Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONAL HERITAGE INSURANCE COMPANY : AUDIT OF MEDICARE CLAIMS BY PODIATRISTS AND OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

FEBRUARY 2001
A-09-99-00101

OFFICE OF INSPECTOR GENERAL

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

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the Department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region IX

NATIONAL HERITAGE INSURANCE COMPANY: AUDIT OF MEDICARE CLAIMS BY PODIATRISTS AND OPTOMETRISTS FOR COMPREHENSIVE NURSING FACILITY ASSESSMENTS FOR CALENDAR YEARS 1995 THROUGH 1998

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://www.hhs.gov/progorg/oig

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5)

-- -- -- -- --

OAS FINDINGS AND OPINIONS

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

FEBRUARY 2001
A-09-99-00101

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

CIN: A-09-99-00101

FEB 26 2001

Mr. Jeff Harrison
Program Safeguards Manager
Medicare
National Heritage Insurance Company
450 West East Avenue
Chico, CA 95926

Dear Mr. Harrison:

The purpose of this letter report is to provide National Heritage Insurance Company (NHIC) with the results of our audit of Medicare claims by podiatrists and optometrists in California for comprehensive nursing facility (CNF) assessments during Calendar Years 1995 through 1998. Our objective was to determine the extent to which podiatrists and optometrists in California inappropriately billed Medicare for CNF assessments.

Attending physicians usually perform CNF assessments and bill them as Current Procedural Terminology Codes 99301, 99302, or 99303. Medicare requires the attending physician to review a skilled nursing facility resident's total program of care. In California, an attending physician must be a physician and surgeon licensed by the California Board of Medical Quality Assurance or by the Board of Osteopathic Examiners and chosen by the patient or the patient's representative to be responsible for the medical treatment of the patient in the facility. Since podiatrists and optometrists are not licensed as physicians by these boards, they do not qualify as an attending physician. Accordingly, they should not be billing for CNF assessments.

Our audit disclosed that podiatrists and optometrists submitted claims for CNF assessment services totaling $1,628,369 and $868,027, respectively. Of the total amount claimed by podiatrists, NHIC allowed $1,438,340 and paid $1,125,043. Of the total amount claimed by optometrists, NHIC allowed $674,226 and paid $525,159. The NHIC's payments for services billed by 25 podiatrists represented 67 percent of the paid $1,125,043, and its payments for services billed by 4 optometrists represented 96 percent of the paid $525,159. We did not determine if the podiatrists and

optometrists performed other, different services and incorrectly claimed CNF assessments.

In our opinion, the inappropriate payments occurred because NHIC had not informed podiatrists and optometrists that CNF assessments were outside the providers' scope of licenses and, therefore, should not be billed. In addition, NHIC did not have computer edits in place to prevent payments to podiatrists and optometrists for CNF assessments.

Subsequent to our initial draft report, NHIC issued guidance to optometrists in its March 2000 Medicare Part B Bulletin. Further, NHIC implemented edits to prevent payments to podiatrists and issued guidance to podiatrists in its December 2000 Medicare Part B Bulletin.

We recommended that NHIC: (1) issue a reminder to podiatrists to bill Medicare only for services they are licensed to perform, and (2) implement computer edits to prevent payment to optometrists for CNF assessments.

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

In a written reply to our revised draft report, NHIC agreed with our findings and recommendations. The company stated it will educate podiatrists and optometrists through Medicare bulletins, provider outreach sessions, and education letters. It also will pursue the establishment of prepayment edits for optometrists similar to the one established for podiatrists. However, it commented that current data indicates that the improper billings by optometrists have been resolved and that a prepayment edit may not be cost effective. Also, NHIC stated that since it assumed responsibility for processing Medicare Part B claims on December 1, 1996, recoveries for several of the podiatrists and optometrists included in our review have already taken place. Claims paid prior to December 1, 1996 were paid by another carrier. The NHIC's comments are included in its entirety as an Appendix to this report.

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, 42 Code of Federal Regulations (CFR) 483.20 and 483.20(b) require SNFs to perform a comprehensive assessment of each resident's functional capacity 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 status, 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 42 CFR 483.40(a) states, "...The facility must ensure that -- (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable." (emphasis added) Additionally, 42 CFR 483.40(b) states, "...The physician must -- (1) Review the resident's total program of care, including medications and treatments, at each visit...." (emphasis added)

California regulations promulgated more specific rules with regard to attending physicians. An ***attending physician*** in a skilled nursing facility is defined as "...the physician chosen by the patient or the patient's representative to be responsible for the medical treatment of the patient in the facility." (emphasis added) (California Code of

Regulations (CCR)Title 22, Division 5, Chapter 3, Article 1, Rule §72085(b)) Further, "Physician services shall include but are not limited to: .... (4) Advice, treatment and determination of appropriate level of care needed for each patient. (5) Written and signed orders for diet, care, diagnostic tests and treatment of patients by others...." (emphasis added) (CCR Rule §72303(b))

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 states that there are three key components in selecting the level of evaluation and management (E&M) service when performing a CNF assessment: (1) a history, (2) a comprehensive examination, and (3) medical decision making that includes either the creation of a new ***comprehensive medical care plan*** or a review and affirmation of the current ***comprehensive medical care plan***. The Memorandum also describes how physicians participating in resident assessments of beneficiaries in nursing facilities are to bill for their services. Physicians should use the Physicians' Current Procedural Terminology[1] (CPT) codes for CNF assessments (99301-99303) to report E&M services involving resident assessments.

The complexity of the E&M service performed determines the CPT code. The CPT manual defines the key components and gives examples[2] of the types of services performed for CNF assessments (CPT codes 99301-99303) as follows:

99301	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive examination; and medical decision making that is straightforward or of low complexity.

[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.

[2] The CPT code examples are from the 1998 version of the American Medical Association's Physicians' Current Procedural Terminology.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient is stable, recovering or improving. The review and affirmation of the medical plan of care is required. Physicians typically spend 30 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

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 Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components:

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

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the patient has developed a significant complication or a significant new problem and has had a major permanent change in status.

The creation of a new medical plan of care is required. Physicians typically spend 40 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

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.

99303 Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission or readmission to the facility, which requires these three key components:

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

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

The creation of a medical plan of care is required. Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

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, either a detailed interval history or a comprehensive history is required. According to the CPT manual, 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." (emphasis added) The CPT manual states that 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)

According to 42 CFR 483.20(d)(1), a comprehensive care plan must be developed for "...each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe...(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...." (emphasis added)

For ***other physician visits*** of new or established patients, the Memorandum states, "Physicians should use the CPT codes for subsequent nursing facility care (99311-99313) when reporting services that do not involve resident assessments." (emphasis added)

With regard to CNF assessments claimed by podiatrists and optometrists, the Social Security Act covers the services of these providers to the extent the services performed comply with ***Medicare regulations*** and are within the scope of their ***State license***.

> *Podiatry*. The Social Security Act, Section 1861(r), states, "The term physician, when used in conjunction with the performance of any function or action, means, ... (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them...." (emphasis added)
>
> *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)

According to Title 22, Division 5, Chapter 3, Article 1, Rule §72085(a) of the CCR, a physician in a SNF is defined as "...a person licensed as a physician and surgeon by the California Board of Medical Quality Assurance or by the Board of Osteopathic Examiners." (emphasis added) Podiatrists and optometrists are not licensed as

physicians by the State Boards of Medical Quality Assurance or Osteopathic Examiners. Rule §72089 of the CCR defines a podiatrist as "...a person licensed as such by the California Board of Medical Quality Assurance." (emphasis added) Further, optometrists are licensed by the California Board of Optometry.

In addition, limited scope providers (such as podiatrists and optometrists) are not licensed to perform the key medical service components required to bill Medicare for CPT codes 99301-99303, such as preparation of a comprehensive medical care plan that is outside the scope of their specialty. The California Business and Professional Code (the Code) restricted podiatrists to treatment and care planning of the foot and ankle. Section 2472(b) of the Code limited the practice of podiatry to "...the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot."

As for optometrists, the Code restricted these providers to treatment and care planning of the eye and its appendages. Section 3041(a) of the Code limited the practice of optometry to "...any or all of the following: (1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively. (2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition. (3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics. (4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye.... (5) The use of topical pharmaceutical agents for the sole purpose of the examination of the human eye or eyes for any disease or pathological condition...."

Since podiatrists and optometrists are not licensed by California law as "attending physicians" and they are limited scope providers, they cannot serve as the patient's attending physician in a skilled nursing facility, and they cannot review a patient's total care program, which includes either creating or reviewing and affirming the medical care plan. Accordingly, podiatrists and optometrists should not be billing Medicare for CNF assessments, CPT codes 99301-99303.

OBJECTIVES, SCOPE AND METHODOLOGY

The objective of the audit was to determine if podiatrists and optometrists in California inappropriately billed Medicare for CNF assessments.

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 NHIC or of the Medicare program. Our review of internal controls was limited to obtaining an understanding of NHIC's payment procedures and system edits for processing California CNF assessment claims for podiatrists and optometrists. We obtained a general understanding of these procedures and system edits through discussions with NHIC personnel and an analysis of claims data.

We obtained an understanding of the Medicare regulations regarding CNF assessments. We reviewed the California Code of Regulations to determine the State's definitions of a physician and an attending physician, and the requirements of an attending physician in a California skilled nursing facility. We also reviewed the California Business and Professional Code to ascertain the scope of medical practice authorized for California podiatrists and optometrists.

Our audit included an analysis of NHIC CNF assessment payments[3] for services billed by California podiatrists and 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 field work was performed from July 1999 through October 2000 and included visits to the NHIC office in Chico, California.

---

[3] During the audit period, NHIC processes Medicare Part B claims for all California counties except the counties of San Luis Obispo, Los Angeles, Ventura, San Diego, Santa Barbara, Orange, and Imperial.

FINDINGS AND RECOMMENDATIONS

California podiatrists and optometrists inappropriately billed Medicare for CNF assessment services totaling $1,628,369 and $868,027, respectively. Of the total amount claimed by podiatrists, NHIC allowed $1,438,340 and paid $1,125,043. Of the total amount claimed by optometrists, NHIC allowed $674,226 and paid $525,159. The NHIC's payments for services billed by 25 podiatrists represented 67 percent of the paid $1,125,043, and its payments for services billed by 4 optometrists represented 96 percent of the paid $525,159. We believe the inappropriate payments occurred because NHIC had not issued guidance to podiatrists and optometrists that they should not bill for CNF assessment services nor implemented computer edits to prevent these payments. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

ANALYSIS OF MEDICARE DATA: PODIATRISTS

We determined that podiatrists submitted claims to NHIC for CNF assessments totaling $1,628,369 during Calendar Years 1995 through 1998. Of the total claimed amounts, NHIC allowed $1,438,340 and actually paid $1,125,043.

Further analysis of the payment data showed that CNF assessments performed by a relatively small number (25 of the 291 podiatrists billing for CNF assessments) accounted for 67 percent of the $1,125,043 in invalid payments. The invalid payments for the 25 podiatrists averaged $30,122 per provider. In contrast, CNF assessments performed by the remaining 266 podiatrists represented payments of $371,992, or an average of $1,398 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 25 providers.

Total Amount Paid	Number of Providers	Percent of Providers
$10,000 to $24,999	18	72%
$25,000 to $49,999	4	16
$50,000 to $99,999	1	4
$100,000 and over	2	8
Totals	25	100%

ANALYSIS OF MEDICARE DATA: OPTOMETRISTS

We determined that optometrists submitted claims to NHIC for CNF assessments totaling $868,027 during Calendar Years 1995 through 1998. Of the total claimed amounts, NHIC allowed $674,226 and actually paid $525,159.

Further analysis of the payment data showed that CNF assessments performed by over one-fifth (4 of the 19 optometrists billing for CNF assessments) accounted for 96 percent of the $525,159 in invalid payments. The invalid payments for the 4 optometrists averaged $126,679 per provider. In contrast, CNF assessments performed by the remaining 15 optometrists represented payments of $18,445, or an average of $1,230 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 4 providers.

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

INSTRUCTIONS AND EDITS

We initially found that NHIC had neither issued guidance to podiatrists and optometrists nor implemented computer edits to prevent the payment of CNF assessments to podiatrists and optometrists. However, after NHIC received our initial draft report, it issued guidance to optometrists in its March 2000 Medicare Part B Bulletin. Also, subsequent discussions with NHIC revealed that it implemented edits to prevent payments to podiatrists on September 11, 2000 and issued guidance to podiatrists in its December 2000 Medicare Part B Bulletin.

In our view, the issuance of a reminder to podiatrists and the implementation of computer edits to deny payment by NHIC should help to eliminate the inappropriate payments for CNF assessments to podiatrists and optometrists.

OTHER SERVICES

For the reasons previously cited, podiatrists and optometrists were not entitled to payment for CNF assessments 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. Such a determination could only be made by a detailed review of the providers' records.

RECOMMENDATIONS

We recommend that NHIC:

1. Issue a reminder to podiatrists not to bill for any service they are not licensed to perform, such as CNF assessments, and

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

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

NHIC'S COMMENTS

In a written reply to our revised draft report, NHIC agreed with our findings and recommendations. The company stated it will:

1. Educate podiatrists through Medicare bulletins, provider outreach sessions, and education letters, and

2. Pursue the establishment of a prepayment edit for optometrists similar to the one established for podiatrists.

However, NHIC commented that current data indicates that the improper billings by optometrists have been resolved and that a prepayment edit may not be cost effective. Also, NHIC stated that it assumed the responsibility of processing Medicare Part B claims in Northern California on December 1, 1996. Claims paid from January 1,

1995 to December 1, 1996 were paid by another carrier. The NHIC stated that, since assuming responsibility, it has expended significant resources on prepayment and post payment review of all claims billed by podiatrists and optometrists. These reviews have resulted in the recovery of Medicare funds from some of the podiatrists and optometrists included in our review. The NHIC's comments are included in its entirety as an Appendix to this report.

OIG RESPONSE

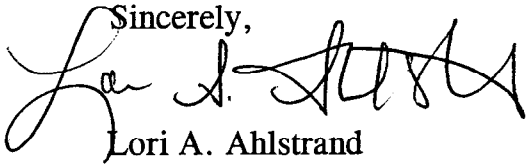
Our audit did not include an analysis of CNF assessment data after December 1998. We believe a prepayment computer edit is the most efficient and effective method to help eliminate improper CNF assessment payments to optometrists.

* * * * * * * * * *

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-09-99-00101 in all correspondence relating to this report.

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 HHS'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 HHS chooses to exercise. (See 45 CFR Part 5)

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Elizabeth Abbott
Regional Administrator
Health Care Financing Administration - Region IX
75 Hawthorne Street, 4th Floor
San Francisco, California 94105

APPENDIX

HCFA
Health Care Financing Administration

MEDICARE PART B

December 15, 2000

Mr. Lawrence Frelot
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General, Office of Audit Services
Region IX
San Diego Field Office
750 B Street, Suite 1820
San Diego, CA 92101

RE: CIN A-09-99-00101

Dear Mr. Frelot:

In response to your request, NHIC has received the OIG audit DRAFT Report from your office dated, November 2000, titled "National Heritage Insurance Company: Audit of Medicare Claims by Podiatrists and Optometrists for Comprehensive Nursing Facility Assessments for Calendar Years 1995 through 1998." The following response is provided regarding your draft report.

Based on our review, NHIC concurs with the findings and recommendations as written. The following additional information is provided relative to the Draft Report.

As a matter of information, NHIC assumed the responsibility for processing Medicare Part (B) claims in Northern California on December 1, 1996. Claims paid from January, 1995 to December 1, 1996, were paid by Blue Shield of California on behalf of the Medicare Part (B) Program. Since assuming its responsibility NHIC has expended significant resources on the Prepayment and Postpayment review of all claims billed by podiatrists and optometrists within our service area. These reviews have resulted in the recovery of Medicare funds through the criminal, civil and administrative process. It is important to note that recoveries have already taken place from several of the podiatrists noted in your report. In addition, NHIC initiated OIG referrals in 1997 on the 4 optometrists identified in your audit for scope of Practice Violations. The referrals were forwarded to the California Board of Optometry and are currently being processed jointly by OIG Investigation and the California Board of Optometry. Administrative recoveries have been completed on the 4 optometrists identified in your audit for some services included in your review.

NHIC
National Heritage Insurance Company
A HCFA Contracted Carrier
402 Otterson • Chico, CA 95928

As stated previously, NHIC concurs with your recommendations and will continue to educate these providers in Medicare bulletins, provider outreach sessions and in education letters. In addition, NHIC will pursue the establishment of a prepayment edit for optometrists similar to the one established for podiatrists on September 11, 2000. I would emphasize that current data would indicate that the improper billing by optometrists has been resolved and a prepay edit may not be cost effective. Finally, NHIC concurs with your request not to seek Administrative Recovery at this time.

I would like to express my appreciation for your Audit Review program in support of the Medicare Program. Feel free to contact me at (530) 896-7043 if I can be of further assistance.

Sincerely,

Jeff Harrison

Jeff Harrison, MBA, MHA, FACHE
Program Safeguards Manager
Medicare

JH:ew
Enc.

cc: Sharon Burgess, Health Insurance Specialist, HCFA Region IX
Marsha Tevis , HCFA Region IX