4514 and 53

5510 (1/84)

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...a—Health and Welfare Agency | Department of Developmental Servi...

NOTE: SEND COPY OF PHYSICIAN'S ORDER TO PHARMACY AFTER EACH ORDER IS SIGNED.

Continue the following orders through (2/20/92) unless specified otherwise.

Time	Stop Date	Cond. No. / RX. No.	Physician's Order and Medication (Orders must be dated, timed, and signed.)	Administrat Time
2/20/92	----------	P9-2 RX [illegible]	DOCUSATE [illegible] DSS 250 MG ORAL [illegible]	[illegible]
	----------	[illegible]	[illegible]	[illegible]
0900			[illegible]	
	----------	[illegible]	[illegible]	[illegible]
			[illegible]	
	----------	[illegible]	[illegible]	
		P19-1	MED. REG. DIET	
		P9-2	BRAN i tbsp. c Breakfast daily	
		P9-2	Extra fluids 350 cc each Meal	
		P6-2	Walker for Mobility due to Motor Dysfunction & atarax.	
		P12-4	Keep finger nails & cuticles @ middle finger trimmed at all times	
		⊖	Activities as tolerated	
		⊖	LOC / ICF / DD	
		Orders	[illegible] for 30 days by [illegible] **	
2/24/92 0900		TC	[illegible] **	
2/24/92 0900			[illegible] x 7 days	
		O	[illegible] **	

ERGIES: NO KNOWN ALLERGIES

Start a New Form If No Number Shows.

PHYSICIAN'S ORDERS **

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EXHIBIT E

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AGNEWS STATE HOSPITAL

Number	BENEFICIARY HIC	BENEFICIARY LAST NAME	ICN	CHECK #	PAYDATE	FROM DOS	TO DOS	DE	TOS	PROC	MOD1	DOLLARS PAID	DEDUCT	AUDIT RESULTS NEW PROC	AUDIT RESULTS ADJUSTED	AUDIT RESULTS OVERPAYMENT AMOUNT
						1/3/95	10/31/94		1 1	99311		22.87	0.00	NR	0.00	22.87
						1/3/95	10/31/94		1 1	99312		36.21	0.00	99312	36.21	0
						1/3/95	10/28/94		1 1	99312		0.00	0.00	NR	0.00	0
						1/3/95	10/28/94		1 1	99312		36.21	0.00	99312	36.21	0
			0294356462870	0166440262		1/3/95	11/8/94		1 1	99312		36.21	0.00	99312	36.21	0
						1/3/95	11/9/94		1 9	90843	Z9	43.26	0.00	0	0.00	43.26
																89.00
21			0295041537300	0166614409	2/23/95	1/10/95	1/10/95		1 1	99312		38.67	0.00	99312	38.67	0
	**				2/23/95	1/11/95	1/11/95		1 9	90843	Z9	43.30	0.00	NR	0.00	43.30
			0295135429060	0166917895	5/26/95	4/9/95	4/9/95		1 1	99231		17.32	0.00	99231	17.32	0
					5/26/95	4/4/95	4/4/95		1 1	99311		27.44	0.00	0	0.00	27.44
					5/26/95	4/4/95	4/4/95		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
																141.76
22			0295135429660	0166917895	5/26/95	4/9/95	4/9/95		1 1	99231		17.32	0.00	NR	0.00	17.32
	**		0295228353080	0167213379	8/28/95	5/4/95	5/4/95		1 1	94760		0.00	0.00	NR	0.00	0
					8/28/95	5/6/95	5/6/95		1 1	99231		29.29	0.00	99231	29.29	0
			0295228353090	0167213379	8/28/95	5/14/95	5/14/95		1 1	99231		17.32	0.00	99231	17.32	0
			0295228353110	0167213379	8/28/95	5/27/95	5/27/95		1 1	99231		17.32	0.00	99231	17.32	0
			0295228353120	0167213379	8/28/95	5/29/95	5/29/95		1 1	99231		17.32	0.00	99231	17.32	0
			0295228353150	0167213379	8/28/95	6/24/95	6/24/95		1 1	99311		27.44	0.00	99311	27.44	0
					8/28/95	6/26/95	6/26/95		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
			0295228353160	0167213379	8/28/95	7/1/95	7/1/95		1 1	99231		17.32	0.00	99231	17.32	0
					8/28/95	7/2/95	7/2/95		1 1	99231		17.32	0.00	99231	17.32	0
																88.36
3			0295038576240	0166600844	2/17/95	12/13/94	12/13/94		1 1	99311		22.87	0.00	99311	22.87	0
	**				2/17/95	12/13/94	12/13/94		1 1	99311		0.00	0.00	99311	0.00	0
					2/17/95	12/13/94	12/13/94		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
			0295041538970	0166612213	2/22/95	12/30/94	12/30/94		1 1	99311		22.87	0.00	99311	22.87	0
			0295074483780	0166715424	3/27/95	1/23/95	1/23/95		1 1	99312		38.67	0.00	99312	22.87	0
			0295114442950	0166851908	5/8/95	3/1/95	3/1/95		1 1	94760		0.00	0.00	NR	0.00	0
					5/8/95	2/26/95	2/26/95		1 1	99231		29.29	0.00	99231	29.29	0
			0295114442970	0166851908	5/8/95	3/10/95	3/10/95		1 1	99311		27.44	0.00	99311	27.44	27.44
			0295114442980	0166851908	5/8/95	3/16/95	3/16/95		1 1	99212		22.75	0.00	99212	22.75	0
			0295198322700	0167118874	7/28/95	5/27/95	5/27/95		1 1	99231		17.32	0.00	NR	0.00	17.32
					7/28/95	5/29/95	5/29/95		1 1	99231		17.32	0.00	99231	17.32	0
																115.80
1			0295166455680	0167018857	6/27/95	5/3/95	5/3/95		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
	**		0295166455690	0167018857	6/27/95	5/6/95	5/6/95		1 1	94760		0.00	0.00	NR	0.00	0

10/4/96 Next Page Blue Shield lifornia Page 3 of 5

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AGNEWS STATE HOSPITAL

Number	BENEFICIARY HIC	BENEFICIARY LAST NAME	ICN	CHECK #	PAYDATE	FROM DOS	TO DOS	POS	TOS	PROC	MOD1	DOLLARS PAID	DEDUCT	AUDIT RESULTS NEW PROC	AUDIT RESULTS ADJUSTED	AUDIT RESULTS OVERPAYMENT AMOUNT	
	**				6/27/95	5/7/95	5/7/95	1	1	94760		0.00	0.00	NR	0.00	0	
					6/27/95	5/7/95	5/7/95	1	1	99231		29.29	0.00	99231	29.29	0	
					6/27/95	5/6/95	5/6/95	1	1	99231		17.32	0.00	99231	17.32	0	
			0295166455700	0167018857	6/27/95	5/14/95	5/14/95	1	1	99231		17.32	0.00	99231	17.32	0	
			0295198320810	0167118874	7/28/95	5/22/95	5/22/95	1	1	99312		38.91	0.00	99312	38.91	0	
			0295228352030	0167213379	8/28/95	6/20/95	6/20/95	1	1	99312		38.91	0.00	99312	38.91	0	
			0295228352050	0167213379	8/28/95	7/3/95	7/3/95	1	1	99311		27.44	0.00	99311	27.44	0	
			0295228352070	0167213379	8/28/95	7/17/95	7/17/95	1	1	99221		46.62	0.00	99221	46.62	0	
					8/28/95	7/17/95	7/17/95	1	1	99231		0.00	0.00	NR	0.00	0	
																	71.04
25			0294356462630	0166440262	1/3/95	11/28/94	11/28/94	1	1	99311		22.87	0.00	0	0.00	22.87	
	**				1/3/95	11/29/94	11/29/94	1	1	99312		36.21	0.00	0	0.00	36.21	
			0295038575820	0166600844	2/17/95	10/27/94	10/27/94	1	1	99312		36.21	0.00	NR	0.00	36.21	
			0295074483350	0166715424	3/27/95	11/28/94	11/28/94	1	1	94760		0.00	0.00	NR	0.00	0	
					3/27/95	12/22/94	12/22/94	1	1	99312		36.21	0.00	NR	0.00	36.21	
			0295074483352	0166715424	3/27/95	1/31/95	1/31/95	1	1	99311		27.44	0.00	99311	27.44	0	
			0295135429940	0166917895	5/26/95	4/4/95	4/4/95	1	1	99312		41.33	0.00	99312	41.33	0	
					5/26/95	4/5/95	4/5/95	1	9	90855	Z9	71.04	0.00	NR	0.00	71.04	
			0295135429950	0166917895	5/26/95	4/9/95	4/9/95	1	1	99231		17.32	0.00	NR	0.00	17.32	
																	219.86
26			0294356461200	0166440262	1/3/95	10/24/94	10/24/94	1	1	99311		22.87	0.00	99311	22.87	0	
	**				1/3/95	10/25/94	10/25/94	1	1	99311		22.87	0.00	99311	22.87	0	
					1/3/95	10/27/94	10/27/94	1	1	99311		22.87	0.00	99311	22.87	0	
					1/3/95	10/27/94	10/27/94	1	1	99312		36.21	0.00	0	0.00	36.21	
					1/3/95	10/26/94	10/26/94	1	1	99312		36.21	0.00	99312	36.21	0	
					1/3/95	10/24/94	10/24/94	1	1	99313		49.95	0.00	0	0.00	49.95	
					1/3/95	10/23/94	10/23/94	1	9	90855	Z9	71.04	0.00	NR	0.00	71.04	
			0294356461210	0166440262	1/3/95	10/31/94	10/31/94	1	1	99312		36.21	0.00	0	0.00	36.21	
																	193.41
27			0294356459480	0166440262	1/3/95	10/24/94	10/24/94	1	1	99311		22.87	0.00	0	0.00	22.87	
	**				1/3/95	10/27/94	10/27/94	1	1	99311		22.87	0.00	0	0.00	22.87	
					1/3/95	10/26/94	10/26/94	1	1	99311		22.87	0.00	0	0.00	22.87	
					1/3/95	10/31/94	10/31/94	1	1	99312		36.21	0.00	0	0.00	36.21	
					1/3/95	11/1/94	11/1/94	1	9	90855	Z9	71.04	0.00	NR	0.00	71.04	
			0294356459490	0166440262	1/3/95	11/7/94	11/7/94	1	1	99313		47.32	0.00	NR	0.00	47.32	
					1/3/95	11/6/94	11/6/94	1	9	90855	Z9	71.04	0.00	NR	0.00	71.04	
			0295198319220	0167118874	7/28/95	6/7/95	6/7/95	1	1	99311		27.44	0.00	99311	27.44	0	
																	204.22

14 OK 17 wrong 4 psych

State of California—Health and Welfare Agency — Department of Developmental Services

INSTRUCTIONS: Initial note to each condition shall contain all SOAP components. Subsequent notes shall include only those components requiring updating.
SOAP Components: S = Subjective O = Objective A = Assessment P = Plan

Date	Time	No.	All entries shall be signed with name and title.
6/12/95 1015		P 4-3	S/O/A seen at ENT clinic c̄ suggestion to consider PEG. P: will discuss c̄ ID team meeting
			**
6/14/95	0925	P 4-4	S/O/A. Skin rash on groin clear after treatment. P: No further Lotrimin required. Resolve problem. **
6/20/95 1100		O	Monthly orders reviewed + renewed. wt: 83 lbs - [illegible] overweight 6 lbs. Continue present NGT feeding - awaiting IDT team meeting discussion about GT placement
		P 4-1	no N+V, no tarry stools, [illegible]
		P 6-1	Dilantin level was 8.8, Phenobarbital level in therapeutic range, had one seizure in 5/95 while in 96.
		P 4-2	responded well to present Rx, Dulcolax supp. [illegible]
		P 2-1	seizure control c̄ Tegretol + [illegible]
		P 3-1	continue postural drainage, monitor for ↑ drooling + salivation
		P 6-1	no fracture [illegible] continue to protect from injury
			**

PHYSICIANS' PROGRESS NOTES

**

Confidential Client/Patient Information
See W & I Code, Sections 4514 and 5328

DS 5510 (1/84)

** Office of Audit Services Note: It is OAS policy to exclude administratively confidential information from reports (including names of individuals and beneficiary numbers).

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AGNEWS STATE HOSPITAL

Number	BENEFICIARY HIC	BENEFICIARY LAST NAME	ICN	CHECK #	PAYDATE	FROM DOS	TO DOS	QB	TOS	PROC	MOD1	DOLLARS PAID	DEDUCT	AUDIT RESULTS NEW PROC	ADJUSTED	OVERPAYMENT AMOUNT
					8/28/95	6/20/95	6/20/95		1 9	90843	Z9	43.30	0.00	NR	0.00	43.30
			0295228353290	0167213379	8/28/95	7/2/95	7/2/95		1 1	99231		17.32	0.00	99231	17.32	0.00
					8/28/95	7/1/95	7/1/95		1 1	99231		17.32	0.00	99231	17.32	0.00
																43.30
14			0295198321640	0167118874	7/28/95	5/14/95	5/14/95		1 1	99231		17.32	0.00	99231	17.32	0.00
	**				7/28/95	5/15/95	5/15/95		1 9	90843	Z9	43.30	0.00	90843	43.30	0.00
			0295198321660	0167118874	7/28/95	5/21/95	5/21/95		1 9	90843	Z9	43.30	0.00	90843	43.30	0.00
			0295198321670	0167184615	8/18/95	5/27/95	5/27/95		1 1	99231		17.32	0.00	99231	17.32	0.00
					8/18/95	5/29/95	5/29/95		1 1	99231		17.32	0.00	99231	17.32	0.00
																0.00
15			0295135429200	0166943764	6/5/95	4/12/95	4/12/95		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
	**		0295261350230	0167312981	9/29/95	7/30/95	7/30/95		1 1	99231		17.32	0.00	99231	17.32	0
					9/29/95	7/30/95	7/30/95		1 9	90855	Z9	71.04	0.00	90855	71.04	0
																71.04
16			0295261349760	0167312981	9/29/95	8/1/95	8/1/95		1 1	99311		27.44	0.00	99311	27.44	0
	**				9/29/95	7/31/95	7/31/95		1 1	99311		27.44	0.00	99311	27.44	0
					9/29/95	8/1/95	8/1/95		1 9	90855	Z9	71.04	0.00	90855	71.04	0
			0295293367220	0167414570	11/1/95	8/14/95	8/14/95		1 1	99312		41.33	0.00	99312	41.33	0
																0
7			0294356462660	0166440262	1/3/95	10/22/94	10/22/94		1 1	99231		9.74	0.00	99231	9.74	0
	**				1/3/95	10/19/94	10/19/94		1 9	90855	Z9	71.04	0.00	90855	71.04	0
			0295074483410	0166715424	3/27/95	2/21/95	2/21/95		1 9	90855	Z9	71.04	0.00	0	0.00	71.04
			0295114442420	0166851908	5/8/95	2/26/95	2/26/95		1 1	99231		29.29	0.00	NR	0.00	29.29
																100.33
			0294356463210	0166445257	1/4/95	10/26/94	10/26/94		1 1	99312		36.21	0.00	0	0.00	36.21
	**				1/4/95	10/26/94	10/26/94		2 1	99312		0.00	0.00	0	0.00	0
					1/4/95	10/24/94	10/24/94		1 1	99313		49.95	0.00	0	0.00	49.95
			0294356463230	0166445257	1/4/95	11/10/94	11/10/94		1 1	99212		21.19	0.00	99212	21.19	0
					1/4/95	11/11/94	11/11/94		1 1	99231		17.19	0.00	99231	17.19	0
					1/4/95	11/11/94	11/11/94		1 1	99311		0.00	0.00	NR	0.00	0
			0295038576340	0166600844	2/17/95	11/29/94	11/29/94		1 1	99312		36.21	0.00	99312	26.21	0
			0295318366220	0167492142	11/27/95	9/30/95	9/30/95		1 1	99231		21.94	0.00	NR	0.00	21.94
																108.10
			0294356460890	0166440262	1/3/95	11/11/94	11/11/94		1 1	99221		46.29	0.00	99221	46.29	0
	**				1/3/95	11/13/94	11/13/94		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
					1/3/95	11/14/94	11/14/94		1 9	90855	Z9	71.04	0.00	NR	0.00	71.04
																142.08
			0294356462850	0166440262	1/3/95	10/28/94	10/28/94		1 1	99311		22.87	0.00	NR	0.00	22.87
	**															

190k 10 weeks 4 paychecks ~15

... and Welfare Agency — Department of Developmental Serv

INSTRUCTIONS: Initial note to each condition shall contain all SOAP components. Subsequent notes shall include only those components requiring updating.
SOAP Components: S = Subjective O = Objective A = Assessment P = Plan

Date	Time	No.	All entries shall be signed with name and title.
/10/95 1400 (cont'd.)		[illegible]	returned from 96 c̄ abrasion 4cm x 5cm at (R) elbow laterally, abrasion 1cm x 2cm c̄ redness at (R) middle back, small abrasion at (R) buttock - at (L) 5th toe; erythema at (L) lateral chest - A: abrasions P: Polysporin ointment - ACNS notified about these abrasion **
/10/95 1100 (cont'd)		[illegible]	repeat CBC showed platelet 240 - Hgb 10.6 g/dl, Hct 32.2% - total iron 20, TIBC: 219 transferrin 11, Ferritin 376 A: (1) Thrombocytopenia resolved. (2) [illegible] P: will order stool for occult blood - ferrous sulfate. **
/14/95 1120		12	Monthly [illegible] [illegible] wt. [illegible] the same as last month
		[illegible]	well controlled seizure - Continue Depakote dose - Depakote level 89.2 on 8/[illegible]
		[illegible]	responded to present laxative
		[illegible]	dandruff cleared c̄ Pentrax
		[illegible]	[illegible] at bedtime [illegible]. Continue [illegible]
		[illegible]	abrasion at (R) elbow not healing - abrasion at (L) buttock darkened c̄ redness 2cm x 2cm abrasion at the [illegible]

PHYSICIANS' PROGRESS NOTES

**

Confidential Client/Patient Information
See W & I Code, Sections 4514 and 5328

10 (1/84)

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HCFA
Health Care Financing Administration

MEDICARE
PART B CARRIER

June 14, 1999

U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services
801 I Street Room 285
Sacramento, CA 95814
Att: Mr. Jerry Hurst, Senior Auditor

Re: Draft Audit Report (CIN: A-09-98-0072)

Dear Mr. Hurst:

We have reviewed the response to the OIG draft audit report from the Directors of the California State Department of Developmental Services and the Department of Mental Health. The majority of the response is dedicated to objections on the sampling methodology, supported by exhibits including statistics, graphs, correspondence and the 1998 testimony of June Gibbs Brown before the House Committee on Government Reform. Since the sampling was done by OIG, we will not comment on it at this time.

There are a few sections we would like to address. We will itemize these by page and paragraph.

Page 10, ¶ 1 – They have stated that the two separate Medicare carriers used different interpretations of the regulations in reference to acceptable documentation for billable services. *"...BSC allowed payments for a monthly physician progress note on the client's condition. This note did not require that the client necessarily be examined by the physician (Medicare Carrier Manual Section 15062)".* (emphasis added)

The referenced section of the MCM states:

> 15062 - DAILY VISIT CHARGES FOR INPATIENT HOSPITAL VISITS – In some instances, physicians make a single inclusive daily visit charge for each day the patient is hospitalized regardless of whether the physician visited the patient every day, more than once a day, or not at all. ***However, the term "physician service" is described in ¶2020A as a service that involves an examination of the patient either by the physician in person or through interpretation of x-rays, tissue examination, etc. by the physician.***

NHIC
National Heritage Insurance Company
P.O. Box 2805
Chico, California 95927
A HCFA CONTRACTED CARRIER

> ***Terms such as daily care are not sufficiently specific to describe a personal, identifiable service furnished by a physician. Therefore, make payment for physicians' visits to hospitalized patients only on the basis of bills and payment claims that identify the specific visits(s) and services(s) furnished by the physician during such visits, the number of such visits and services, and the dates, or the inclusive dates, on which they were furnished to the patient.*** (emphasis added; copy enclosed)

It is apparent that the State Directors took a portion, out of context, to suit their purposes. In addition, every Medicare Carrier is driven by Title XVII of the Social Security Act with specific regulations, described in detail, in the Medicare Carriers Manual (MCM). There are explicit guidelines regarding documentation in the medical records. There must be sufficient documentation to support a Medicare claim and it should be of such content and clarity as to make it abundantly clear to any third party reviewer, the patient's symptoms, history, physical findings, and plan of treatment.

Also included in this section of the response is a reference to communication with ** , NHIC Educational Outreach. A copy of her letter addressed to ** , DDS, dated April 10, 1999 is identified as exhibit C. The portion of her letter that is of concern reads:

> *"In your example in Visits to Nursing Home Patients, observation, to me, means that the physician "looks over" the patient's care to determine if there are any changes in the patient's condition. The patient's condition is usually non-acute and therefore doesn't require frequent visits from the physician. Medicare guidelines allow for one nursing home visit per month for this "observation" visit.*

Again, it appears that statements are being taken out of context and given a twist to suit their purposes. Without having access to the letter to which ** was responding, it is difficult to determine whether or not her reply is right on target in this situation. We do, however, question the inference that the physician is just overlooking the patient's care without active involvement. Also, Medicare allows for as many visits as is necessary to our SNF patients, guided by medical necessity. We do ***NOT*** make allowance under any level of Evaluation and Management code for observation alone.

There *ARE* observations codes (99217-99220) in the CPT, however, these codes incorporate specific components such as history, examination, decision making etc. as do all E&M codes. These observations codes are specifically for use in maintaining a patient under observation prior to making a decision of whether or not they require admission to an acute care facility. This service is generally done in the emergency room but can also be done in a physician's office or nursing facility. This is NOT a code that is to be used for routine, monthly visits to SNF patients. It should also be noted that we did not observe the use of any of these codes in the State review.

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Page 11, ¶ 4 – The Directors reference a letter from ** ., Medical Review Manager of Blue Shield. This letter is a request for medical records in conjunction with a HCFA mandated review of documentation to support the new coding methodology (Evaluation & Management codes replacing physician visit codes). Please note, this record request is for ***one date of service.*** We do not have the corresponding Medicare claim so we are unable to evaluate the level of service by the documentation in the medical records. However, we are able to state that the date of service in question was supported for services rendered. ***This is the only issue the Medicare Carrier was looking at.*** It was not intended to be a blanket approval for documentation requirements, rather it was to be used as an educational tool to assist providers in making the transition in coding.

Page 13, ¶ 2 - *"Medicare Part B clinical services (outpatient) are made up of a professional component and a technical component. The Medicare Carrier pays the professional component and the intermediary pays the technical component.*

This has been entirely misconstrued. The E&M codes ***do not*** have professional and technical components. We believe what the Directors are referring to is that physician's services to in-patients may be billed to Part B while the facility charges are billed to Part A. We cannot understand the explanation they give for the underpaid/overpaid portions on CPT code 99232. Our claims are processed following the fee schedules established by HCFA.

Page 13, ¶ 3 – The Directors indicate their knowledge of problems revolving around claims for psychologists' services and state that the billings were terminated. There is no mention that a voluntary refund was made to the Medicare Program for inappropriate payments received.

Page 14, ¶ - *"DDS and SMH were not aware that profound mentally retarded beneficiaries were not entitled to psychologist services until they read it in the Carriers Bulletin dated June 1998."* This policy was initiated with the professional advice of our medical advisors in psychology and psychiatry, both of whom concur that the profoundly retarded beneficiaries cannot and do not benefit from psychological intervention. This was also presented to the Carrier's Advisory Committee for open comment and critique before the policy was effected. It is incomprehensible that the staff psychologists and psychiatrists at DDS and DMH are unaware of the scope of benefits from their services. Being unaware that beneficiaries with this diagnosis are not entitled (covered) does not make it appropriate to solicit payment from the Medicare Program for services the medical community agrees is without merit.

If we can be of any further assistance, please contact me.

Sincerely,

Jeff Harrison

Jeff Harrison, Manager
Program Safeguard Department

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