Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE PART B PAYMENTS TO A SOUTHERN CALIFORNIA PODIATRIST FOR THE PERIOD JUNE 1, 1992 THROUGH MAY 31, 1997

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EXECUTIVE SUMMARY

This report contains the results of our audit of Medicare Part B payments made by Transamerica Occidental Life Insurance Company (Transamerica) to the Medical Provider, a podiatrist located in southern California. The Medical Provider has offices located in Covina and Yorba Linda, California and specializes in convalescent podiatry care.

The objective of our review was to determine whether Medicare's Part B reimbursements of about $1.2 million made to the Medical Provider for services performed during the period June 1, 1992 through May 3'1, 1997 were appropriate.

With the assistance of Transamerica, we audited a random sample of 100 of the Medical Provider's claims for this 5-year period to determine whether these payments were appropriate. We found that the Medical Provider was overpaid for services included in 84 and underpaid for 15 of the 100 sample claims.

The 100 claims in our sample included payments for a total of 167 separate services. Our review determined that 15 1 services, or 90 percent, of the 167 services were either completely unallowable or partially unallowable for Medicare reimbursement. The 151 overpayments consisted of:

- 87 evaluation and management (E&M) services for which the medical record documentation did not support the claimed services or which were upcoded[1]. Seven of the upcoded E&M services were for comprehensive nursing facility assessment codes which are to be used by the admitting or attending physician in establishing the patient's plan of care. The Medical Provider was not the patients' attending physician;

- 60 procedural services which were not medically necessary, were not documented, or were upcoded; and

- 4 E&M services for which the Medical Provider could not provide any supporting medical records.

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[1] Services claimed using CPT codes with higher reimbursement rates than was justified by the supporting medical records.

In addition to the 15 1 overpayments, the sample included 27 unpaid procedural services supported by the medical records. After appropriate medical review, we have included the reimbursable amounts for these previously unpaid procedural services in our overpayment projection.

We estimate based on a projection of our sample results that the Medical Provider received at least $683,264 in overpayments for claims for services performed during the period June 1, 1992 through May 3 1, 1997. Our policy for estimating overpayments uses the lower limit of the 90 percent two-sided confidence level when recommending financial recovery of a projected amount.

In addition to the audit of the random sample of 100 claims, we analyzed the Medical Provider's billings to identify days with the highest number of services. We identified 61 days where the Medical Provider was paid for 50 or more claims, with 98 claims being the highest number of claims for 1 day. The 98 claims paid included 60 E&M services and 140 procedural services. Using the Phvsician's Current Procedural Terminology (CPT) time guidelines, we determined that the E&M services alone should have taken approximately 18 hours to perform. The CPT does not include time estimates for procedural services and we did not estimate the time needed to travel between facilities. Therefore, we could not determine exactly how many additional hours would be necessary to complete the procedural services claimed by the Medical Provider. To us, it seems improbable that the 200 different services and the required traveling between facilities could have been performed in one working day.

Our review also identified three patients who had one of their feet amputated. For these patients, the Medical Provider billed for debridement of six or more toenails, which would include services on the feet which had been previously amputated. The Medicare claim records show that the Medical Provider was paid for a total of 14 claims for debridement of more than 5 nails for these 3 patients from 1995 through 1997.

We recommend that Transamerica:

1. Recover from the Medical Provider the lower limit of our statistical projection of $683,264;

2. Review payments to the Medical Provider for all services after May 3 1, 1997, and for services prior to May 3 1, 1997 which were paid after July 3 1, 1997 to identify potential overpayments;

3. Provide written, educational materials relevant to the issues identified in this report to the Medical Provider; and

4. Perform prepayment reviews of the Medical Provider's Medicare billings and supporting medical records until such time as the Medical Provider demonstrates that he is consistently preparing billings in compliance with Medicare regulations.

In response to the Draft report, the Medical Provider agreed that the audit revealed a problem with his office billing process for amputee patients and stated that he will promptly refund the overpayment. In addition, the Medical Provider agreed with our disallowance of several debridement claims for six or more toenails and our disallowance relating to the use of comprehensive nursing facility assessment codes. In regards to our other findings and questioned costs, the Medical Provider generally disagreed.

The comments identified three global audit issues with which the Medical Provider disagreed. He questioned the inclusion of services in the sample period which were more than 3 years old, contending that the provider should be considered "without fault" with respect to overpayments after 3 years. He questioned the randomness of the sample selection and claimed that the manner in which the sample cases were extrapolated resulted in overstating the projected overpayment. The Medical Provider also disagreed with our assessment of the high service days and indicated that the CPT time guidelines used in our evaluation were not applicable to his billings.

We considered the Medical Provider's comments and concluded that the audit findings were valid. We determined that the Medical Provider's claims met the fault requirements and were subject to recoupment of overpayments. The Office of Audit Services (OAS) sampling methodology and overpayment projections were statistically valid and the CPT guidelines were applicable.

In comments to our Draft report, Transamerica agreed with our audit findings and recommendations. Transamerica also agreed with the statistical methodology used to calculate the projected overpayment.

We have summarized the Medical Provider's comments and the OAS response to those comments at the end of the report. The text of the Medical Provider's comments is included as Appendix E to this report, excluding additional documentation provided for reconsideration of the disallowed costs. The complete text of Transamerica's comments is included as Appendix F to this report.

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INTRODUCTION

We performed an audit of Medicare Part B payments made to the Medical Provider, a podiatrist located in southern California. The objective of our audit was to determine whether Medicare's Part B payments to the Medical Provider for claims paid during the period June 1, 1992 through May 3 1, 1997, totaling about $1.2 million, were appropriate.

BACKGROUND

Licensed in the State of California as a doctor of podiatric medicine since August 1971, the Medical Provider has offices in Covina and Yorba Linda, California. The Medical Provider primarily specializes in convalescent podiatry care. The State Medical Practice Act defines podiatric medicine as the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of: (i) the human foot, (ii) the ankle, (iii) the tendons that insert into the foot, and (iv) the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

During our audit period, the Medical Provider submitted claims to Medicare's Part B Carrier, Transamerica Occidental Life Insurance Company (Transamerica) , for reimbursement using three Medicare provider identification numbers. The Medical Provider had a separate provider identification number for each of his three billing offices. The claims submitted by the Medical Provider were prepared by either the Medical Provider's billing staff or by Mobile Podiatry Care.

According to the Medical Provider, Mobile Podiatry Care provided on-site assistance, billing and medical record retention services for the Medical Provider. The Medical Provider stated that he paid Mobile Podiatry Care a fee for the services performed.

The Medical Provider submitted claims identifying the services performed using the Physician's Current Procedural Terminology (CPT) codes published by the American Medical Association. The claims included CPT codes for evaluation and

management (E&M) services, and procedural services consisting of debridement[2] of nails, paring or curettement[3] of skin lesions, and routine foot care[4].

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of our audit was to determine whether Medicare's Part B payments for 22,629 claims billed by the Medical Provider for services performed for the period June 1, 1992 through May 3 1, 1997 were appropriate. Transamerica paid $1,244,450 for these 22,629 claims as of July 3 1, 1997.

To accomplish our objective, we reviewed a random sample of claims paid by Transamerica for the Medical Provider's three Medicare provider identification numbers. The sample was selected from paid claims as of July 3 1, 1997 for services provided during the period June 1, 1992 through May 3 1, 1997. The 100 sampled claims consisted of 167 separate services. Appendix A presents the details of our sampling methodology and projection of sample results.

We consulted with Health Care Financing Administration and Transamerica representatives about Medicare rules and reimbursement rates for the Medical Provider. Transamerica also identified and provided the population of paid claims, generated the random numbers identifying the claims for the statistical sample, provided copies of the sampled claims, and provided the medical consultant for review of the medical records. The criteria used for the review is detailed in the "FINDINGS AND RECOMMENDATIONS" section of the report, except for the detailed reimbursement criteria relating to routine foot care which is included as Appendix B.

We obtained copies of the pertinent medical records from the patients' medical files. For services claimed to have been performed at a facility which provides medical services, such as a nursing facility or hospital, we obtained the records from the facility. For services provided in a patient's home or in any other non-medical setting,

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[2] Debridement is the removal of foreign material and dead or damaged tissue, especially in a wound (Taber's Cyclopedic Medical Dictionary, Edition 14.)

[3] Curettement is the removal of growths or other material from the wall of a cavity or other surface, as with a curet (Dorland's Medical Dictionary, Edition 28.)

[4] Routine foot care is reimbursable by Medicare when the beneficiary has a qualifying medical condition. Sample item 63 was billed using the Health Care Financing Administration Common Procedure Coding System code MO101 which is used to bill for routine foot care.

such as a board and care home, the physician providing the services is required to keep the medical records and we requested these records from the Medical Provider's staff or Mobile Podiatry Services.

The documentation gathered included, when available: (1) the Medical Provider's podiatry report documenting his evaluation of the patient, the services performed, and any prescriptions ordered, (2) physician progress notes, (3) physician orders, and (4) pictures of the patient's feet when the patient consented.

At our request, a physician consultant for Transamerica reviewed the medical records we obtained to determine whether the medical records supported the services paid to the Medical Provider. The consultant provided an expert opinion as to whether the services paid were medically necessary, reasonable, and were billed using the correct CPT codes. Where the Medical Provider asserted that the medical record supported additional services for which he had not been reimbursed, the medical reviewer determined the allowability of these asserted claims.

We interviewed the Medical Provider, his billing staff, the apparent owner of Mobile Podiatry Care, and nursing staff/administrators at the facilities where services were provided for our sample items. In addition to the sample items discussed in the body of the report, we provided the Medical Provider with the details of all other disallowed sample items for evaluation and use in preparing comments to the Draft report.

Our review was conducted in accordance with generally accepted government auditing standards. We obtained an understanding of the Medical Provider's Medicare billing procedures through interviews with the Medical Provider, his billing staff and the apparent owner of Mobile Podiatry Care. We did not perform a review of the Medical Provider's internal control structure because a review of internal controls was not necessary in order to accomplish the specific objectives of our audit. In addition, we did not review the overall internal control structure of Transamerica or of the Medicare program.

The fieldwork was performed from September 1997 through April 1998 at the various nursing facilities and board and care facilities where services were rendered for the sampled claims, at Transamerica in Los Angeles, California, and at the Medical Provider's business office in Yorba Linda, California.

FINDINGS AND RECOMMENDATIONS

Our review of 100 randomly selected Medicare Part B claims submitted by the Medical Provider determined that the provider was overpaid in 84 and underpaid in 15 of the 100 claims. We estimate that the Medical Provider received at least $683,264 in overpayments for paid claims as of July 3 1, 1997 for services provided during the period June 1, 1992 through May 3 1, 1997. The overpayment was determined by projecting the results of our sample to the $1,244,450 paid to the Medical Provider for the sample period.

Our policy for estimating overpayments uses the lower limit of the 90 percent two-sided confidence level when recommending financial recovery of a projected amount. The details of our sample projection are included as Appendix A of this report.

The sample projection was based on the amount of inappropriate payments for services included in the claims. Each claim consisted of one or more services for which the Medical Provider was paid. The 100 claims in our sample included payments for a total of 167 separate services. Our review determined that 15 1 of the claimed services, or 90 percent, were either completely unallowable or partially unallowable for Medicare reimbursement. The categorization of the 167 services into the allowable and unallowable categories is shown in Appendix C - Summary of Sample Results.

The 151 overpayments consisted of:

(i) 87 E&M services for which the medical record documentation did not support the claimed services (56) or which were upcoded[5] (31). Seven of the upcoded E&M services were for comprehensive nursing facility (CNF) assessment codes which are to be used by the admitting or attending physician in establishing the patient's plan of care;

(ii) 60 procedural services which were not medically necessary or not documented (58), or were upcoded (2), and

(iii) 4 E&M services for which the Medical Provider could not provide any supporting medical records.

[5] Services claimed using CPT codes with higher reimbursement rates than was justified by the supporting medical records.

In addition to the 15 1 overpayments, the sample included 27 unpaid procedural services supported by the medical records. After appropriate medical review, we have included the reimbursable amounts for these previously unpaid procedural services in our overpayment projection discussed above. These unpaid procedural services are listed by sampled claim in Appendix D - Summary of Allowable Unpaid Services.

The overpayments and the reasons for disallowance are presented below in the three overpayment categories. Our report also includes three additional sections related to unrequested services, high services days and debridement of six or more nails for patients with an amputated foot.

The section for unrequested services relates to a disallowance included in the Draft report for services which were not requested by an attending physician. As part of the comments to the Draft report, we were provided a letter by the attending physician stating that the patient required podiatry care by a podiatrist during the period including the sample date. We have accepted this letter as a substitute for the physician order and have incorporated the results of our medical review of this sample item in the appropriate categories of this report.

We also performed an analysis of the Medical Provider's billings during the 5-year period to identify days with the highest number of services. Our analysis identified 61 days where the Medical Provider was paid for 50 or more claims, with 98 claims being the highest number of claims for 1 day. The 98 claims paid included 60 E&M services and 140 procedural services. According to the Medical Provider's billing staff, these services were provided at three different facilities. Using the CPT time guidelines, we determined that the E&M services alone should have taken approximately 18 hours to perform. The CPT does not include time estimates for travel between facilities or for procedural services; therefore, we did not estimate how many additional hours would be necessary to complete all the services claimed by the Medical Provider.

We asked the Medical Provider and his billing clerk how these services could have been performed in one day. The billing clerk stated that the Medical Provider worked very long days and that an 18-hour day would not be out of the ordinary. The Medical Provider stated that he used to work long days quite frequently, but he does not do this anymore because he was informed that the Medicare carriers did not like seeing large numbers of claims for one day and may audit the claims. He stated that he made these visits and performed the services claimed for this day.

In addition to the sample results, our review identified three patients who had one of their feet amputated. The Medical Provider billed for debridement of six or more

toenails, which would include services on the feet which had been previously amputated. The Medicare claim records show that the Medical Provider was paid for a total of 14 claims for debridement of more than 5 nails for these 3 patients from 1995 through 1997,

UNDOCUMENTED OR UPCODED E&M SERVICES

The Medicare Provider was paid for 56 E&M services which were not supported by documentary evidence in the beneficiaries' medical records, and he was paid for another 31 E&M services that were upcoded.

Lack of Medical Documentation for E&M Services

Of the 56 E&M services not documented, 19 included an E&M service billed in conjunction with a procedural service(s). When the E&M service was billed in conjunction with a procedural service, the CPT code billed by the Medical Provider included a modifier 25. The CPT manual describes the modifier 25 as a significant, separately identifiable E&M service by the same physician on the day of a procedure. The modifier 25 definition states:

> "The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed." (Emphasis added)

Review of these 19 E&M services determined that the supporting documentation for the E&M services billed on the same day as a procedure code did not justify that a significant separately identifiable E&M service was performed.

Of the 56 E&M services without supporting documentation, 37 involved payment only for an E&M service. Although the medical records did not support an E&M service, some of the records did support procedural services. When these previously unpaid procedural services were supported by the medical records, we included the reimbursable amounts for these services in our overpayment projection. These unpaid procedural services are listed by sampled claim in Appendix D - Summary of Allowable Unpaid Services.

We discussed 3 examples of the 56 disallowances with the Medical Provider (sample items 14, 39 and 94). Sample items 14 and 39 were examples of instances where a modifier 25 was used to indicate that a separately identifiable E&M service was performed. Sample item 94 was an example of an E&M service billed when the medical records did not support that any service was performed. The Medical Provider demonstrated that a separately identifiable E&M service was performed for sample item 14, and we have adjusted our report accordingly. The Medical Provider stated in his comments to the Draft report that he agreed that his medical record documentation for sample items 39 and 94 did not include the information we considered necessary to support the claim. However, the Medical Provider asserted that the medical record documentation includes adequate support for his billings, but provided no documentary evidence to support his assertion.

Upcoded E&M Services

The 31 upcoded services consisted of 2 types:

(i) incorrect place of service code (19); and

(ii) more complex E&M services than was justified by the medical records (12).

E&M Services With an Incorrect Place of Service Code

There were 19 sample items where the Medical Provider billed for E&M services using CPT codes with an incorrect place of service. Services may be performed at various locations such as a nursing facility, a custodial care facility, a patient's home, or the physician's office. The CPT manual provides separate codes for billing E&M services at these various locations, and each code has a different Medicare reimbursement rate. The Medical Provider billed using either the nursing facility or the home visit CPT codes for all the E&M services included in our sample.

We contacted the facility administrators where the services were performed and were informed that some of the facilities are board and care facilities. For those identified as board and care by the facility administrators, we contacted the State of California, Department of Social Services, Community Care Licensing Division to determine the licensing for each facility. We determined that the facilities were licensed as residential care facilities. Residential care facilities provide non-medical care and supervision for their residents.

The CPT manual states that the custodial care billing codes apply to E&M services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. The residential care facilities meet this definition, and therefore, the Medical Provider should have billed using the custodial care CPT codes for services at these facilities. The reimbursement rate for the home visit E&M CPT code exceeded the reimbursement rate for the custodial care E&M CPT code.

We asked the Medical Provider why the services performed at these facilities were not billed using the custodial care codes. The Medical Provider stated that he asked Transamerica representatives how these facilities should be classified and that the Transamerica representatives had informed him that it was his responsibility to determine the correct classification. The Medical Provider stated that he decided to use the home visit code because the regional centers which license the facilities considered the facility to be the person's home. The Medical Provider also stated that he believed that if his classification was incorrect, then Transamerica would reject the claim.

The Medical Provider's comments to our Draft report stated that our report appeared to allege that the provider billed for a home visit when it was established that these were board and care facilities. We believe that the evidence was clear that these facilities were board and care facilities and that the Medical Provider either knew or should have known that these were board and care facilities. For example, the documentation included in the Medical Provider's comments to our Draft report for two sample items indicated that these facilities were board and care facilities. The comments for sample items 65 and 76 included a physician report for the patient that was on a form published by the "State of California-Health and Welfare Agency, Department of Social Services Community Care Licensing." The form stated that it was for resident/client of, or applicants for admission to, Community Care Facilities, and/or Residential Care Facilities For The Elderly. The form also included a "NOTE TO PHYSICIAN" section which stated that "These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients."

E&M Services Claimed Using a More Complex CPT Code Than Was Supported

There were 12 sample items where the Medical Provider billed for the correct place of service using a more complex E&M service than was justified by the medical record. Seven instances were billed as CNF assessments and the remaining five were billed at a higher level of subsequent nursing facility care than was justified.

Our review of the seven cases which were billed as CNF assessments determined that the CNF assessment codes are to be used by the admitting or attending physician in establishing the patient's plan of care. The admitting/attending physician requested podiatry services for these patients, and therefore, the CNF CPT code for an E&M evaluation is not the appropriate code for the services rendered by the Medical Provider. These visits have been allowed at the appropriate E&M code for subsequent nursing facility care.

We discussed sample item 31 with the Medical Provider. The Medical Provider stated that at the time the CNF assessments were billed he did not know that podiatrists could not bill using the comprehensive nursing facility code. The Medical Provider agreed with our reduction.

The CPT manual includes three levels for billing E&M services performed at nursing facilities, custodial care facilities and at a patient's home. The CPT manual states that there are six components which are used in defining the levels of E&M services. These components are:

- history,
- examination,
- medical decision making,
- counseling,
- coordination of care, and
- nature of presenting problem.

The CPT manual states that the first three components should be considered the key components in selecting the level of E&M services. For the E&M services billed by the Medical Provider, two of the three key components must meet the stated requirements to qualify for a particular level of E&M service.

An example of services billed at a higher level of subsequent nursing facility care than was justified by the supporting documentation is sample item 2 which was billed as a middle level E&M code for subsequent nursing facility care (993 12). To qualify for a 99312, the services must meet at least two of these three key components:

- an expanded problem focused interval history;
- an expanded problem focused examination;
- medical decision making of moderate complexity.

Review of the supporting documentation for sample item 2 indicated that no history was performed, the examination was problem focused instead of expanded problem focused, and the medical decision making was straightforward instead of being of moderate complexity. We allowed reimbursement for sample item 2 at a lower level of E&M service (993 11) which requires only two of the following three components:

- a problem focused interval history;
- a problem focused examination;
- medical decision making that is straightforward or of low complexity.

We discussed sample item 2 with the Medical Provider who agreed that the E&M code should be reduced to the lower level (993 11) E&M code., However, the Medical Provider believed that the record supported other charges which had not been claimed. We have allowed two additional services, see Appendix D.

UNNECESSARY, UNDOCUMENTED, OR UPCODED PROCEDURAL SERVICES

The Medical Provider was paid for 58 procedural services which were not medically necessary or not documented as having been performed as claimed, and he was paid for 2 procedures which were upcoded.

Medical Necessity and Documentation for Procedural Services

Medicare generally does not pay for routine foot care. However, there are certain circumstances where routine foot care is covered under Medicare. Routine foot care may be reimbursed if there is a localized illness, injury, or symptoms involving the feet. In addition, routine foot care may be reimbursed if the patient suffers from certain systemic conditions which would put the patient's health at risk if the services were performed by a non-professional. Routine foot care may also be reimbursed for specific circumstances involving mycotic nails. The specific criteria relating to routine foot care is detailed in Appendix B of this report. In addition to the routine foot care criteria, Medicare rules require that services provided must be reasonable and medically necessary.

Review of the medical records for the 58 procedures determined that the services were unallowable because:

(i) the routine foot care services did not meet the exceptions noted above, and therefore, were not medically necessary; or

(ii) the medical records did not provide support which would indicate that a procedure was performed.

Eleven of the 58 CPT procedures were instances where the Medical Provider billed for debridement of six or more nails when the medical records only indicated that five or less nails met Medicare reimbursement requirements for debridement. The Medical Provider should have billed for an 11700 code (debridement of nails, five or less.) However, he billed using both 11700 and 11701 codes. The 11701 code represents debridement of additional nails, five or less.

We discussed four examples of these disallowances with the Medical Provider (sample item numbers 10, 14, 39 and 63). Two sample items (14 and 39) are examples where the debridement of the first five nails was allowable, but the medical records did not support that the additional five nails met Medicare reimbursement criteria. The Medical Provider stated that he had a misconception at the time these billings were prepared and believed that the 11700 and 11701 codes were used to designate services to the left and right foot and not how many nails met Medicare reimbursement requirements. The Medical Provider stated that he debrided all 10 toes for these patients and at least 1 toe on each foot was reimbursable by Medicare. Therefore, he billed for both the 11700 and 11701 codes. The Medical Provider stated that he recently became aware of the correct billing procedures for debridement codes.

For sample item 10, the Medical Provider agreed in his comments to the Draft report that the treatment section of the medical record had not been completed. However, he did not agree with our determination that a treatment was not performed, but provided no documentary evidence to support his assertion.

For sample item 63, the Medical Provider's comments to the Draft report indicated that he disagreed with our statement that he had agreed that the patient did not suffer from a condition which would put the patient's health at risk. He agreed that his medical record did not include this information but indicated that the patient's chart may include additional documentation on the patient's medical condition. However, he did not include any additional documentation with his comments.

The Medical Provider subsequently provided a revised written analysis of sample item 63. The analysis indicated that the Medical Provider believed that he should have billed for an 11700 code, which represents debridement of mycotic nails, instead of the MO101 code, which represents routine foot care for a person with a qualifying medical

condition. His analysis also included a note stating that the medical record for the sample date included a clerical mistake. The clerical mistake was that no nails were identified as mycotic. As support for the 11700 code which he claims should have been billed, the Medical Provider then made reference to a medical record from 4 months later which indicated that the patient had mycotic nails. The Medical Provider's analysis also asserted that the patient had a past history of pain and difficulty walking due to mycotic nails.

Our analysis of the Medical Provider's comments for sample item 63 determined that no payments should be allowed for this sample item. We believe that the Medical Provider either knew or should have known when he submitted the original billing for the MO10 1 code that the service was not supported by the medical record. The Medical Provider has agreed that his medical record did not document that the patient had a medical condition which would qualify for Medicare reimbursement for the MO101 service.

We also believe that the Medical Provider's current assertion that he should have billed an 11700 code is inappropriate. In order for the debridement of mycotic nails to be reimbursed by Medicare, the patient would need to have symptoms such as pain or secondary infection associated with the mycotic nails. The medical record includes no indication of such symptoms. In order to be reimbursed, regulations require that this information be documented on the medical record supporting the claim. In addition, the Medical Provider's records for his visit prior to the sample date, the sample date, and the two visits following the sample date all indicate, under the ambulatory status section of the record, that the patient ambulated with no limitations. Therefore, the Medical Provider's assertion that the patient had difficulty walking was not supported by the medical record.

Upcoded Procedural Service

Review of the medical records determined that two procedural services in our sample had been upcoded. We discussed with the Medical Provider the billing for sample item 39 which included a charge for paring or curettement of two to four lesions. Review of the medical records indicated that a single inflamed corn was debrided. We allowed a charge for paring or curettement of a single lesion. The Medical Provider disagreed with our determination. He believed the medical record supported debridement of two corns.

PHYSICIAN COULD NOT LOCATE MEDICAL RECORDS

The Medical Provider could not provide medical records to support five claims which 'included five E&M services. In his comments to the Draft report, the Medical Provider provided copies of medical records for one of the sample items which previously could not be located (sample item 16). The medical records have been reviewed and the results of our analysis of sample item 16 have been incorporated into the appropriate sections of this final report. Therefore, only four sample items are classified under this caption.

As discussed in the "OBJECTIVE, SCOPE AND METHODOLOGY" section of this report, the physician is required to retain the medical records to support billings provided in a patient's home or in any other non-medical setting, such as a board and care home. The E&M services on the remaining four claims were not performed in a medical or nursing facility. Since the Medical Provider could not provide medical records to support the claims, payment for these E&M services was unallowable.

UNREQUESTED SERVICES

Our review determined that sample item 1, which consisted of an E&M service and a procedural service, was unallowable because the services provided were not requested by the attending physician. In order to qualify for reimbursement under the Medicare program, consultation services must be requested by the patient's attending physician. The Medicare Carrier's Manual (MCM) B3 2020.D states:

> "A consultation is reimbursable when it is a professional service furnished a patient by a second physician or consultant at the request of the attending physician. Such a consultation includes the history and examination of the patient as well as the written report, which is furnished to the attending physician for inclusion in the patient's permanent medical record. "

The patient for sample item 1 was located at a nursing facility and was under the care of an attending physician. Podiatry services would need to be ordered by the attending physician before the charges would be allowable for reimbursement under the Medicare program. Review of the medical record for sample item 1 indicated that the patient's attending physician did not order podiatry care. Therefore, the Medical Provider's visit was not authorized and did not qualify for Medicare reimbursement.

As part of the comments to the Draft report, we were provided a letter by the attending physician stating that the patient selected as sample item 1 required podiatry care by a podiatrist during the sample date. We have accepted this letter as a substitute for the physician order. The results of the medical review of sample item 1 are included in the appropriate categories of this report.

HIGH SERVICE DAYS

We performed an analysis of the payments to the Medical Provider during the 5-year period to identify days with the highest number of services. Our analysis identified 61 days where the Medical Provider was paid for 50 or more claims. The highest number of claims for a day was for June 29, 1995 which had 98 paid claims. The 98 claims paid included 43 low-level E&M home services (CPT code 99351), 17 middle level E&M subsequent nursing facility services (CPT code 99312), and 140 procedural services (CPT codes 11700, 11701 and 11051).

According to the Medical Provider's billing staff, these services were provided at three different locations in Pomona, Montclair, and Anaheim, California. Using the CPT time guidelines for E&M services at nursing facilities, we estimate that the E&M services alone should have taken approximately 18 hours to perform. Although the E&M services billed by the Medical Provider included 43 E&M home services, we used time estimates for the E&M nursing facility services. This approach was used to estimate the time requirements because the CPT does not include time estimates for E&M home or custodial care services. Therefore, the nursing facility tune guidelines provide the best estimate of the time required to perform the claimed E&M services.

The 18-hour estimate does not include time for travel between facilities or for the 140 procedural services. The CPT does not provide time estimates for procedural services and, therefore, we did not estimate how many additional hours would be necessary to complete all the services claimed by the Medical Provider.

We asked the Medical Provider and his billing clerk how these services could have been performed in 1 day. The billing clerk stated that the Medical Provider worked very long days and that an 18-hour day would not be out of the ordinary. The Medical Provider stated that he used to work long days quite frequently, but he does not do this anymore because he was informed that the Medicare carriers did not like seeing large numbers of claims for 1 day and may audit the claims. He stated that he made these visits and performed the services claimed for this day.

DEBRIDEMENT OF SIX OR MORE NAILS FOR PATIENTS WITH AN AMPUTATED FOOT

While performing survey work for this audit, we identified billings by the Medical Provider for debridement of nails for six or more toes for a patient who had only five toes due to a below-the-knee amputation. Review of the medical records determined that the patient had a below-the-knee amputation performed in November 1992. Our analysis of the Medical Provider's billings for this patient showed that the Medical Provider started billing for debridement of six or more nails in September 1995. Since September 1995, the Medical Provider has billed non-performed debridement services a total of 11 times for this patient.

The Medical Provider indicated that his billing staff prepare billings by reviewing the Medical Provider's medical records and identifying the services performed during the visit. Review of the podiatry medical records prepared by the Medical Provider for three visits to this patient showed that the Medical Provider indicated in the medical records that the patient only had five toes. Although the Medical Provider's medical records clearly indicate that the patient only had five toes, the billings for all three of these visits included a charge for debridement of six or more nails.

The Medical Provider stated that the patient was an amputee and only had five toes. The Medical Provider also stated that he did not have any explanation as to why the debridement of more than five nails was billed for this patient.

We performed an analysis of Medicare's claim records to determine if there were additional payments to the Medical Provider for services which could not have been performed due to an amputation procedure. We identified payments to the Medical Provider for two additional patients from 1995 through 1997. There were two instances of billings for debridement of more than five nails for one patient and only one instance for the other patient.

RECOMMENDATIONS

We recommend that Transamerica:

1. Recover from the Medical Provider the lower lirnit of our statistical projection of $683,264;

2. Review payments to the Medical Provider for all services after May 31, 1997, and for services prior to May 31, 1997 which were paid after July 31, 1997 to identify potential overpayments;

3. Provide written, educational materials relevant to the issues identified in this report to the Medical Provider; and

4. Perform prepayment reviews of the Medical Provider's Medicare billings and supporting medical records until such time as the Medical Provider demonstrates that he is consistently preparing billings in compliance with Medicare regulations.

MEDICAL PROVIDER'S COMMENTS AND OAS RESPONSE

The Medical Provider's comments to our Draft report consisted of a letter which addressed the "global" audit issues and several documents and photocopies of photographs addressing issues specific to each audited claim. In general, the Medical Provider disagreed with the audit fmdings and questioned costs. However, he agreed that the audit revealed a problem with his office billing process for amputee patients and stated that he will promptly refund the overpayments relating to claims for the amputee patients. In addition, the Medical Provider agreed with our disallowance of several debridement claims for six or more toenails and our disallowance relating to the use of comprehensive nursing facility assessment codes. The text of the Medical Provider's letter is included as Appendix E to this report.

The Medical Provider's comments stated that the enclosed documents were intended to show that there were sufficient references in the medical records to establish what medical treatment and procedures were performed and the supporting "medical necessity." The OAS sent a letter to the Medical Provider on July 30, 1998 to obtain clarification of the documentation provided for several sample items. We received additional documentation for 12 sample items on September 11, 1998.

The OAS considered all documentation submitted by the Medical Provider for each sample item and incorporated any changes considered appropriate into the final report.

The "global" audit issues raised in the Medical Provider's comments were (i) the period of time covered by the audit; (ii) the validity of the sample and projection; (iii) the assessment that services claimed for high service days could not have been performed; and (iv) the analysis showing that claims were made for debridement of toenails for feet which were previously amputated. Details of these audit issues and OAS response about them follow. The other non-global audit issues included in the Medical Provider's comments and the OAS response are incorporated in the applicable section of the report, as appropriate.

Period of Time Included in the Audit

Medical Provider's Comments

The Medical Provider questioned the inclusion of services in the sample period which were more than 3 years old. The Medical Provider stated that Congress enacted law which includes provisions to the effect that after 3 years have expired, it will be presumed in the absence of evidence to the contrary that the provider was "without fault" with respect to overpayment, and under such circumstances no overpayment collection will be made. The comments stated that "it appears that in reviewing the provider's medical records for claims more than three years old, the auditors clearly were working on the presumption that the provider was at fault, and interpreted the medical records and all reasonable inferences derived therefrom against the provider."

OAS Response

The claims for 1992 and 1993 were included in our sample because we believe the claims did meet the fault requirements, and therefore, were subject to recoupment of overpayments. Under 20 CFR 404.507, one of the elements considered in determining fault is whether the overpayment resulted from an incorrect statement made by the individual that he or she knew or should have known to be incorrect.

During our preliminary work of reviewing the Medical Provider's Medicare claims, we identified several instances which indicated that the provider was at fault and either knew or should have known that certain CPT codes billed to Medicare were incorrect. The instances identified consisted of billings for debridement of toenails on amputated feet and billings for services during a one-day period which, due to the time necessary to perform the services, could not have been performed at the levels for which they were billed.

The assertion that the auditors interpreted the medical records and all reasonable inferences derived therefrom against the provider is incorrect. We have allowed the Medical Provider all payments which our review determined were supported by the medical records. For example, the Medical Provider claimed five services in our sample as comprehensive nursing facility assessments. As discussed in the report, podiatrists are not qualified to perform comprehensive nursing facility assessments. However, we reviewed the medical record and have allowed the appropriate CPT code supported by the medical records. Also, see Appendix D - Summary of Allowable Unpaid Services for a listing of all previously unpaid allowable services that were included as allowable in our overpayment projection.

Statistical Sampling Methodology and Extrapolation of Sample Results

Medical Provider's Comments

The comments questioned the randomness with which the samples were selected. The Medical Provider also questioned the manner in which the sample cases were extrapolated over the audit period, stating that the Medical Provider's business increased over the course of the audit and the sampling did not take into account the true distribution of the provider's billings. The comments stated that this (not taking into account the true distribution) causes the overpayment request to be skewed in a manner that prejudices the provider. The example used in the comments to demonstrate the unfairness of the extrapolation indicated that four claims for which the Medical Provider could not locate the medical records for services in 1992 and 1993 were extrapolated over the whole audit period. The comments indicated that extrapolation to the whole audit period was unfair because the 1992 and 1993 claims represented only 22 percent of the claims paid to the provider during the audit period.

OAS Response

The random numbers and extrapolation for this audit were generated using our computer software package called RATS-STATS. This software has been tested and determined to provide valid random numbers. The Department of Health and Human Services, Departmental Appeals Board (DAB), under DAB No. 153 1, stated that me RATS-STATS software performed reliably as a random number generator. The DAB decision stated that the evidence presented showed that the RATS-STATS software passed a standard battery of recognized statistical tests for randomness and was entirely suitable for producing lists of random numbers to select sample cases for review.

The example presented by the Medical Provider to demonstrate the unfairness of the audit extrapolation was not valid. The Medical Provider's position assumed that the only records which he would not be able to locate in the audit universe would be from 1992 and 1993. However, no evidence was provided to support this assumption. The premise of statistical sampling is that every item in the universe has an equal chance of being selected. There was no reason to believe that the number of claims for which the Medical Provider could not provide supporting medical records in the sample were not representative of the number of similar unreviewed claims in the universe. Therefore, the disallowance for missing medical records should be extrapolated to all claims in the audit universe.

High Service Days

Medical Provider's Comments

The comments stated that the report implies that the provider billed for services not rendered due to the number of services billed for on particular days, and that the Medical Provider denied this contention. The comments stated that the time guidelines set forth by Medicare for E&M services were only guidelines if the doctor set his E&M services by time alone. The Medical Provider indicated that he did not use time alone to set his E&M service billings.

OAS Response

The Medical Provider's assertion that the time guidelines only applied if the doctor set his E&M services by time alone is incorrect. There is nothing in the CPT manual that states that the time guidelines apply only if the doctor uses time alone to set his E&M billings. The 1997 CPT manual states that the descriptors for the level of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These six components are discussed in detail on page 9 of this report. The seventh component, time, which is discussed in detail on page 4 of the CPT manual, stated "The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist Dhysicians in selecting the most appropriate level of E/M services." (emphasis added) The manual noted that the specific times expressed in the visit code descriptors are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

Using the average time guidelines provided in the CPT manual, it is highly improbable that the 200 different services claimed and the required traveling between facilities could have been performed in one working day.

Billings for Amputee Patients

Medical Provider's Comments

The Medical Provider agreed that our audit revealed a problem in his office billing process regarding 11 nail debridement billings for amputee patients. The comments stated that the provider generated a computer billing sheet from the computerized records that summarized the services that needed to be billed. The problem, according to the Medical Provider, was that the computer program cut off the remarks part of the billing sheet; the provider stated that he was not aware of this until our audit. The

Medical Provider stated that the problem has been rectified and that he will promptly refund the overpayment.

OAS Response

The report discusses 14 nail debridement paid claims for 3 patients who had an amputated foot.

During our discussion with the Medical Provider, he had no explanation of how these debridements could have been billed. His subsequent written comments identified a problem with a computer billing sheet as the cause for billing these services. However, the Medical Provider's explanation of the cause of these errors did not correspond with the information provided and statements previously made by the Medical Provider. The Medical Provider and his staff informed us during the audit that the billing staff determined the CPT codes to be billed by reviewing the medical record or a copy of the medical record. Neither the Medical Provider nor his staff mentioned a computerized sheet where the Medical Provider summarized the services to be billed.

The Medical Provider did not provide any copies of computerized billing records where he summarized the services that needed to be billed. Since we have never been provided with the computerized billing sheet described in the comments, we cannot determine whether or not all information concerning an amputation would have been lost if the program cut off the remarks section as is described in the comments.

TRANSAMERICA'S COMMENTS

Transamerica representatives agreed with our audit findings and recommendations. Transamerica representatives also agreed with the statistical methodology used to calculate the projected overpayment. The complete text of Transamerica's comments is included as Appendix F to this report.

APPENDICES

Sampling Methodology

OBJECTIVE

To determine if Medicare Part B payments to the Medical Provider for services paid by Transamerica for the period June 1, 1992 through May 3 1, 1997 were appropriate.

POPULATION

We used the universe of claims paid by Transamerica during the period June 1, 1992 through May 31, 1997 for the Medical Provider's three Medicare provider numbers. As of July 1997, the universe for the three Medicare provider numbers consisted of 22,629 paid claims totaling $1,244,450.

SAMPLING UNIT

The sample unit was a paid Medicare Part B claim submitted by the Medical Provider. A paid claim may include charges for multiple services performed on the same date for the same beneficiary.

SAMPLING DESIGN

A single stage, unrestricted random sample was used.

SAMPLE SIZE

The sample consisted of 100 paid claims.

ESTIMATION METHODOLOGY

Using the RATS-STATS Variables Appraisal Program, we projected the overpayments made to the Medical Provider for services that did not meet Medicare Part B reimbursement requirements. The projected overpayment was calculated at the lower limit of the 90 percent two-sided confidence level using the difference estimator.

RESULTS OF SAMPLE

We reviewed 100 paid claims representing services totaling $5,355. Our analysis determined that the payments by Transamerica under Medicare Part B should be adjusted for 99 of the 100 paid claims sampled. The adjustments consisted of net overpayments for services claimed by the medical provider in 84 paid claims sampled, and net under-payments in 15 paid claims sampled. The net value of overpayments in the sample was $3,483.

We used the results of the 100 sample items to project the value of the net overpayments for the universe of 22,629 paid claims. The results of the projection are:

Point Estimate of Differences:	$788,188
Precision Amount:	$104,925
Lower Limit at the 90 Percent Confidence Level:	$683,264

Based upon the sample projection data above, we are 95 percent confident that the overpayments to the Medical Provider were equal to or greater than $683,264.

Criteria Relating To Routine Foot Care

SOCIAL SECURITY ACT:

The Social Security Act, Sec. 1862. [42 U.S.C. 1395y] states that:

"(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services--

(l)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

. . . . . .

(13) where such expenses are for--
(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,
(B) the treatment of subluxations of the foot, or
(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care);"

CODE OF FEDERAL REGULATIONS (CFR)

42 CFR, Section 4 11.15.

"The following services are excluded from coverage.

. . . . . .

(k) *Any services that are not reasonable and necessary* for one of the following purposes:
(1) For the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

. . . . . .

(1) *Foot* care--(l) *Basic rule.* Except as provided in paragraph (l)(2) of this section, any services furnished in connection with the following:

Criteria Relating To Routine Foot Care
(Continued)

42 CFR, Section 411.15. (Continued)

(i) *Routine foot care,* such as the cutting or removal of corns, or calluses, the trimming of nails, routine hygienic care (preventive maintenance care ordinarily within the realm of self care), and any service performed in the absence of localized illness, injury, or symptoms involving the feet.

(ii) *The evaluation or treatment of subluxations of the feet* regardless of underlying pathology. (Subluxations are structural misalignments of the joints, other than fractures or complete dislocations, that require treatment only by nonsurgical methods.

(iii) *The evaluation or treatment offlattened arches* (including the prescription of supportive devices) regardless of the underlying pathology.

(2) Exceptions. (i) Treatment of warts is not excluded.

(ii) Treatment of mycotic toenails may be covered if it is furnished no more often than every 60 days or the billing physician documents the need for more frequent treatment.

(in) The services listed in paragraph (1)(1) of this section are not excluded if they are furnished--

(A) As an incident to, at the same time as, or as a necessary integral part of a primary covered procedure performed on the foot; or

(B) As initial diagnostic services (regardless of the resulting diagnosis) in connection with a specific symptom or complaint that might arise from a condition whose treatment would be covered. "

MEDICARE CARRIERS MANUAL (MCM)

MCM B3 2323.B(3)

"Presence of Systemic Condition.--The presence of a systemic condition such as metabolic, neurologic, or peripheral vascular disease may require scrupulous foot care by a professional that in the absence of such condition(s) would be considered routine (and, therefore, excluded from coverage). Accordingly, foot care that would otherwise be considered routine may be covered when systemic condition(s) result in severe circulatory embarrassment or areas of diminished sensation in the individual's legs or feet. (See subsection C .)"

Criteria Relating To Routine Foot Care
(Continued)

MCM B3 2323.B(4)

"Mycotic Nails.--In the absence of a systemic condition, treatment of mycotic nails may be covered.

The treatment of mycotic nails for an ambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

The treatment of mycotic nails for a nonambulatory patient is covered only when the physician attending the patient's mycotic condition documents that (1) there is clinical evidence of mycosis of the toenail, and (2) the patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate. "

MCM B3 4120.2.

"Application of the "Reasonable and Necessary" Limitation to Foot Care Services.-- In evaluating claims for foot care services, in addition to determining whether any of the other statutory limitations apply, carriers should assure that payment is made only for services which are "reasonable and necessary" for diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member (see $2303). Determinations as to whether a foot care service is reasonable and necessary should be made on the same basis as all other such determinations--that is, with the advice of medical consultants and with reference to accepted standards of medical practice and the circumstances of the individual case. "

Summary of Sample Results

		Allowable		Unallowable					Other Allowable
				E&M		Procedural	Other		
ample tem #	CPT Code Paid	E&M	Procedural	Not Documented	Upcoded[1] Place	Complexity	Medical Necessity	Upcoded[1]	No Physician Records	
1	99312			X						
	11721							11720		See Appendix D
2	99312					99311				See Appendix D
3	99351			X						
	11700						X			
	11701						X			
4	99312			X						See Appendix D
5	11700						X			
	11701						X			
6	99312					99311				
7	99312			X						
8	99312			X						
9	99312			X						
10	99351				99331					
	11700						X			
	11701						X			
11	99312			X						
12	99351			X						
	11700		X							
	11701						X			
13	99351			X						
	11700						X			
	11701						X			
14	11700		X							
	11701						X			
	11051						X			
	99351	X								
15	99312			X						
16	99351			X						
17	99312			X						
	11700						X			
	11701						X			

[1] For services classified as upcoded, we have identified the CPT code allowed for each service instead of placing an "X" in the appropriate column.

		Allowable		Unallowable					Other Allowable
				E&M			Procedural	Other	
Sample Item #	CPT Code Paid	E&M	Procedural	Not Documented	Upcoded Place	Upcoded Complexity	Medical Necessity Upcoded	No Physician Records	
18	99312					99311			
19	99312				99331				See Appendix D
20	99312			X					
21	99312			X					
22	99312					99311			See Appendix D
23	99342			X					
	11700						X		
	11701						X		
24	99312			X					
25	99312				99331				See Appendix D
26	99312			X					See Appendix D
27	99312			X					
28	99351				99331				
	11700		X						
	11701						X		
29	99313	X							
	11700		X						
	11701		X						
30	99312			X					
31	99302					99312			See Appendix D
32	99302					99312			
33	99312			X					See Appendix D
34	99351			X					
	11700		X						
	11701						X		
35	99312							X	
36	99312			X					
	11700						X		
	11701						X		
37	99312			X					
	11700						X		
	11701						X		
38	99351				99331				
	11700						X		
	11701						X		

		Allowable		Unallowable					Other Allowable
				E&M			Procedural	Other	
Sample Item #	CPT Code Paid	E&M	Procedural	Not Documented	Upcoded Place	Upcoded Complexity	Medical Necessity Upcoded	No Physician Records	
39	99312			X					
	11700		X						
	11701						X		
	11051						11050		
40	99312			X					
41	99372			X					
42	99351				99331				
	11700						X		
	11701						X		
43	99351				99331				
	11700						X		
	11701						Y		
44	99312			X					
45	99312			X					
46	99312			X					See Appendix D
47	99351			X					
48	11700		X						
	11701						X		
49	99312			X					
50	99342			X					
51	11700						X		
	11701						X		
	99312			X					
52	99357			X					
	11700						X		
	11701						X		
53	99357			X					
	11700						X		
	11701						X		
54	99372							X	
55	99351			X					
56	99351			X					See Appendix D
57	99351	X							
	11700						X		
	11701						X		
58	99302					99312			
59	99312			Y					

		Allowable		Unallowable					Other Allowable
				E&M			Procedural	Other	
Sample Item #	CPT Code Paid	E&M	Procedural	Not Documented	Upcoded Place	Upcoded Complexity	Medical Necessity	Upcoded No Physician Records	
60	99312				99331				See Appendix D
61	99312				99332				See Appendix D
62	99312			X					
	11700		X						
	11701						X		
63	MO101						X		
64	11700						X		
	11701						X		
65	99351				99331				
	11700						X		
	11701						X		
66	99312				99332				See Appendix D
67	99302					99311			
68	11700		X						
	11701						X		
69	99351				99331				
	11700						X		
	11701						X		
70	11700						X		
	11701						Y		
71	99351				99331				See Appendix D
72	99312			X					See Appendix D
73	99312			X					See Appendix D
74	99351			X					
	11051						X		
75	99302					99311			
76	99351			X					
77	99312				99332				See Appendix D
78	99312				99331				See Appendix D
79	99312			X					
80	99312			X					
81	99312				99332				See Appendix D
82	99312				99331				See Appendix D

		Allowable		Unallowable						Other Allowable
				E&M			Procedural		Other	
Sample item #	CPT Code Paid	E&M	Procedural	Not Documented	Upcoded Place	Upcoded Complexity	Medical Necessity	Upcoded	No Physician Records	
83	99312			**X**						
	11700						. x			
	11701						X			
84	99312								X	
85	99312			**X**						
	11700						X			
	11701						Y			
86	99312			**X**						
	11700		X							
	11701						X			
87	99312								**X**	
88	99351			**X**						
	11700						X			
	11701						X			
89	99302					99311				
90	99312					99311				
	11700		X							
	11701						X			
91	99312			X						
92	99302					99312				See Appendix D
93	99312			X						See Appendix D
94	99312			X						
95	99312			X						
96	99312			X						
97	99312			X						
98	99312			**X**						
99	99351				99331					See Appendix D
100	99351				99332					
	11700		X							
	11701						X			
Totals	167	3	13	56	19	12	58	2	4[2]	

[2] All four are E&M services.

SUMMARY OF ALLOWABLE BUT UNPAID SERVICES

Sample Item #	Codes Allowed
1	MO101
2	11700 11701
4	11700
19	11700
22	11700
25	11700 11701
26	11700
31	11700
33	11700
46	11700
56	11700
60	11700
61	11700
66	11700
71	11700
72	11700
73	M0101
77	11700
78	11700
81	11700
82	11700 11701
92	11700
93	11700
99	11700
Total Codes Allowed	27

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July 24,1998

Lawrence Frelot

[NOTE 1]

Office of Inspector General
750 B Street, Suite 1820
San Diego, CA 92101

Re: CIN A-09-07-0078
[NOTE 1]

Dear Sirs:

This letter and the enclosed documents and photographs constitute the provider's response to the draft audit report for the period June 1, 1992 through May 3 1, 1997. The provider's original of these documents highlights the annotations added to aid with this audit. The copies provided to you do not. Rather we have included the original un-annotated records followed by the annotated versions so you can discern the annotations. You may review the originals at any time, or, if you prefer, we can transfer the highlighting at your convenience. The provider has additional photographs which are being processed, and others that will be taken shortly. However, in the interest of moving this matter forward in a timely fashion, we are forwarding these materials rather than wait for the additional photographs. We will supplement this response with the additional photographs as soon as they are available.

Pursuant to my meeting with [NOTE 1] last week, I have organized this response in a manner addressing the "global" audit issues in this letter, and addressing issues specific to each audited claim by the enclosed documents. There is an audit work sheet for each of the claims which elaborates on information contained within the original charts. These audit worksheets are not intended to "add" to the medical record, but rather are intended to show that there are sufficient references in the medical records to establish what medical treatment and procedures were provided, and the supporting "medical necessity." If you have any questions regarding the audit work sheets, please call me and I will promptly provide the additional information.

NOTE 1 Specific references to people working on this audit and the medical provider have been removed from this document.

The remainder of this letter will address broad legal and factual issues raised in the audit that affect a number of line items. The first of these issues is one not raised in the audit report, that being the statue of limitations and burden of proof for this type of audit. In response to concerns over the inherent unfairness arising when, as here, the government alleges long after the payment is made that a provider has been overpaid, Congress enacted law which includes provisions to the effect that after three years have expired, it will be presumed in the absence of evidence to the contrary that the provider was "without fault" with respect to the overpayment, and under such circumstances no collection will be made. The Secretary is also authorized to make the presumption before three years have expired if he fmds that to do so would be consistent with the objectives of the Medicare program. See Sections 1870(b), (c) of the Social Security Act, as amended, 42 U.S.C. §1395gg(b), (c). This is particularly relevant in this case since it appears that in reviewing the provider's medical records for claims more than three years old, the auditors clearly were working on the presumption that the provider was at fault, and interpreted the medical records and all reasonable inferences derived therefrom against the provider. The provider thus requests that this issue be addressed in the final audit report.

The manner in which the sample cases were extrapolated over the full audit period is also inherently unfair. Although the provider's business increased over the course of the audit, from gross billables of $97,690 in 1992, to $372,317 in 1996, the sampling did not take into account the true distribution of the provider's billings. This causes the overpayment request to be skewed an a manner that prejudices the provider. By way of example, there were three patient charts for which records could not be found, reflecting four line items; two from 1992, and two from 1993. Thus even though these four charts are from a period constituting approximately 22% of the total survey base, they are extrapolated over 100% of the audit period. This defect in the audit also fails to consider changes in the provider's charting and billings that took place over time due to changes with Medicare and currently applicable billing practices. Finally, we question the "randomness" with which the samples were selected.

The audit report implies that the provider billed for services not rendered due to the number of services billed for on particular days. Since there are no overpayment requests based on this innuendo, there is no need to address it here. Nonetheless, the provider vehemently denies this contention and will fully address this at the next level of review. Suffice it to say that the manner in which the audit report portrays this hard working provider reveals the inherent bias against the provider that pervades the draft audit report.

The provider concedes that this audit revealed a problem in his office billing process regarding 11 nail debridement billings for amputee patients. Although the charts accurately reflect the treatment that was provided, the billings reflected bilateral debridements. The problem has been rectified and the provider will promptly refund the overpayment.

The provider wishes at this juncture to address the following specific statements contained in the draft report:

Response to Page ii of Draft paragraph 3: "Medicare provider also stated that he recently attended..." This statement is misleading. [NOTE 1] has attended billing training sessions as part of his continuing education requirements since the beginning of his career in Podiatry in 1971. However, [NOTE 1] began attending more intensive billing training seminars beginning in 1989.

Response to Page ii of Draft paragraph 4: "In addition to the audit of the random samples..."
The time guidelines set forth by Medicare for E&M services, are only guidelines if a doctor sets his E&M services by time alone. This has not been the case in the provider's billings and no time increments have been referred to in any written documentation.

Response to Page 1 paragraph 5: "The Medical Provider submitted claims identifying the services performed..." The end of this paragraph states that the provider billed for E&M services, etc. and ends with "routine foot care." The provider has not billed any of the claims in this audit as "routine foot care" and this addition seems to allege that he has done so.

Response to Page 3 paragraph 5: "The fieldwork was performed..." The term at various nursing facilities and "board and care facilities" appears to allege that the provider billed a home visit when it was established that these were board and care facilities. The term "various other facilities" would be more appropriate.

Response to Page 5 paragraph 4: "We asked the Medical Provider..." The provider's statement to the auditors was that he was told at a billing seminar by [NOTE 1] , any provider rendering services to 80 or more patients will likely be audited. This seminar was in 1997.

NOTE 1 Specific references to people working on this audit and the medical provider have been removed from this document.

Response to Page 6 paragraph 4: "We discussed 3 examples..." The sentence that states "The Medical Provider agreed that the medical record..." The provider did not agree that his documentation did not support his billing. The provider was listening to their statements about what they wanted to see in the documentation, and that what they wanted to see was not in his documentation. The provider never made a statement that he agreed that he had inadequate documentation to support his billings. The provider only agreed with. [NOTE 1] that certain things that [NOTE 1] wanted in the records were not there.

Response to Page 7 paragraph 3: "We discussed sample item 46..." The provider agreed that a procedural service could have been billed but the provider did not agree that it should have been used in place of the E&M service I billed.

Response to Page 11 paragraph 3: "The other two sample items..." The provider did not agree that "the record" for sample item 10 did not document that a treatment was performed. The provider agreed that what [NOTE 1] wanted to see in the documentation was not present. The provider disagreed vehemently that treatment was not performed and states so on the record noting the various sores on the feet. The provider agreed that the treatment section of the sheet did not have a distinct treatment code checked' but all other documentation was present. The provider also did not agree that the record did not justify that a patient suffered from a condition which would put the patient's health at risk. The provider said that there may be other documentation in the patient's chart that might show this, but the records shown to the provider did not.

Response to Page 11 paragraph 4: "Review of the medical records..." This patient was discussed and argued about for many reasons. The provider's feeling was that he had documented that there were two corns on the patient and he had identified symptomatic lesions. The auditors stated that this did not mean that the provider treated both corns. The provider treats all lesions he sees that are symptomatic, and even though the record included a statement that he debrided "a corn" in one place, in another it states that "all lesions on the feet were treated." The record clearly shows two distinct corns on the patient. The statement "The Medical Provider agreed with our determination" is totally wrong.

Response to Amputee Claims: The audit report states on Page 3 paragraph 4 "We did not perform a review of the Medical Provider's internal control structure..." At this point [NOTE 1] stated that if the provider had used a superbill type procedure that this type of problem would have been avoided. The provider actually left the report at the facility and

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generated a computer billing sheet from the computerized records that summarized the services that needed to be billed. The problem was that the program cut off the remarks part of the billing sheet. This was not realized until this audit, and was the reason why his billing person was unaware that the several patients discussed in the audit had only one leg.

Additional Comments: the provider wishes to personally assert the following comment: Obviously, the slant of the written documentation is that I agreed to everything that they [the auditors] presented. They conveniently left out that at the end of their presentation, I asked what my appeal rights were to all of their claims against me. They said they had no idea what my rights were and needed to inquire as to this information. If I had agreed to all they had said, why would I be asking for appeal rights to their comments? These rights were presented in a letter to me at a later date.

At this time, the provider also requests that all documents and information, including studies, reports and work sheets, that were reviewed and/or relied on in preparing the draft audit be provided to the provider's counsel pursuant to the Freedom of Information Act. [NOTE 2]

The provider understands that all issues in the audit can not be resolved at this juncture, and respectfully reserves his right to refute all matters addressed in the fmal audit report.

Yours truly,

C. K. Greer

C. Keith Greer

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NOTE 2 Freedom of Information Act (FOIA) request was forwarded to the FOIA Office, Department of Health and Human Services, Office of Inspector *General.*

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July 2, 1998

[NOTE 1]
Department of Health and Human Services
Office of Audit Services
Region IX
750 B Street, Suite 1820
San Diego, CA 92101

RE: CIN:A099700078

Dear [NOTE 1]

We have reviewed the draft audit report on your review of billings to Medicare by the medical provider referenced on the above CIN.

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

We concur with your recommendations. We will be glad to assess and demand the projected overpayment, provide educational materials relevant to the findings and to establish a prepayment edit.

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

Sincerely,

Herb Fernandez, Manager
Comprehensive Medical Review
Medicare Audit

cc: Ed Velasco

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