Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY

AUDIT OF MEDICARE CLAIMS BY OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

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OAS FINDINGS AND OPINIONS

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

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1999
A-09-99-00095

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office of Audit Services

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CIN: A-09-99-00095

September 30, 1999

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

Dear Mr. Velasco:

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

We found that optometrists were not licensed to perform CNF assessments. Nonetheless, optometrists submitted claims totaling $1,759,492 for these services, and Transamerica paid them $957,366 for their claims. Ten of the optometrists received 98 percent of the $957,366. We did not determine if the optometrists performed other, different services and incorrectly claimed CNF assessments.

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

In a written reply to our draft report, Transamerica representatives agreed with our audit findings and recommendations. Transamerica's comments are included in their entirety as Appendix A, except we excluded Transamerica's documentation

demonstrating implementation of the computer edits. Transamerica notified optometrists in its September 1999 issue of "Your Medicare Newsletter" that they are not to bill for CNF assessments (see Appendix B).

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

INTRODUCTION

BACKGROUND

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

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

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

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

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

The Health Care Financing Administration (HCFA) issued guidance to carriers in a Program Memorandum (Carriers) No. B-93-3, dated August 1, 1993 (the Memorandum), which describes how physicians participating in resident assessments of beneficiaries in nursing facilities are to bill for their services. The Memorandum states

that physicians should use the Physicians' Current Procedural Terminology' (CPT) codes for CNF assessments (99301-99303) to report evaluation and management (E&M) services involving resident assessments. The CPT codes 99301-99303 represent the E&M of a new or established patient involving an annual nursing facility assessment.

There are three key components in selecting the level of E&M service: (1) a history, (2) an examination and (3) medical decision making. The complexity of the medical service performed determines the CPT code. The CPT manual defines the key components and gives examples of the types of services performed for CNF assessments (CPT codes 99301-99303) as follows:

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

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

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

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

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

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

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

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

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

For other physician visits, the Memorandum states, "Physicians should use the CPT codes for subsequent nursing facility care (993 1 l-993 13) when reporting services that do not involve resident assessments."

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

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

> ***Optometry.*** The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, . . . (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them...." (emphasis added)

OBJECTIVES, SCOPE AND METHODOLOGY

The first objective of our audit was to ascertain whether the California Board of Optometry allowed optometrists to perform comprehensive evaluations of the physical and mental well-being of patients in nursing homes. The second objective was to determine the extent to which Transamerica allowed payment on invalid claims submitted by optometrists for CNF assessments during the Calendar Years 1995 through 1998.

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

We contacted representatives of the California Board of Optometry and reviewed their regulations to ascertain the scope of medical practice authorized for optometrists.

Our audit included an analysis of CNF payments made to optometrists. The data for this payment analysis were obtained from HCFA's National Claims History database. We did not perform an analysis of the procedures used to accumulate the Claims History data nor did we validate the accuracy of the data.

The text of Transamerica's written comments is included as Appendix A, except we excluded Transamerica's documentation demonstrating implementation of computer edits. We have summarized Transamerica's comments following our RECOMMENDATIONS section of this report.

The fieldwork was performed from July 1999 through August 1999 at Transamerica, Los Angeles, California, and at the Office of Audit Services' San Diego Field Office, San Diego, California.

FINDINGS AND RECOMMENDATIONS

We found that the California Board of Optometry did not allow optometrists to perform CNF assessments. However, Medicare payment data showed that optometrists submitted claims for CNF assessments totaling $1,759,492 during Calendar Years 1995 through 1998, of which Transamerica paid $957,366 of the claimed amounts. Ninety eight percent of the $957,366 in payments made were made to 10 optometrists. Whether or not the optometrists performed other, different services and incorrectly claimed CNF assessments is not known.

SCOPE OF OPTOMETRISTS' LICENSES

We determined that the California Board of Optometry did not permit optometrists to conduct comprehensive evaluations of the overall medical conditions of patients. Rather, the licenses held by optometrists were restricted to treatment of the eye.

Section 3041 of the California Business and Professional Code limits the practice of optometry to the examination and treatment, with restrictions, of the human eyes and their appendages. We also contacted an official with the Board of Optometry and discussed the scope of the optometrists' licenses. According to the Board official, CNF assessments are outside the scope of optometrists' licenses.

Given that the State limits the scope of practice for optometrists to services related to the eye, the Social Security Act, Section 1861(r)(4), would effectively not authorize Medicare payment for claims by optometrists for CNF assessments.

ANALYSIS OF MEDICARE DATA

We determined that optometrists submitted claims to Transamerica for CNF assessments totaling $1,759,492 during Calendar Years 1995 through 1998. Of the total claimed amounts, Transamerica allowed $1,220,101 and actually paid $957,366. The paid amounts represented approximately 80 percent of the allowed amounts since the beneficiaries were responsible for the 20 percent coinsurance liability.

Further analysis of the payment data showed that over one third, 10 of the 26 optometrists receiving CNF assessment payments, accounted for 98 percent of the $957,366 of the invalid payments. The 10 providers were paid $937,860, or an average of $93,786. In contrast, the remaining 16 providers were paid $19,506, or an average of $1,219. The following is a frequency distribution summary of the payments to the top 10 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $24,999	4	40%
$25,000 to $49,999	2	20
$50,000 to $149,999	1	10
$150,000 to $199,999	2	20
$200,000 and over	1	10
Totals	10	100%

TRANSAMERICA'S EDITS AND INSTRUCTIONS

As described in the BACKGROUND section of this report, podiatrists had billed Medicare for insignificant amounts for CNF assessments. We found that Transamerica had issued reminders to podiatrists in August 1994, January 1995 and February 1996 telling them not to submit claims for CNF assessments. In addition, Transamerica had implemented computer edits to prevent the payment of CNF assessments to podiatrists. Consequently, Transamerica's payments to podiatrists for CNF assessments were very small ($377). Although the carrier took this action on podiatrists, nothing had been done to prevent payment to optometrists for CNF assessments.

Transamerica issued the reminders to podiatrists and initiated the edit as the result of a 1993 study that identified podiatrists as frequently using the CNF assessment codes. In June 1998, Transamerica representatives stated they had not performed a review of CNF billings by other limited scope providers. The representatives also stated that optometrists are not allowed to bill for CNF assessments and that Transamerica had not issued any reminders to optometrists regarding the use of these codes.

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

OTHER SERVICES

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

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

RECOMMENDATIONS

To address the improper payments made to optometrists, we recommended that Transamerica:

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

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

TRANSAMERICA'S COMMENTS

In a written response to our draft report, Transamerica agreed with our audit findings and recommendations, and have initiated the following actions:

1. Issued a reminder in its September 1999 issue of "Your Medicare Newsletter" stating that optometrists are not to bill for any CNF assessment services since these services are outside of the scope of their practice (see Appendix B); and

2. Implemented computer edits on July 27, 1999, to prevent payment for CNF assessments claimed by optometrists.

Transamerica's comments are included in their entirety as Appendix A, except we excluded Transamerica's documentation demonstrating implementation of the computer edits.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to common identification number (CIN) A-09-99-00095 in all correspondence relating to this report.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services' reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

Sincerely,

Lawrence Frelot

Lawrence Frelot
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Rich Valley
Health Insurance Specialist
Health Care Financing Administration
75 Hawthorne, 4th Floor
San Francisco, CA 94 105

APPENDICES

HCFA
Health Care Financing Administration

Medicare
Part B Carrier
(213) 748-2311 Beneficiaries Only
(213) 742-3996 Providers Only

Mr. Lawrence Frelot
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San Diego, CA 92101

RE: CIN A-09-99-00095

Dear Mr Frelot:

This is in response to your letter of August 20, 1999. Thank you for giving Transamerica Occidental Life Insurance Company (TOLIC) the opportunity to furnish you with written comments regarding the findings and recommendations on your audit of claims submitted by optometrists for comprehensive nursing facility (CNF) assessments during Calendar Years 1995 through 1998.

We do agree with your findings and recommendations. In response to your recommendations, TOLIC have initiated the following actions.

Recommendation #I: Issue a reminder to optometrists not to bill for any service outside of the scope of their medical licenses, such as CNF assessments.

Action taken by TOLIC:
The September 1999 "Your Medicare Newsletter" contains an article (see page 28) [1] informing optometrists that the requirements for performing CNF assessments are outside the scope of the optometrist's practice. Enclosed is a copy of the September 1999 "Your Medicare Newsletter".

Recommendation #2: Implement computer payment edits to prevent payment for CNF assessments claimed by optometrists.

Action taken by TOLIC:
On July 27, 1999 edits were placed in our systems to prevent payments from being made to optometrists (Specialty 41) for procedure codes 99301, 99302, 99303. Enclosed are hardcopy prints of our master procedure file screen showing Specialty 41 as an excluded specialty (Enclosure 1 – 3). [2] Also enclosed are hardcopy prints of our audit trail showing the date the edits were implemented (Enclosure 4 – 6). [2]

If you have any questions regarding the actions that we have taken, please call me at (213) 742-3831.

Sincerely,

Ed Velasco
Manager, Medicare Audit

Enclosure

cc: Mr. Rich Valley, Health Insurance Specialist, HCFA – Region IX

Footnotes added by Office of Audit Services:

[1] Page 28 of the September 1999 "Your Medicare Newsletter" is included as Appendix B in this report.

[2] Enclosures 1 through 6 are not included in this report.

Railroad Retirement Electronic Claim Submission

The following article was published at the request of United HealthCare, which processes Railroad Retirement Medicare Claims.

If you've been submitting paper claims for your Railroad Medicare patients, consider this: Through electronic claim submission, you can receive claim payments twice as fast and claim payments can be transferred directly to your office bank account!

If you would like to learn more about this option, please visit the Railroad Medicare Website at: **http://www.medicare-link.com.** Instructions and enrollment forms are available on the site.

You can also write or call:

United HealthCare - Railroad Medicare
P.O. Box 10066
Augusta, GA 30999-0001

Phone: 706-855-3078
Fax: 706-855-3085
Email: Augemc@uhc.com

Note:
If you are currently submitting Railroad Retirement paper claims to Transamerica, you can expedite the processing of these claims by sending them directly to United HealthCare at the address shown above. Qualified Railroad Retirement Beneficiaries (QRRBs) may be identified by the fact that they have either a six-digit Health Insurance Claim Number (HIC) or an HIC number with one of the following **prefixes:**

A, MA, WA, CA, WCA, PA, JA, WD, WCD, PD, H, MH, WH, WCH, or PH.

Zinecard® Dexrazoxane Coverage

Effective immediately, Zinecard® dexrazoxane (J1190) is indicated for reducing the incidence and severity of cardiomyopathy associated with the administration of Adriamycin® doxorubicin hydrochloride (J9000). Zinecard should only be used for those patients who have received a cumulative dose of 300 mg/m2 of Adriamycin® doxorubicin hydrochloride therapy, or those with a documented preexisting cardiomyopathy and/or history of congestive heart failure (CHF).

Zinecard® dexrazoxane may be administered either by slow intravenous push or by rapid drip intravenous infusion from a bag. Adriamycin® doxorubicin hydrochloride should be given within 30 minutes after beginning the infusion with Zinecard.

Zinecard® dexrazoxane is covered when billed on the same claim, for the same date of service with Adriamycin® doxorubicin hydrochloride. Add as a secondary diagnosis ICD-PCM codes, 425.0 - 425.9 - cardiomyopathy, or ICD-PCM code 428.0 - congestive heart failure, as appropriate when billed for a patient with preexisting cardiomyopathy or history of CHF. When billed alone, Zinecard will be denied as not proven effective.

Optometrists Billing

Optometrists may not bill for CPT codes 99301 – 99303 (evaluation and management, annual nursing facility assessment). These codes require an evaluation and management of a new or established patient involving an annual nursing facility assessment. The requirements for performing these services include areas of assessment, which are outside the scope of an optometrist's practice. The patient's attending or admitting physician performs a full assessment. Optometrists may bill for 993 11 – 993 13, which, by definition, includes new or established patients.