Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICARE PART B SERVICES BILLED BY COMMUNITY URGENT CARE MEDICAL GROUP FOR THE PERIOD JANUARY 1, 1995 THROUGH JULY 31, 1999

JANET REHNQUIST
INSPECTOR GENERAL

NOVEMBER 2001
A-09-00-00089

Office of Inspector General

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

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REGION IX

AUDIT OF MEDICARE PART B SERVICES BILLED BY COMMUNITY URGENT CARE MEDICAL GROUP FOR THE PERIOD JANUARY 1, 1995 THROUGH JULY 31, 1999

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.

JANET REHNQUIST
NSPECTOR GENERAL

NOVEMBER 200 1
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

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

CIN: A-09-00-00089

NOV 1 5 2001

Dr. James Loftus
Dr. Joel Geiderman
Community Urgent Care Medical Group
Cedars-Sinai Medical Center
8700 Beverly Boulevard
Los Angeles, California 90048

Dear Drs. Loftus and Geiderman:

This report provides you with the results of our joint review of the Medicare Part B payments (about $3.7 million) to Community Urgent Care Medical Group, Inc. (Community) for services rendered from January 1, 1995 through July 31, 1999. Our objective was to determine if the payments were appropriate for the services that were billed.

Community contracts with Cedars-Sinai Medical Center (Cedars-Sinai) to provide its emergency room services. As part of the agreement, Cedars-Sinai performs billing, accounting, and certain administrative functions for Community.

With the assistance of National Heritage Insurance Company's (NHIC) medical review staff, we reviewed a random, statistical sample of 100 claims containing 135 services for which Community was paid by Medicare. Our combined review disclosed that 29 of the 135 services had been overpaid. Six of these were determined to be completely unallowable, and 23 were allowed but at lesser amounts. One of the 135 services was determined to be underpaid. We identified one service that was performed but not billed; therefore, we allowed an additional payment for it.

The 29 overpaid services included:

- 23 which had been upcoded,

- 3 for which the documentation did not support that the services were performed as billed, and

- 3 for which the documentation did not support that a teaching physician was present when a resident performed the service.

Based upon our random sample, we estimate that Community received $266,236 in Medicare overpayments during our audit period.

We concluded that the overpayments occurred because the Cedars-Sinai and Community coding staff: (1) had a lenient interpretation as to whether the documented services met the stated requirements for a particular code, and (2) in a few instances, did not follow their procedures to ensure that billings complied with Medicare's requirements.

In response to our draft report, CUCMG provided additional documentation to support its disagreement with many of our findings and conclusions (see APPENDIX C). The NHIC, in its response, concurred with our findings (see APPENDIX D). After reviewing and considering the additional documentation and conclusions, we revised some of our findings for specific services, but decided that our overall conclusions remain valid.

We recommend that Community refund the identified overpayment of $266,236.

INTRODUCTION

BACKGROUND

Community is a professional medical corporation that contracts with Cedars-Sinai, a large nonprofit hospital located in Los Angeles, California, to operate its Emergency Medicine Department. Under the agreement, the medical center performs all cost recovery processes, including billing Medicare, Medicaid, private insurance, and other legally responsible payors and provides other administrative functions for Community.

Medicare Part A provides basic protection against the costs of inpatient hospital care. Medicare Part B covers physicians’ services and a number of other items and services not covered under Part A. Each part is financed separately.

Cedars-Sinai is a major teaching hospital affiliated with the University of California at Los Angeles School of Medicine. As such, Cedars-Sinai participates in Medicare’s Graduate Medical Education program, a Part A program that pays for the costs of the residents’ salaries and the teaching physicians’ supervision (teaching) of the residents.

Payments under Part B are administered by carriers, usually existing private insurance companies that contract with the Federal Government for this purpose. During our audit period, Transamerica Occidental Life Insurance Company[1] was the Medicare carrier for Community and Cedars-Sinai.

Medicare Part B payments to Community totaled about $3.7 million during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

We conducted our audit in accordance with generally accepted government auditing standards. Our objective was to determine if Medicare's Part B payments were appropriate for the services billed.

To accomplish this objective, we reviewed a random, statistical sample of 100 claims (135 paid claim lines) from a universe of claims paid by Medicare Part B to Community with dates of service from January 1, 1995 through July 31, 1999 and with payment dates prior to September 24, 1999. This universe contained 38,680 claims for which Community was paid $3,735,677.

We obtained copies of pertinent medical records from the patients' medical files located at Cedars-Sinai. In some instances, we obtained information from Cedars-Sinai staff and Community staff concerning who wrote specific medical record entries. In addition, we consulted with NHIC's staff about Medicare's rules.

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

At Community, we interviewed the two physician shareholders who function as the management team for Community, three other physicians of Community who were involved in the coding of bills, and Cedars-Sinai billing staff. We also obtained documentation of various policies and procedures pertaining to the Medicare billing process at Community and Cedars-Sinai.
In addition, we used information developed by a consultant that contracted with Community to review all 54 sample services which were questioned based on an initial review by NHIC's medical reviewer. In our draft report, we identified 54 lines of service which were not correctly billed based on the medical records and

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[1] Effective December 1, 2000, NHIC assumed the carrier responsibilities from Transamerica Occidental Life Insurance Company.

related information provided to us. The 54 lines of service were reduced to 29 based on additional information provided by the consultant. In certain instances, the additional information eliminated an error and in other instances it reduced the dollar value of an error. The final report describes the 29 errors, 23 related to upcoding and six related to documentation.

During our review of medical records, we identified one service for which Community did not bill Medicare. Although the service that was not billed had not been subjected to the claims adjudication process, we used the claim to reduce the dollar value of the error, which worked to lower the dollar amount identified as an overpayment.

We did not review Community's or Cedar-Sinai's internal controls over the processing of Part B Medicare claims because a review of such controls was not necessary to accomplish the objectives of this audit.

Our fieldwork was performed from May 2000 to July 2001 at Community and Cedars-Sinai.

FINDINGS AND RECOMMENDATION

Our audit, using statistical sampling techniques, disclosed that Community was overpaid for 29 of the 135 sampled services included in the sample of 100 claims. We reviewed the medical records for all services in the sample to determine if services were: (1) medically necessary, (2) billed using the correct descriptive codes, (3) covered services, and (4) compliant with Medicare reimbursement rules. We did not find any services in the sample that were determined to be medically unnecessary or were not covered by Medicare. However, we did find 23 services which were billed using incorrect descriptive codes and 6 services which did not comply with Medicare rules regarding documentation of services.

Six of the services were determined to be completely unallowable, and 23 were allowed but at lower reimbursement amounts than those originally paid. In addition, one service was underpaid and one service that was performed but not billed was identified and allowed. We estimate that Community was overpaid $266,236 (mid-point estimate). Details summarizing our sample methodology and statistical projection are contained in Appendices A and B, respectively.

The 29 overpayment errors fell into the following 3 categories:

- Upcoded services (23),

- Documentation did not support that the services were performed as billed (3),

- Documentation did not support that a teaching physician was present when a resident performed the service (3).

We concluded that Cedars-Sinai and Community coding staff had a lenient interpretation as to whether the documented services met the stated requirements for a particular code, and in a few instances, did not follow their procedures to ensure that billings complied with Medicare's requirements.

UPCODED SERVICES

Our review found that 23 of the 135 examined services were billed using numeric coding descriptors (i.e., procedure codes) that described services more complex than those actually provided (a condition commonly referred to as upcoding). One of the 135 examined services was determined to have been billed one CPT code lower than it could have been, and thus, was underpaid (for a more complete description of this underpaid service, see "UNDERCODED SERVICE" on page 8 of this report).

Medicare pays for emergency department visits (one of the categories of physician evaluation and management services) based upon the coding descriptions developed by the American Medical Association (AMA) and published in its Current Procedural Terminology[2] reference book. There are five levels for emergency department visits. The various levels encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of an illness or injury.
There are three key components in selecting the appropriate level, i.e., determining the nature and complexity of the: (1) history, (2) examination of the patient, and (3) medical decision making. There are other contributory factors (counseling, coordination of care, nature of the presenting problem, and time) that may impact the selection of the proper level of care to bill to Medicare.

Of these 23 upcoded services, 18 were upcoded 1 level and 5 were upcoded 2 levels.

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[2] The 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.

SERVICES NOT PERFORMED AS BILLED

In three instances, the documentation in the medical record did not support the services that were billed. Of the 3 services, 2 were for an interpretation and report of a
12-lead electrocardiogram (EKG), and 1 was an external cardioversion service.

For one of the EKGs, the medical record did not contain the tracing or the physician's interpretation of the tracing. For the other EKG, the medical record did not contain an interpretation of the EKG. In these cases, the payments were determined to be unallowable.

For the external cardioversion service, the medical record indicated that the patient had an internal defibrillator. As a result, the service that was billed was not possible to render.

In addition to the three services described above, one of the claims that was billed did not include an EKG that was actually performed and documented. NHIC's medical reviewer allowed this additional service and we used it to reduce the dollar value of error in the sample.

LACK OF DOCUMENTED TEACHING PHYSICIAN PRESENCE

In three instances, Community billed for services performed by residents without documentation that teaching physicians were present. Services performed by a resident without a teaching physician's presence are not reimbursed by Medicare Part B because the residents' salary and the costs for the teaching activities that the faculty provide to the residents are paid to the hospital under Medicare Part A. Payment for services provided by a resident under Part B would represent double payment.

Teaching physicians who supervise residents may be reimbursed by Medicare Part B for their own professional services to patients even if a portion of the services was actually provided by the resident. In this case, however, the teaching physician must be present when the service was performed by the resident and must document that presence in the medical record.

Federal law, implementing regulations, and Medicare issued guidance has long required that teaching physicians billing Part B provide the services themselves or be physically present while a resident provides the service. Federal regulations applicable to services in our sample before July 1, 1996 (42 Code of Federal

Regulations (CFR) 405.521 (b)), stated that payment is appropriate under Part B when:

> "...the attending physician furnishes personal and identifiable direction to interns or residents who are participating in the care of the patient."

Medicare instructions relating to the providing of services of supervising physicians in a teaching setting (Intermediary Letter No. 372 and its subsequent guidance) provided that:

> "If Part B bills are submitted for services performed by a physician in either the emergency room or in any part of the outpatient department, the hospital records should clearly indicate either that the supervising physician personally performed the services; or he functioned as the patient's attending physician and was present at the furnishing of the services for which payment is claimed." (Emphasis added)

Federal regulations applicable to services after June 30, 1996 (42 CFR 415.172 (a)), provided that:

> "General rule. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought."

Furthermore, 42 CFR 415.172 (a) (2) states that:

> "In the case of evaluation and management services, the teaching physician must be present during the portion of the service that determines the level of service billed."

In addition, 42 CFR 415.172 (b) addresses certain documentation requirements:

> "...the medical records must document the teaching physician was present at the time the service is furnished....In the case of evaluation and management procedures, the teaching physician must personally document his or her participation in the service in the medical records." (Emphasis added)

One of the three services that lacked documentation of a teaching physician's presence was rendered before July 1, 1996 and two were rendered after that date.

In all three instances, handwritten notes by a resident documented the development of the patient's pertinent medical history, examination of the patient, and the medical decision that was made. The residents signed these notes. However, the attending physician simply added his signature without any additional notes; thus, there was no documentation of the teaching physician's presence at the time that the resident examined the patient.

There were 26 emergency department visits in our sample that involved residents. Except for the three discussed above, we found that the teaching physicians had adequately documented in the medical records the services they had personally performed.

Community's physicians explained that Cedars-Sinai's policy is that attending physicians are to see all patients, that the medical care is to be rendered by the attending physicians, and that the residents are there for the purpose of learning. The physicians also explained that their signature on the treatment record meant that they had seen the patient. However, this does not meet Medicare's documentation requirements.

UNDERCODED SERVICE

One service was billed at a service level of lower complexity than the medical record actually supported. In this instance, Community billed an emergency department visit using the CPT code 99282. The medical reviewer allowed the CPT code 99283, a higher reimbursed service, based upon the documentation in the medical record. We included the underbilling in the sample analysis, effectively reducing the amount of the identified overpayment.

RECOMMENDATION

We recommend that Community refund the identified overpayment of $266,236.

SUMMARY OF FINAL FINDINGS

In our draft report, we identified 54 services that had been overpaid. Community engaged a third-party coding consultant to review the 54 services and gather additional documentation to support the claims. NHIC's medical reviewer considered the additional information and documentation that Community and its consultant provided to support its position on the findings presented in the draft report. As a result of his review of this additional material, the medical reviewer revised many of his decisions supporting our findings in the draft report. In certain instances the additional information eliminated an error and in other instances it

reduced the dollar value of the error. However, the OIG and NHIC concluded we did not agree with Community's position on 29 sample services.

COMMUNITY'S COMMENTS

Community pointed out that the majority of the upcoding errors for evaluation and management services (E&M) occurred prior to October 1995 when the Documentation Guidelines for Evaluation and Management Services was first published by the AMA and HCFA. Community's consultant performed an analysis of the 54 errors as shown in our draft report and determined that Community's error rate was less than that disclosed for Medicare services in a recent OIG report on the Department's financial statements. Community concluded that it had appropriately applied the E&M Guidelines because its error rate was less than that shown in the OIG report. And, in those instances where the documentation guidelines were ambiguous, Community felt that it had adopted a reasonable interpretation.

Community maintained that the medical record for sample number six complied with the rules and regulations for Medicare teaching physician reimbursement that existed at the time the service was provided, and that the medical record provided clear evidence that the teaching physician was present when the emergency room service was rendered.

With respect to the cardioversion service (a service not performed as billed), Community agreed that the service was inappropriately billed. However, it thought that the circumstances involved in this error, as well as the low number of times this service was claimed, made the error sufficiently unique to preclude any extrapolation to the universe.

NHIC'S COMMENTS

In a response to our draft report (see Appendix D), NHIC indicated that they reviewed and concurred with our findings.

OIG'S COMMENTS

Contrary to Community's statement that the Documentation Guidelines for Evaluation and Management Services was released in October 1995, it was published by HCFA and the AMA in November 1994. In December 1994, Transamerica published a newsletter (number 80) that made these documentation guidelines effective beginning in January 1995. As such, the guidelines were effective for the entire period of our audit. Therefore, we did not exclude any of our findings from Community's revised error rate of 21 percent. Community's comparison of its error rate with the error rates of any other provider or set of

providers does not relate to the Medicare regulations which determine allowable charges to the Medicare program. Our review of the 100 sample claims identified 23 claim lines or services which were upcoded and 6 which were not supported by appropriate medical records.

Regarding sample service number six, involving a teaching physician service that Community thought had been properly documented, NHIC's medical reviewer wrote that he found no evidence that the emergency room physician was present during the resident's work-up, or that the attending physician participated in the patient's care. The medical reviewer also noted that the guidelines that he followed in determining whether the service was allowable were in effect beginning in 1977. Thus, he concluded that Community's physician had not followed the rules and regulations in effect at the time for teaching physician services.

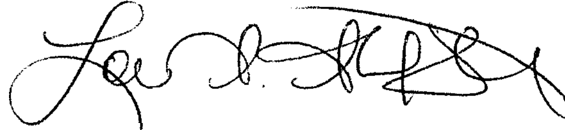
Concerning the extrapolation of the cardioversion service to the universe, the projection of the error in the random sample was limited to the universe from which the sample was drawn and is the only statistically valid application.

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 the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See

45 CFR Part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number A-09-00-00089 in all correspondence relating to this report.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

APPENDICES

APPENDIX A

Sampling Methodology

Objective:

Our audit objective was to examine a statistical sample of Medicare payments made to Community to determine if the payments were appropriate for the services that were billed.

Population:

The population was all Medicare Part B claims for which the carrier had paid Community for services with dates of service from January 1, 1995 through July 31, 1999 (and with payment dates prior to September 24, 1999) that were billed indicating that one of the co-heads of the emergency department had actually performed the services. For this population, Community was paid $3,735,677 on 38,680 claims.

Sampling Unit:

The sampling unit was one Medicare Part B claim paid to Community.

Sampling Design:

A single stage, unrestricted random sample was used.

Sample size:

Our sample size consisted of 100 claims. For the 100 claims, there was a total of 135 paid claim lines.

Estimation Methodology:

Using the Variables Appraisal Program of the Office of Audit Services (RATS-STATS), we calculated the 90 percent two-sided confidence interval using the difference estimator.

Variables Projection

The lower and upper limits of the dollar value of overpayments are shown at the 90 percent confidence level. We used our random sample of 100 claims out of the universe of 38,680 claims (51 ,1 43 paid services) to project the value of the overpayment. The result of this projection is presented below:

Difference Value Identified in the Sample	$ 1,063
Point Estimate of Overpayment	$411,095
Lower Limit	$266,236
Upper Limit	$555,954

Point Estimate by Type of Error

Point Estimate - Upcoded Services	$288,004
Point Estimate - Lack of Documented Teaching Physician Presence	$ 71,423
Point Estimate - Services Not Performed as Billed	$ 55,811
Point Estimate - Benefit for Service Not Previously Billed	$ (4,143)
Total of Point Estimate by Type of Error	$411,095

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James J. Loftus, M.D.
Joel M. Geiderman, M.D

June 1, 2001

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services, Region IX
Office of Inspector General
50 United Nations Plaza
San Francisco, California 94102

Re: CIN: A-09-00-00089
Draft Audit Report: Audit of Medicare Part B Services Billed by Community Urgent Care Medical Group for the Period January 1, 1995 through July 1,1999

Dear Ms. Ahlstrand:

This letter is submitted in response to the draft audit report dated March 2, 2001 (the "Report") issued by the Office of Audit Services ("OAS") with respect to emergency department services provided by Community Urgent Care Medical Group (the 'Group") for the period January 1, 1995 through July 3 1, 1999 and billed to Medicare Part B, as modified to reflect revised findings of OAS' medical reviewer following a meeting on April 25, 2001.

I. **The Report Affirms that All Services Were Medically Necessary and Appropriately Rendered.**

As a preliminary matter, we wish to stress that the OAS medical reviewer was requested to review, among other things, whether the services in question were medically necessary and represented Medicare covered services. There is no suggestion in the Report that any of the 135 services that formed the basis of the audit were unnecessary, substandard, or otherwise raised any quality of care issues. Rather, the audit confirms the Group's commitment to providing high quality care to all individuals who present to the emergency department -- a department that provides substantial uncompensated care, sees over 70,000 patients each year, and maintains a Level I Trauma Center. We have also been informed that the audit was not precipitated by any allegation of fraud or wrongdoing by any party.

II. The Report Found that One Hundred Percent Services were correctly Coded.

All services billed using critical care codes were found by the OAS medical reviewer to have been correctly billed. There was not a single instance of upcoding of an evaluation and management (E&M) service to a critical care service.

III. Evaluation and Management Services.

The great majority of the overpayments alleged in the Report derive from evaluation and management (E&M) services. The controversy surrounding the E&M guidelines and the difficulty in applying the rules relating to E&M services is well known. Currently, providers may utilize either of two different sets of E&M guidelines (the 1995 and the 1997 guidelines) that coexist. There are also draft revisions proposed by HCFA in a June 2000 town meeting that represent a substantial re-thinking of the E&M coding system, A recent study of E&M coding of emergency department medical records found significant disparities among experienced coders. Bentley, *et* al., Reliability of Assigning Correct E&M Codes: Is Compliance Possible?, ***Academic Emergency Medicine*** 8:479 (2001).

It is also important to understand the methodology used by OAS in conducting its audit. The findings in the Report are the coding interpretation of a single medical reviewer. The findings by that reviewer were not validated by a second, blind review. They were not compared to norms in similarly-situated tertiary hospital emergency departments. They are the judgments of a single individual, with each judgment extrapolated across an enormous universe of claims.

Our review of the charts indicated that the vast majority were appropriately coded. In order to test our review, we engaged an independent third party coding expert, Cathy Plunkett at 3M Health Information Systems Consulting Services, whose report is attached to this letter as Appendix A. As described more fully in that report, her review team is made up of Certified Professional Coders, each with over 20 years experience in health care. Ms. Plunkett and her team provided train-the-trainer programs on E&M coding for HCFA and the Medical Association of Georgia in 1992 when the levels were first designed, and continues to provide these programs nationwide as changes in documentation requirements occur. She and her team have also served as the independent auditor for OIG-directed PATH II Program coding and billing reviews.

Of the 27 E&M services identified by the OAS reviewer as incorrectly upcoded, the independent expert concluded that:

- 18 were accurately billed or billed at a ***lower*** level than actually rendered
- 7 were coded only a single level higher than reflected by the documentation.

- Only 2 services represented an upcode of more than 1 level, and these may be the result of lost documentation (dictation reports) subsequent to coding.

For the four and one half year period under audit, 69% of the overpayment identified by the independent expert related to E&M services rendered between January and October 1995, prior to or concurrent with the official adoption of the 1995 guidelines. The 1995 error rates are not representative of the error rates in later years.

Excluding the E&M visits prior to October 1995, when the E&M Guidelines were first released, the independent expert found an overall error rate of under 4% and an E&M error rate of under 2%. By way of comparison, a recent OIG study found that the overall Medicare fee-for-service overpayment rate for FY 2000 was 6.8%, while that for FY 1996 was double that number. Department of Health and Human Services Office of Inspector General, ***Improper Fiscal Year 2000 Medicare Fee-For-Service Payment*** (A-17-00-02000). The same study found average error rates for E&M services to be particularly high, with the percent of services in error for 99214, for example, exceeding 37% for FY 2000. We therefore believe the Group appropriately applied the E&M Guidelines and, where those Guidelines are vague or ambiguous, adopted a reasoned and moderate standard of interpretation.

IV. Teaching Physician Services.

The Report indicates that of 26 emergency department services that involved residents, 23 were found by the OAS reviewer to have complied with all Medicare teaching physician rules and regulations. Of the remaining three services, one was furnished prior to the effective date of the new teaching physician regulations on July 1, 1996, and there is nothing in Intermediary Letter No. 372 as quoted in the Report that indicates the need for a separate note signed by the attending physician We concur with the findings for the other two services, but we would note: (1) that while the record may not satisfy all technical Medicare documentation guidelines, there is clear evidence in both cases that the attending physician was present and involved in the patient's care; and (2) in one case, the record reveals that the attending physician even entered the diagnosis in his own handwriting.

V . Miscellaneous Services.

The final area identified in the Report relates to three services that the Audit indicates were not performed as billed. Two relate to EKG interpretations, and one to a cardioversion. We concur that the documentation available in the charts do not include the EKG interpretations, although in one of the cases it is clear from the context of the chart that the interpretation was performed as a repeat EKG was ordered by the treating physician, and there was a clear dictation transcription error as the dictation indicates that the "EKG showed congestive heart failure." With respect to the cardioversion, the circumstance of this service is sufficiently unique that the propriety of seeking to extrapolate it across a constellation of claims is highly questionable. Here, there was a charge for an external defibrillation where an internal defibrillator was reprogrammed in the emergency room and the patient was

cardioverted from ventricular tachycar lia to normal sinus rhythm. We do not believe there is a basis for extrapolating this event, wh :h in our 'experience is unique. The code for external cardioversion appears in the entire uni /erse of 38,660 claims a total of 50 times. It is difficult to imagine the event under audit occur ing again in that universe.

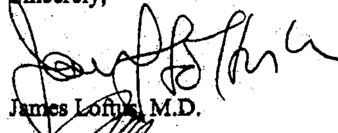
VI. Conclusion.

In conclusion, the records reflect that a uniformly high level of care was provided. Additionally, our review and the review of an independent coding expert indicates that the vast majority of the services questioned in the Report were correctly billed, and we intend to vigorously defend those claim,

* * *

We appreciate the opportunity to respond to the draft report.

Sincerely,



James Loftus, M.D.

Joel Geiderman, M.D.

Enclosure as noted.

APPENDIX A

Independent Review of Medicare Claims for

Community Urgent Care Medical Group

May 31, 200[illegible]

Innovation

Consulting services
3M Health Information Systems

100 Ashford Center North
suite 200
Atlanta, GA 30338-4844
770 394 8800

May 31, 2001

Eric B. Gordon, Esq.
McDermott, Will & Emery
2049 Century Park East
Los Angeles, CA 90067-3208

Dear Mr. Gordon:

3M Health Information Systems Consulting Services, ("3M Consulting"), a business unit of the Minnesota Mining and Manufacturing Company ("3M"), is pleased to provide this report of our independent review of the 100 claims submitted by Community Urgent Care Medical Group in response to a review by the Office of Inspector General Office of Audit Services ("OAS"). The purpose of this review was to assess the records to determine whether tbe medical record and related documentation supports the code billed or the code assigned by OAS, or whether the medical record and related supporting documentation supports a different code.

BACKGROUND AND CREDENTIALS OF 3M HIS CONSULTING SERVICES

3M Consulting provides a wide range of services to the healthcare industry nationwide. We conducted the coding, documentation and billing review for the first OIG-directed PATH II Program audit at a major university teaching hospital and continue to represent providers nationwide on similar regulatory matters. We provided train-the-trainer programs on evaluation and management service level coding for HCFA and the Medical Association of Georgia in 1992 when the levels were first designed, and we continue to provide these programs nationwide as changes in documentation requirements occur. Most recently we have participated in speaking *engagements* sponsored by *Part B News and American Health Lawyers Association* on evaluation and management services, specifically changes in documentation requirements for critical care with Dr. Paul Rudolph (medical officer at HCFA). Our review team is made up of Certified Professional Coders, all with over 20 years of experience in healthcare.

Healthcare consulting comprises 100 percent of our business. Our team of industry experts includes seasoned physicians, certified public accountants, registered nurses, industrial engineers, medical record/HIM specialists, billing and coding specialists, reimbursement specialists, and operations and management experts. We frequently serve as outside experts to Arthur Andersen and to numerous national, regional and local law firms related to coding, documentation, and billing issues.

3M Consulting offers services in various areas, including coding, documentation and billing reviews, compliance plan development, PATH II (Physicians at Teaching Hospitals) audits, coding and documentation training for physicians and employees, physician practice compliance services, Medicare and Medicaid reimbursement, CPT/ HCPCS reviews and clinical resource management.

PROJECT SCOPE AND APPROACH

3M Consulting performed a review of 54 claims for services that included:

- 27 services that had been upcoded based on the OAS report;
- 1 service that had been downcoded based on the OAS report;
- 3 services that were identified in the OAS report as not meeting the teaching physician presence guidelines;
- 2 services that were identified in the OAS report as EKG interpretations where the documentation did not support an interpretation by the emergency physician;
- 1 service identified in the OAS report involving a charge for external cardioversion that was not perform&, and,
- 20 services that were identified in the OAS report as being correctly coded.

We reviewed the medical records and submitted charges for the following:

- Reviewed the documentation for compliance with the July 1, 1996 requirements for Physicians at Teaching Hospitals;
- Confiied the accuracy of the E&M levels, as supported by the documentation and the accuracy of the procedural CPT code assignments;
- Identified the correct billing codes and report our specific findings relative to potential overbilling or underbilling;
- Maintained a database of each record reviewed, including physician, and specific reasons for exception; and,
- Compared our findings with those of the OAS reviewer.

FINDINGS

We reviewed 54 services totaling $16,351.60 in submitted charges, representing $5,366.15 in estimated Medicare allowed payments. Based on our review, the estimated Medicare allowed payments should have been $4,817.79. We found $617.35 in overpayments and $68.99 in underpayments, with a net overpayment of 5548.36. Our findings in comparison to the results of the OAS review are as follows:

Mr. Eric Gordon, Esq.
McDermott, Will & Emery
Re: Community Urgent Care Medical Group
May 31, 2001
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Evaluation and Management Services

- For 19 services, we agreed with the OAS reviewer that the services were coded accurately based on the documentation.
- 2 services billed as 99282 were determined to be upcoded by the OAS reviewer by one level ofservice (R1.2.1): * and * We disagreed with the reviewer's assessment of both of these cases. The documentation supports at a minimum: an expanded problem-focused history, expanded problem-focused exam and low-complexity medical decision-making.
- 7 services billed as 99283 were determined to be upcoded by the OAS reviewer by one level (R1.3.2): * and * We disagreed with the reviewer's assessment of level 2 on two of these cases. Our review found that the documentation supported 99283 for * and * We agreed with the reviewer's assessment on the remaining five cases.
- 3 services billed as 99284 were determined by the OAS reviewer to be upcoded by two levels (R1.4.2): * and We disagreed with the reviewer's assessment of two of these cases * and' * and found that the documentation supported 99284 as billed. Patient * is a unique case in that it appears that portions of the medical record are missing. This psychiatrically disturbed patient gave one name when she presented to the Emergency Department and another name when she arrived on the psychiatric unit. The patient's name changed from * to * In all likelihood, the patient's medical condition contributed to the loss of part of her chart. The OAS reviewer assigned a level 2 without use of specific criteria for assessing the documentation but rather elements of the patient's condition. Using the documentation that was available from the nursing notes, the psychiatric unit notes and the discharge summary, it was apparent that a complete psychiatric evaluation was performed in the Emergency Department, the patient was placed in restraints and given IV Haldol for sedation in an attempt to minimize the risks of the patient's causing harm to herself or others. The history would have been waived due to the patient's altered mental status. It is our opinion that this service was high complexity and supported at least a level 4 as billed.
- 10 services billed as 99284 were determined by the OAS reviewer to be upcoded by one level (R1.4.3): * and * We agreed with the reviewer's assessment of one of these cases, * In one case, * we found that the documentation supported a level 5 service. On the remaming eight cases, we found that the documentation was sufficient to support a level 4 as billed.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by three levels (R1.5.2): * We disagreed with the reviewer on this case and found that the documentation supported 99283.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by two levels (R1.5.3): * We agreed with the reviewer's findings on this case.

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- 2 services billed as 99285 were determined by the OAS reviewer to be upcoded by 1 level *(R1.5.4):* * and * We disagreed with the reviewer's determination on each of these cases and found that the documentation supported 99285 as billed.
- 1 service billed as 99285 was determined by the OAS reviewer to be upcoded by 1 level (R1.5.4): * We agreed with the reviewer's determination that this service was documented as 99284.
- 1 service billed as 99282 was determined by the reviewer to be undercoded by one level of service *(R2.2.3):* * We agreed with the reviewer that this service was under coded, but disagreed that the appropriate level was 99283. We believe the level should have been 99284.

Of the 27 E/M services downcoded by the reviewer, we found that in 18 of the services, the documentation was present to support or exceed the level of service billed under the 1995 AMA/HCFA guidelines for history, examination and medical decision-making. In seven of the remaining nine cases, the level of service exceeded that documented by a single level only. There were only two cases that our review determined to be upcoded more than one level based on the documentation: * and * In both of these cases, there was a question as to whether the entire medical record was available for review. The record that was dictated by the emergency physician was not located for review in either case.

Teaching Services

- Three services were determined by the reviewer not to meet the July 1, 1996 physicians at teaching hospitals guidelines for documentation of presence and involvement in the key elements (R13): * and * Although we found that in each case there was sufficient evidence to support physician presence and involvement in the patient's care, the documentation on * and * did not satisfy the July 1, 1996 guidelines for documentation of involvement in each of the three elements. Patient * service occurred prior to the 1996 guidelines, and we believe the documentation of the physician's signature and entries into the clinical management system did support the presence rules in effect at that time. Prior to July 1, 1996, there were no guidelines requiring documentation to support each of the key elements, only documentation to support presence and participation in the patient's care. This was clearly documented by the attending physician's participation in determination of the diagnosis and preparation of the discharge instructions for the patient.

Other Services

- Two services related to EKG interpretations that the reviewer did not find documented (R6): * and * On patients * and * we agreed with the reviewer that specific documentation to support the EKG interpretation was not found.
- One service was inadvertently coded as an external defibrillation, Patient * (R6). Gut of the entire universe of over 38,000 claims, CPT 92960 was used approximately 50 times. We

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agreed with the reviewer that this service was not performed; however, we believe this to be a posting error.

- One critical care service reviewed by the OAS reviewer was coded accurately based on the documentation. We agreed with this determination.

DISCUSSION OF E/M SERVICES:

The audit template provided by the OAS, "Medical Reviewer's Decision on Difference in Level of Key Components Between Code Billed and Code Allowed," suggests that where the reviewer downcoded the level of service, the history and exam components were insufficient in the majority of cases when a lower level of service was determined. We did not find that the documentation of history and exam were insufficient in most of these cases. We believe these differences in opinion may relate to the following:

- The reviewer did not identify all elements of the HPI: location, context, quality, timing, duration, severity, modifying factors, and associated signs and symptoms that were documented in the patient history.
- The reviewer may not have considered the review of systems documented as part of the HPI in the physician's history.
- The reviewer may have relied exclusively on the 1997 delayed guidelines for physical examination that require a much more stringent documentation than the 1995 AMA/HCFA guidelines that are still available to be used by the provider.

To make a lower determination on several of the cases, the reviewer used medical decision-making complexity. Complexity of medical decision making is subjective under the 1995 AMA/HCFA guidelines and is determined based on the nature of the presenting problem, number of diagnoses or management options, amount and complexity of data to be reviewed, and risk of complication and/or morbidity or mortality. Most carrier reviewers have been trained to use the point assignment system that is used to rate each component:

- Number of diagnoses or treatment options: 3 points for new problem to examiner; no additional workup planned or 4 points for new problem to examiner; additional workup planned. By nature of the presenting problems in the emergency department setting, almost every patient seen is new to the examiner and would start out as a level 3 or 4, based on whether any additional workup is planned.
- Amount and/or complexity of data to be reviewed: Points for clinical lab tests, radiology test, medicine section tests (including EKG), discussion of case with another healthcare provider. The majority of level 4 and level 5 patients in this sample had laboratory tests, radiology tests, EKG and documentation of discussion with another healthcare provider (primary physician). This would represent extensive data and support high complexity medical decision-making.
- The final element is related to the Medicare Table of Risk. Low risk is defined as a patient with two or more self-limited minor problems, stable chronic illness, or acute uncomplicated

illness or injury receiving treatment options such as over-the-counter drugs or IV fluids. Moderate risk is defined as a patient with one or more chronic illnesses with mild exacerbation, two or more stable chronic illnesses, undiagnosed new problem with uncertain prognosis, acute illness with systemic symptoms, or acute complicated injury and may receive treatments such as IV fluids with additives or prescription medications. High risk is defined as a patient with one or more chronic illnesses with severe exacerbation, acute. of chronic illnesses or injuries that may pose a threat to life or bodily functions, or an abrupt change in neurological status (Conditions all consistent with need for admission to the hospital).

EXTRAPOLATION

We applied the methodology used by the Department of Health and Human Services, Office of Inspector General ("HHS") to extrapolate an estimated potential overpayment amount. We used the population of claims provided by HHS, the variables appraisal report, and the Variables Appraisal Program of the Office of Audit Service (RATS-STATS) to calculate these results. The revised point estimate (overpayment amount) based on our record review findings is approximately $150,918 compared to the OAS figure of approximately $469,000.

EXTRAPOLATION ISSUES

The 1995 AMA/HCFA documentation guidelines for E/M services were not officially adopted by HCFA until fall of 1995. When these guidelines were released, HCFA had indicated that reviews of documentation would not occur until 1996. Five of the services downcoded by the reviewer occurred between January and October of 1995:
* and * These five services represented an overpayment of $245.22 or 69% of the total E&M overpayment ($353.10), determined from our review to be due to the E/M documentation not supporting the level of service billed. It is clear from the review that the coding improved significantly in relation to the 1995 AMA/HCFA documentation guidelines for evaluation and management services for subsequent years. Due to the fact that the guidelines were new in 1995 and providers and coding personnel were in the process of learning the guidelines, these services should not be considered in the extrapolation. If the 1995 E/M items were removed from the population, the E/M error rate on the remaining years would be less than 2% and the overall error rate for the sample would be under 4%.

Case number 16, patient * is an anomaly. Out of over 38,000 claims in the total sample universe, CPT 92960 was used approximately 50 times. In this case, an external cardioversion was inadvertently charged on a patient having an internal defibrillation device. The record states that a cardiologist reprogrammed the AICD to deliver a shock, and the patient was successfully cardioverted. We recommend that this record be removed from the sample and treated as a simple overpayment in the amount of $157.65.

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We appreciate the opportunity to assist with this review. Attached are the following:

- Description of Findings Codes
- Findings in Sample
- Findings By Code By Patient
- Detail Findings by Patient

Sincerely,

Minnesota Mining and Manufacturing Company

By: Cathy Plunkett
Cathy Plunkett
Director
3M HIS Consulting Services

Enclosures

Community Urgent Care Medical Group Description of Findings Code

R0	Accurately coded
R1	Service(s) Upcoded
R1.2.1	Service billed as 99282, audited 99281
R1.3.1	Service billed as 99283, audited 99281
R1.3.2	Service billed as 99283, audited 99282
R1.4.1	Service billed as 99284, audited 99281
R1.4.2	Service billed as 99284, audited 99282
R1.4.3	Service billed 99284, audited 99283
R1.5.2	Service billed as 99285, audited 99282
R1.5.3	Service billed as 99285, audited 99283
R1.5.4	Service billed as 99285, audited 99284
R2.2.4	Service billed as 99282, audited 99284
R2.4.5	Service billed as 99284, audited 99285
R6	Service was not documented
R13	Documentation did not support 1996 PATH guidelines
R15	Documentation supported pre-1996 Teaching guidelines
R18	Critical care time not supported in documentation
R25	Documentation was not available for review
R90	Service billed at level other than stated by reviewer.

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Community Urgent Care Medical Group

Findings in Sample

Reviewer CD	CPT CD REV	Units	Charge Am!	Allowed	Audited	N e t Dif.	Under	Over
RO	RO	20	$6,993.00	$2,297.78	$2,297.78	$0.00	so.00	$0.00
R1.2.1	RO	2	$216.00	$73.45	$73.45	$0.00	$0.00	$0.00
RI .3.2	RO	2	$372.00	$131.69	$131.69	S0.00	$0.00	$0.00
Rt. 3. 2	R1. 3. 2	5	$930.00	$329.02	$162.62	($146.40)	$0.00	5146.40
R1. 4. 2	RO	2	$627.00	$201.30	$201.30	$0.00	$0.00	So. 00
RI. 4. 2	R25	1	$276.00	$94.36	$94.36	$0.00	$0.00	$0.00
R1. 4. 3	RO	8	$2,433.00	5792.45	5792.45	so. 00	$0.00	$0.00
Rl. 4. 3	Rl. 4. 3	1	$304.00	$99.06	$64.96	;$34.10)	$0.00	$34.10
Rl. 4. 3	R2. 4. 5	1	$323.00	$102.07	$106.32	$4.25	54.25	50.00
R1. 5. 2	Rl. 5. 3	1	$501 . oo	$160.32	$66.51	($93.61)	$0.00	$93.81
R1. 5. 3	R1. 5. 3	I	5366.00	$155.90	SW 96	($90.94)	$0.00	$90.94
Rl. 5. 4	RO	2	$1,002.00	$321.66	$321.86	$0.00	$0.00	$0.00
Rl. 5. 4	R1. 5. 4	1	$388.00	$155.90	$99.06	($56.84)	$0.00	$56.84
R13	R13	2	$509.00	$168.78	$0.00	($166.76)	$0.00	$168.78
R13	R15	1	$186.00	[illegible]1.62	561.62	$0.00	$0.00	$0.00
R2. 2. 3	R22. 4	1	$109.00	$37.19	$101.93	564.74	S64.74	$0.00
R6	ALT CPT	1	$636.00	$157.65	5156.92	($0.73)	$0.00	$0.73
R6	R6	2	$166.60	$25.75	$0.00	(525.75)	so. 00	$25.75
		54	$16,351.60	$5,366.15	$4,817.79	($548.36)	$68.99	$617.35

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Community Urgent Care Medi

Findings By Code By Patient

OAS	3M	Patient	Units	Chg. Amt	Allowed	Audited	Difference	Under	Over
R0	R0	*	1	$186.00	$65.16	$65.18	$0.00	$0.00	$0.00
		*	1	$501.00	5160.93	$160.93	$0.00	$0.00	$0.00
		*	1	$472.00	$156.92	$156.92	$0.00	$0.00	$0.00
		*	1	5695.00	$206.44	$206.44	$0.00	$0.00	$0.00
		*	1	$472.00	$156.92	$156.92	50.00	50.00	$0.00
		*	1	$501.00	$160.93	$160.93	$0.00	$0.00	$0.00
		*	1	$323.00	$101.93	$101.93	so.00	$0.00	$0.00
		*	1	$323.00	6101.93	$101.93	$0.00	$0.00	$0.00
		*	1	$276.00	$94.36	$94.36	$0.00	$0.00	so.00
		*	1	$276.00	$94.36	$94.36	$0.00	$0.00	$0.00
		*	1	$472.00	$166.92	$166.92	$0.00	$0.00	50.00
		*	1	$186.00	$66.65	$66.65	$0.00	$0.00	$0.00
		*	1	$109.00	533.42	533.42	$0.00	$0.00	$0.00
		*	1	$472.00	$156.92	$156.92	$0.00	50.00	$0.00
		*	1	$276.00	$94.36	$94.36	$0.00	$0.00	$0.00
		*	1	$304.00	$99.37	$99.37	$0.00	so.00	$0.00
		*	1	$501.00	$160.32	$160.32	$0.00	$0.00	$0.00
		*	1	$186.00	$66.51	$66.51	$0.00	so.00	$0.00
		*	1	$276.00	$94.36	$94.36	$0.00	$0.00	$0.00
		*	1	$186.00	$66.65	$66.85	$0.00	so.00	50.00
		Subtotals:	20	$6,993.00	S2.2S7.78	$2,297.78	$0.00	$0.00	$0.00
R1.2.1	R0	*	1	$109.00	$37.19	$37.19	$0.00	$0.00	$0.00
			1	$109.00	$36.26	$36.26	$0.00	so.00	$0.00
		Subtotals:	2	$218.00	$73.46	$73.45	$0.00	$0.00	50.00
R1.3.2	R0	*	1	5166.00	$66.51	$66.51	$0.00	$0.00	$0.00
		*	1	$186.00	$65.16	$65.16	$0.00	50.00	$0.00
		Subtotals:	2	$372.00	$131.69 $64.96	$131.69	$0.00	so.00	$0.00
R1.3.2	R1.3.2	*	1	$186.00		$35.72	($29.24)	$0.00	$29.24
		*	1	S166.W	$66.85	$37.19	($29.66)	$0.00	$29.66
		*	1	$186.00	$65.16	$36.26	($26.92)	$0.00	$28.92
			1	$166.00	$65.18	$36.26	($26.92)	50.00	$26.92

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Findings By Code By Patient

OAS	3M	Patient	Units	Chg. Amt	Allowed	Audited	Difference	Under	Over
Rl. 3. 2	Rl. 3. 2	*	1	$186.00	$66. 65	$37. 19	($29.66)	50. 00	$29. 66
		Subtotals:	5	$930. 00	$329.02	$162. 62	($146. 46)	so. 00	$146.40
Rl. 4. 2	R0	*	1	$323. 00	5101. 93	$101. 93	$0. 00	$0. 00	50. 00
		*	1	$304. 00	599. 37	$99. 37	50. 00	50. 00	so. 00
		Subtotals:	2	$627. 00	6201. 30	$201. 30	$0. 00	50. 00	$0. 00
Rl. 4. 2	R25	*	1	$276. 00	$94.36	$94. 36	50. 00	50. 00	$0. 00
		Subtotals:	1	$276. 00	SD4. 36	$94.36	so. 00	$0.00	50. 00
Rl. 4. 3	R0	*	1	$323.00	$101.93	5101. 93	50.00	50.00	$0.00
		*	1	$323.00	5102. 07	$102. 07	$0.00	$0.00	50.00
		*	1	$304.00	$99.37	$99. 37	$0.00	$0.00	$0.00
			1	$323.00	$101. 93	$101. 93	$0.00	$0.00	$0.00
		*	1	5304. 00	SDS. 06	SDS. 06	$0.00	50.00	$0.00
		*	1	$276.00	$94. 36	$94.36	$0.00	$0.00	50.00
			1	$304.00	$99. 37	$99. 37	$0.00	$0.00	$0.00
		*	1	$276.00	$94. 36	$94. 36	$0.00	50.00	$0.00
		Subtotals:	8	$2,433.00	$792.45	$782. 45	$0. 00	$0.00	$0.00
Rl. 4. 3	Rl. 4. 3	*	1	$304. 00	$99.06	$64.96	($34.10)	$0.00	$34.10
		Subtotals:	1	5304.00	$99.06	$64.96	($34.10)	so.00	$34. 10
Rl. 4. 3	R2. 4. 5	*	1	$323. 00	$102. 07	$106. 32	$4. 25	$4. 25	$0. 00
		Subtotals:	1	$323.00	$102.07	$106.32	$4.25	$4.25	S0. 00
RI. 52	Rl. 5. 3	*	1	5501. 00	$160. 32	$66. 51	(893. 61)	$0. 00	593. 61
		Subtotals:	1	$501. 00	$150. 32	$66. 51	($93.81)	so. 00	$93.81
Rl. 5. 3	Rl. 5. 3	*	1	$388.00	$155. 90	$64. 96	090. 94)	so. 00	$90.94
		Subtotals:	1	$388. 00	$155. 90	SM 98	($90.94)	$0.00	$90.94
Rl. 5. 4	R0	*	1	$501.00	$160. 93	$160. 93	$0. 00	$0.00	50. 00
		*	1	$541. 00	$160. 93	$160. 93	$0.00	$0.00	50.w
		Subtotals:	2	$1,002.00	$321. 86	$321. 86	$0.00	50. 00	50. 00

Thursday, May 31, 2001

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Findings By Code By Patient

OAS	3 M	Patient		Units	Chg. Amt	Allowed	Audited	Difference	Under	Over
R1.5.4	Rl.5.4	*		1	$386.00	$155.90	599.06	($56.84)	50.w	556.84
			Subtotals:	1	$386.00	$155.90	$99.06	($56.84)	50.00	$5664
R13	R13	*		1	$323.00	$101.93	$0.00	(5101.93)	$0.00	5101.93
				1	$186.00	$66.65	$0.00	($66.85)	$0.00	$66.65
			Subtotals:	2	$509.00	$188.76	S0.00	($188.76)	$0.00	$168.78
R13	R15	*		1	$186.00	$61.62	$51.62	so.00	50.w	$0.00
			Subtotals:	I	$186.00	$81.62	$61.62	$0.00	$0.00	$0.00
R2.2.3	R2.2.4	*		1	$109.00	$37.19	$101.93	$64.74	$64.74	$0.00
			Subtotals:	1	$109.00	$37.19	$101.93	$84.74	$84.74	so.00
R6	ALT CP	*		1	$636.00	$157.65	$156.92	(50.73)	50.w	$0.73
			Subtotals:	1	$636.00	$157.65	$156.92	($0.73)	so.00	so.73
R6	R6	*		1	$80.60	$13.39	$0.00	($13.39)	$0.00	$13.39
		*		1	$76.00	$12.36	$0.00	(512.36)	so.00	$12.36
			Subtotals:	2	5158.60	$26.75	S0.00	($25.75)	so.00	$25.75
			Grand Totals:	5 4	$16,351.60	$5,366.15	$4,817.79	($548.36)	$68.99	$617.35

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Community Urgent Care Medical Group

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99265	03/05/1995	$366.06	$155.96	R1.5.4	Rl.5.4	99284	$99.06	556.84

hx: Swelling right hand (location), over last 2 weeks (duration), intermittant (timing) fever. Felt sick (signs). ROS: Nausea/vomiting, diarrhea, urinary symptoms. Pert past hx. Detailed history.
Exam Const, HEENT, Neck, CVS. Lungs. Abdomen/rectal, Neurological. Detailed- seven systems
MDM Congestive heart failure. rule-out sepsis (acute life threatening condition-high) Data review: Diicussbn with family physician, decision to admit, labs, xrays. Overall high

Exam would be considered comprehensive under 99285 guidelines for appropriate exam Medical decision making is high complexity. History is detailed.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99283	09/07/1995	$186.00	$64.96	R1.3.2	R1.3.2	99282	535.72	$29.24

Hx: as above: Rash all over (quality). both extremities (location).w/o relief from cream (modifying factor) ROS: Allergies none. EPF history.
Exam skin both legs, constitutional. EPF exam
MDM: Acute allergic reaction (acute uncomplicated illness). Treatment: Decadron IM (moderate) Overall low.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99265	10/13/1995	$388.06	$155.96	Rl.5.3	R1.5.3	99283	$64.96	$90.94

Reviewer downcoded service from 5 to 3

hx: Severe pain (quality), both knees, left hip (location), HIV+ (modifying factor), has new onset (duration) ILS (Ext hpi) ROS: musculoskeletal, const. Pert past. Detailed history.
Exam EPF exam of extremity covering (ski"), musculoskeletal, neurological systems.
MDM Acute condition with mild progression (Full blown HIV with sudden onset of arthralgia both knees) Limited data (lab and xray), treatment with multiple IM meds (Toradol, demerol, phenegran) Overall moderate.

99283 based on exam

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99264	10/14/1995	$364.66	$99.06	R1.4.3	R1.4.3	53283	t64.96	$34.10

Dictation could not be located for our review. Reviewer also acknowledged dictation not available and allowed a 99283. Since there is not a documented physical exam we would agree to yield to the reviewers dedsion.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99264	10/29/1995	$304.00	$99.06	R1.4.3	R0	99284	$99.06	$0.00

Hx: Twitching (CC) Neck and shoulders (location). pain (signs and symptoms) chronic (quality) intermittent (timing), no numbness (ROS). electrolyte disturbance in past (pert Past.) No chest pain (ROS) Detailed.
Exam Const. Lungs dear, heart- NSR. Abdomen benign and BS +, Extremity, musculoskeletal. (Detailed).
MDM: Involuntary twitching (chronic problem with mild exacerbation), IV meds given (moderate), data reviewed (labs, limited) Overall moderate.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rv	Aud CPT	Audited	Difference
*	99283	01/24/1996	$186.00	$61.82	R13	R15	99283	561.62	50.00

Government states presence not supported.

Attending presence is supported under the pre-July 96 rules. Attending physician per nursing record assigned final diagnosis of cyanosis. which was not specified in resident's assessment, demonstrating participation In the patient's care. The attending physician signed the emergency treatment record and ordered the discharge.

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Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99264	02/05/1996	$276.60	t94.36	R1.4.2	R25	66265	594.36	$0.00

Reviewer used psych consult as record reviewed. This is not the ED record.
History would be waived due to patient's delusional status. It appears from the discharge summary that a complete mental status examination was performed in the ED. This would constitute a comprehensive singel system psych. Based on documentation in the nursing records the patient was placed In restraints (at risk for harm to self or others), hiih complexity, treated initially with Haldol (high risk medication), accompanied to floor by ED staff. If this record were treated by the reviewer in the same way as record 91, * the service would be implied to be a level 5 service.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	63284	02/24/1996	5276.00	$94.36	R1.4.3	R0	66264	594.36	S0.00

Hx: 1 month (duration), sharp (quality), left apical (location), radiating to left shoulder (signs), SOB on exertion (context). Ext HPI. ROS: N/v (GI), Chills (const), cough (resp) Ext ROS. Pert past and social. Detailed history.
Exam Detailed, heart, lungs. abdomen.
MDM: Acute condition posing threat to life (angina),moderate data:(labs, EKG, xray). Moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	66282	04/24/1996	$109.00	$33.42	R0	R0	88282	$33.42	$0.00

Hx: Patient tripped and fell (context). hit face on curb today (location, duration). Immediate pain(signs) and bleeding (Pert ROS). EPF hx.
PE: Nose. const (alert and appropriate), neck supple, EN7 neg. EPF exam
MDM Acute complicated injury (face trauma with laceration), Limited data EKG and xrays. (LOW) Overall low.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	88284	05/16/1996	$278.00	$94.36	R1.4.3	R0	68284	$94.36	S0.00

Reviewer downcoded from 4 to 3

Hx: MVA (modifying factor), hit car head on (context), pain(sign) In neck. right chest and RUQ (location). EXT hpl. Ext ROS- Pert (not uptight or walking at seen), Allergies none. Past medical history. Detailed history.
Exam Ears, eyes, neck, chest, lungs, abdomen, and extremities- detailed exam
MDM: Multiple data, labs, xrays, ekg, Acute complicated injury (chest contusion, patient having prior open head surgery), Overall moderate.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	88284	05/22/1996	$276.00	$94.36	R0	R0	99284	$94.36	$0.00

Hx: 2 day h/o (duration), LUQ abdominal pain (location), per paramedic hx, pt c/o burning pain (quality), no dyspnea a diaphoresis (signs). Ext HPI. ROS: cough (resp), fever (const), Diarrhea (GI). Extended. Pert past (meds) Detailed.
Exam: Const, Eyes, ears, neck. chest, heart, abdomen, neuro, extremities, Detailed exam or comprehensive single system cardiac exam.
MDM: Acute condition with mild exacerbation (diverticulitis with chest pain), Multiple data: labs, ekg, xrays. Multiple medications: vicodin, bactrim, flagyl. Discussion with family physician. Overall moderate.

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Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	10/06/1996	$276.00	$94.36	R0	R0	99284	$94.36	$0.00

hx: severe (quality) back pain (location) for two days (duration), relieved with pain meds at home (modifying factor) Ext hpi, ROS: Constitutional (fever), osteomyelitis (musculoskeletal), sickle cell (hematological) Ext ROS. Past history, social. Detailed history.
Exam: Constitutional, chest, CV, abdomen, extremity, (detailed- 5 areas)
MDM: Acute illness with severe progression,exacerbation (sickle cell crisis-high), treatment IV pain meds and need for admission for parenteral therapy (high)- Overall high complexity

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	10/11/1996	$276.00	$94.36	R0	R0	99284	$94.36	$0.00

OAS agreed to accept this as a 99284.

cc: Fall, pain low back, right knee and mid chest (location), stumbled over heating pad (context), broke fall with hands (modifying factor), worried about right knee (sign). Ext hpi. ROS: dizziness (neuro), CP (CV), Headache (const)- Ext ROS. Pertinent past and social. Detailed history.
Exam: Constitutional, Eyes, ENT, Resp, CV, Musculoskeletal, Psych (alert and cooperative). Detailed exam.
MDM: Acute complicated injury (Fall with chest wall contusion, arrived by ambulance), limited data (xray), moderate risk- patient on medication requiring monitoring (coumadin, used in decision making for medication management and treatment options). Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	11/08/1996	$276.00	$94.36	R0	R0	99284	$94.36	$0.00

OAS agreed with level 4

Hx: Duration (ongoing 2 weeks), quality (increasing SOB), Tongue swelling (signs), modifying factor (pessary in place). Extended ROS: Allergies, GU (diif voiding), GI (neg n,v,d)- Extended. Pert past. (Detailed hx)
Exam: Constitutional (alert), Lungs: clear, CV: SS, no murmurs.
Abdomen, Skin and ENT. Detailed exam.
MDM: Acute illness with progression (allergic reaction with increasing SOB), discussion with other physicians (GYN resident called, family physician called), interventions: foley cath, IV solumedrol.(IV with additives) Moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	01/07/1997	$304.00	$99.37	R1.4.3	R0	99284	$99.37	$0.00

hx: back(location) pain since last night (duration), given rx for vicodin but did not have it filled (modifying factor), has had right buttock pain since bumping it on a table (context). Ext Hpi.
ROS: Allergies none, no urinary or bowel incontinence (Ext ROS), Pert past. Detailed history.
Exam: Const, HEENT, Lungs, Back, neuro (Detailed exam)
MDM: Pneumonia and back pain. (chronic illness combined with new acute illness) discussion with family physician. Moderate presenting problem.
Treatment: Vicodin and f/u with family physician. (moderate for Rx meds)

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	93010	01/27/1997	$76.00	$12.36	R6	R6		$0.00	$12.36

Cannot find support for EKG interpretation in the physicians treatment record.

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Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99265	01/27/1997	$472.00	$156.92	RO	RO	99285	$156.92	$0.00

Hx: chest pressure since 7 AM (duration, location), gradually intensified (quality). assoc SOB. palpitations and diaphoresis (signs and symptoms). chest pressure subsided to 2/10 (severity). Ext HPI. ROS: Const, GI, resp, GU,CV (Due to urgency to treat, this would be considered complete under AMA guidelines for 99285.) Past. family, social. Comprehensive.
Exam Const, resp, Eyes, ENT, CV. Neuro,. (Comprehensive single system cardiovascular exam).
MDM: Acute condition posing threat to life (chest pain, r/o MI), High risk: treatment with nitropaste and IV Lasix, discussion with other physicians. decision to admit. Overall high

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99285	03/12/1997	$472.00	$156.92	RO	R 0	99265	5166.92	$0.00

Hx: cough, fever, chills (signs), right upper quadrant pain (location), pain is respirophasic (quality). alcoholic (modifying factor). Ext hpi. Complete ROS: see pink sheet. Pink sheet addreses at least 10 systems. Past medical history, family history. Comprehensive history. (also has qualifying statement that history Is difficult to obtain).
Exam Constitutional, neurological, pyschological, musculoskeletal, respiratory, integumentary, eyes. ent, and cardiovascular. (comprehensive exam).
MDM Chronic condition with sever exacerbation (alcoholism associated with hepatitis, jaundice and thrombocytopenia with pleural effusion, elevated heart rate. Extensive data: multiple labs. xrays. Treated with IV with additives.Decision to admit. Overall high complexity.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99203	04/08/1997	$188.00	$65.18	RO	RO	99263	$65.18	So.00

hx: Tripped and fell (context). bruised right hand (location), no pelvic pain (pert ROS) Past hx Post valve replacement. EPF hx.
Exam: Const. back. chest, heart. abdomen and extremities. Detailed.
MDM: contusion on back and laceration to hand. (complicated injury- patient with allergy to lidocaine, no sutures placed), Keflex given (Rx meds). Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99264	05/09/1997	$304.00	$99.37	Ro	RO	99284	$99.37	so.00

hx: back pain (location) since 2 am (duration). worse at about 4-5 PM this evening (quality and timing), fever and shivering (signs) Ext hpl. ROS: GU. GI. const. Pert Past- detailed history.
Exam: Eyes. ENT, neck, chest, heart, abdomen. back, extremities, and rectal. Detailed exam.
MDM:Presenting problem: acute illness with systemic involvement, Multiple data: labs, ekg. chest xray. Treatment: IV with additives, discussion with primary physidan. decision to transfer for admission. Moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99203	07/19/1997	$186.00	$65.18	Rl.3.2	Rl.3.2	99202	$36.26	$28.92

History should be wiaved. Patient is not forthcoming with history.
Exam Expanded problem focused- conjunctiva and follicular exam both eyes.
MDM Acute uncomplicated illness (low), two medications (diamox, and benadryl) Moderate. Overall low

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Patient Name	CPT Code	Date	charge Ant	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99262	07/31/1997	$109.00	$36.26	R1.2.1	RO	992.32	$36.26	S0.00

Hx: Patient walking outside (context) hitting the pavement, broke Sunglasses (modifying factor). no bc (pert ROS). Laceration right eyebrow (location), Brief hpi. Extended ROS- respiratory, GI. GU. musculoskeletal. Pert Past. Expanded problem focused history.
Exam Eyes, ENT, CV. Resp, neck. abdomen. Detailed.
MDM Patient had an acute umcomplicated injury with history of hypertension (low), treated with over-the-coun ter drugs- polysporin. Head injury with laceration, needed to rule-out any other injury.Overall low.

Patient Name	CPT Code	Date	charge Ant	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99293	0972411997	$472.00	$156.92	RO	RO	99299	$159.92	$0.00

Hx: 3 day history (duration), abdominal pain (location), radiating to his back (quality), nauseated (signs) Ext hpi. ROS complete. Past, family and social. Comprehensive history.l
Exam: Const, Eyes,ENT, Resp, CV. GI, Musculoskeletal, Skin (comprehensive multisystem exam).
MDM Acute condition with severe exacerbation (pancreatitis, aortic aneurysm, rule-out dissection/rupture). Extensive data: labs, ekg. xrays, CTs, decision to admit (overall high complexity)

Patient Name	CPT Code	Date	charge Ant	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99295	08/24/1997	s472.w	$156.92	RO	RO	99295	$156.92	$0.00

Hx: Since July (duration). pain in neck (location), feeling like thiis stuck (Context). slight choking sensation (quality), and difficulty breathing (signs) Ext HPI. ROS: Comprehensive. Past, family and social. Comprehensive history.
Exam Constitutional, Eyes, ENT. Rasp. CV. Musculoskeletal, Skin, and Neurological. Comprehensive Exam.
MDM Chronic illness with severe exacerbation (esophageal spasm with a near syncopal episode occurring during treatment). moderate data (labs, ekg, xrays), Discussions with multiple physicians- Dr. * Dr. * decision to admit. treatment with IV meds- high complexity.

Patient Name	CPT Code	Date	charge Ant	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	08/30/1997	$304.00	$99.37	Rl.4.2	RO	99264	$99.37	$0.00

hx: one week (duration), left sided abdominal and left side chest pain (location). feels like pressure sensation (quality), decreased appetite (signs). pain worse when she eats (modifying factors). ROS: GI, const, respiratory and CVS. Pert past, social and family. Detailed history.
Exam eyes, ENT, neck. lungs. CVS. Abdomen, rectal, extremity and neuro. Detailed exam.
MDM: Abdominal pain, unknown etiology. (Acute illness with systemic symptoms- inability to eat), additional w/u including:.
Multiple data: EKG, labs, xrays. (moderate)
Treatment: GI cocktail. Overall moderate.

Patient Name	CPT Code	Date	charge Ant	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	09/23/1997	$304.00	$99.37	R1.4.3	RO	99264	$99.37	$0.00

Hx: Patient arrived by ambulance. Coughing, without hemoptysis (resp ROS), c/o chest pain (location), stopped on *and* off (timing), SOB (signs). Ext HPI, ROS: Resp, const, GI. Past medical aand social history. Detailed history.
Exam Const, Eyes, ent, Resp, CV. skin and neuro. (Detailed).
MDM: Chronic condition with mild progression (coughing secondary to reflux, had similar condition prior- Moderate). review and comparison of EKG to old EKG (no new changes compared to 9-19- independent review of images-moderate), prescription management (addition of Reglan). Overall moderate.

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administratively confidential information fro eport: .n
names of individuals and beneficiary numbe

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Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	10/07/1997	$186.00	$65.16	R1.3.2	R1.3.2	99282	$36.26	$28.92

hx: nausea and vomiting times 6 in 1 and 1/2 hours (timing and signs). moderately throbbing headache (quality). ROS: no SOS (resp) No CP (CV) Hx taken from paramedic trip report and MD history. EPF hx.
Exam Const, Eyes, Neck. chest, abdomen (detailed)
MDM Persistent vomiting (acute uncomplicated illness) Treatment- observed and fed. Overall low.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	9 9 2 8 3	10/17/1997	$186.00	$65.18	R1.3.2	RO	99283	$65.18	$0.00

Reviewer downcoded from level 3 to 2.

Dr. staled 99282 period. This is a problem focused history.

Hx: do vomiting and dizziness since 2300 (signs and duration), No chest pain (pert review of systems) EPF history.
Exam Constitutional, Eyes. ears, neck. lungs, heart. abdomen (detailed exam)
MDM: Acute illness with systemic symptoms,(vertigo with vomiting), treatment included IV's with additives Compazine. Overall moderate.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	92960	10/20/1997	$636.00	$157.65	R6	ALT CPT	99285	$156.92	30.73

OAS states service could not be performed. External cardioversion of internal AICD.

Agree with reviewer. However, this appears to be a charging mistake. The dictation reflects that the cardiologist came in to reprogram the AICD to deliver a shock, and patient was cardioverted toa sinus rhythm. It is easy to see how someone reading the note may not have seen the portion addressing the AICD.

In addition, most likely, the leve of service was denied for the 99285. It should be considered-
There is a comprehensive history: Crushing (quality), substernal (location), and diaphoresis (signs), did not feel his AICD go off (context). Comprehensive review of systems. Past medical history. Due to critical nature of case, remainder of history would be waived.
Exam Const, neck. lungs, heart. chest, abdomen, neurological. Comprehensive single system cardiology exam
MDM: Acute condition posing threat to life (ventricular tachycardia, rule out MI), left saving treatment of bolus's of Lidocaine, Lasix, Nitro-drip. Admitted. High Complexity

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	02/20/1998	$323.00	$101.93	RO	RO	99284	$101.93	$0.00

Hx: HIV+ (last t-cell 200 x 3 weeks). ROS: Immunological, neuro, GI- ext ROS. Chronic(quality) back pain (location) since 1991(duration), secondary fall (context). Increased back pain associated with dysuria (signs).Ext HPI, Ext ROS. past medical (Detailed history)
Exam Constitutional. ENT, Neck. Chest. Heart, Abdomen. Extremities, Back. Detailed exam
MM Chronic condition with mild progression (continued back pain). Treated with IV fluids with additives- demerol, compazine. (IV fluids with additives) Moderate overall.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99291	04/23/1998	$695.00	$208.44	RO	RO	99291	$208.44	$0.00

Paramedic record show patient was in Ed at 13:41, nursing record supports Dr. * present, patient started on heparin. Looks like cardiology fellow, Dr. * assumed care at 14:20. This would support Dr. * in attendance for at least 39 minutes(exceeding 30 minutes).

If critical cam would not be allowed, the documentation would support 99285 and partial credit of 160.93 should be given.

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Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	04/26/1998	$186.00	$66.85	R1.3.2	Rl.3.2	99282	537.19	$29.66

Hx: Twisted right foot,ankle (location), pain(signs) on weight bearing (context). No known allergies per electronic nursing record (part ROS) EPF history.
Exam Right foot and ankb (EPF)
MDM: uncomplicated injury (low), dab review: xrays Treatment: Vicodin (Rx management) Overall low.

Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99265	04/28/1998	6501.60	$160.93	R1.5.4	R0	99285	$160.93	$0.00

hx: Patient was on bathroom scale and passed out (context). fell so hard she dented the door (severity), having low hack pain (location, signs). Ext hpi. ROS: Complete
Past , Social (per nursing record-married,lives with husband). Comprehensive
Exam Const, Psych/ Neurological, Eyes, ENT, Resp, CV. Musculoskeletal Comprehensive exam
MDM: Abrupt change in neurological status (syncopal episode with brief LOC complicated by compression fracture to spine- high), Extensive data: labs, multiple xrays, EKG, discussion with other physicians.(high) Treatment: IV. po meds, and admit. Overall high

Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	04/30/1998	5323.90	$101.93	R13	R13		so.00	$101.93

.Although we agree that presence Is established through the nursing notes, the documentation is not sufficient to support presence and involvement In the all of the key elements.

Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	93010	04/30/1998	$80.60	$13.39	R6	R6		so.00	513.39

Government auditor states that the interpretation of the EKG is not documentad.

EKG interpretation is not specifically documented.

Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99285	07/09/1998	6501.00	$160.93	R0	R0	99285	5160.93	50.00

hx: on coumadin (modifying factor). at 10;30 (timing), left arm, left leg (location), incoordination (signs), now improving (quality).l Ext hpi. ROS: complete; const, resp, eyes, ent, CV, GI, GU, Musculoskeletal, Neurologic, Psych, Endocrine, Allergic. Past medical and social (accompanied by spouse). Comprehensive history.
Exam Comprehensive neurological single system exam
MDM: An abrupt change in neurological status (high), treatment with IV heparing (drug requiring intensive monitoring-high risk), need for admission- discussion with other physicians Overall high.

Patient Name	CPT Cede	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	07/09/1998	$166.69	666.85	R0	R0	99283	366.85	S0.00

Hx: Got up because of leg cramps (context), struck forehead on the ground (location), takes ativan (modifying factors). ROS: no loc (neuro), no nausea (GI), no palpitations (CV) Other negative (Complete). Pert socbl: lives with husband. Detailed history.
Exam Const. Eyes. ENT. neck, chest, abdomen, back, pelvis, extremities. Detailed exam
MDM: Acute complicated injury (fall with laceration-neuro checks), treatment: discussion with husband to observe patbnt post discharge frequently for possible neurological changes, instructions to call patient in AM to make sure she was OK neurologically Overall moderate.

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Patient Name	CPT Code	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	07/20/1998	5186.00	$66.85	R0	R0	99263	666.85	$0.00

cc: Feel sick. HPI: rash 4 days (duration), on abdomen and right thigh (location), Itching (signs). Brief HPI, ROS: const (no fever), respiratory, GI, Psych and allergies. Pert past and social. EPF history.
Exam Constitutional, CV, respiratory. neuro, skin. Detailed.
MDM Acute uncomplicated illness (rash. tinea pedis) but combined with abnormal behavior, requiring discussion with other physicians and psych personnel. Moderate Complexity.

Patient Name	CPT Code	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	08/02/1998	$323.06	$101.93	R1.4.3	R0	99284	$101.93	$0.00

HX: Pinching pain (quality), left knee (location), 2-3 days (duration), pain increasing (severity) with walking (context). Ext HPI. ROS: Respiratory, CV, and Allergy. Pertinent past history. Detailed.
Exam: Detailed exam of left knee- including musculoskeletal review (tenderness), neurological (without spasm) and vascular flow. 3 systems. Detailed.
MDM Extensive data reviewed: labs, vascular duplex study, pulse oximetry, EKG plus discussion with primary care physician. Presenting problem is chronic illness with mild progression. (thrombosed vein). Overall moderate.

Patient Name	CPT Code	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	09/25/1998	$186.00	368.85	R13	R13		so.00	$66.85

Reviewer found documentation did not support teaching rules.

It is clear from documentation that Dr. * participated in the medical decision making by establishing the final diagnosis of dermatitis. He must also have participated in the examination (cannot diagnose dermatitis without an exam of the skin). The only element not addressed is a review of the history.

Patient Name	CPT Code	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99285	10/15/1998	$501.06	6160.93	R1.5.4	R0	99285	$160.93	So.00

Hx: feeling weak (signs) for a few days (duration), fait down yesterday (context), unable to walk today (timing). Ext hpi. ROS: complete. Past, family and social. Comprehensive history.
Exam Const, eyes. ENT. Resp, CV. GU, Neurological, muculoskeletal. Comprehensive.
MDM Advancing renal failure (chronic condition with severe progression- high), Treatment Plan- discussions with other physicians, decision to admit for additional workup. High

Patient Name	CPT Code	Date	Charge Amt	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99282	10/26/1998	$109.00	$37.19	R2.2.3	R2.2.4	99284	$101.93	(36474)

OAS agreed that this service was undercoded, but felt it at most supported a level 3.

Hx: Tripped end fell (context), hit face on wound (location), not on coumadin or aspirin (modifying factors), no loc (signs and symptoms(. Ext hpi. ROS: constitional (h/a). GI (N/v), and musculoskeletal (neck and pelvis) Pert past. Detailed history.
Exam: Const, Eyes, Musculoskeletal, resp, CV, Integumentary, neuro, and psych. (Comprehensive
MDM Presenting problem is an acute complicated Injury; facial injury with complex laceration. Ruling out neurological involvement. Limitad data-xrays. Prescription meds- penicillin. Overall moderate.

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Community Urgent Care Medical Group

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	10/29/1998	$323.00	$101.93	R0	R0	99284	$101.93	$0.00

hx: left arm and pain in neck (location), times 2 days(duration), numbness (signs), increase pain with neck movement (context). Ext hpi.
ROS: Allergies, GI, Neuro.
Pert past, social. Detailed hx.
Exam: Const, Eyes, ENT, Neck, CVS, Chest, Abdomen, Extremities, Neuro. Detailed exam-6 systems.
MDM: Acute cervical strain with radiculopathy (acute illness with systemic involvement). Data reviewed: xrays, discussion with other physician, Dr * Treatment: Naprosyn Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	11/12/1998	$323.00	$101.93	R1.4.3	R0	99284	$101.93	$0.00

Hx: pt eating dinner, went to bathroom (context), feeling improved while lying down (modifying factor), nearly fainted twice over last year (timing), feeling dizzy (signs). Ext hpi. ROS: Respiratory, CV, const, GI. Extended ROS. Pertinent past Detailed History.
Exam: Const, Eyes, ENT, Heart, Lungs, Abdomen, Extremities, Neuro (detailed)
MDM: Abrupt change in neurological status-near syncopal episode (high), limited data: labs, ekg (low), IV fluids referral to family physician for re-evaluation, arrived by ambulance.(moderate) Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	11/14/1998	$323.00	$101.93	R1.4.2	R0	99284	$101.93	$0.00

Hx: brought in by paramedics, severe chest pain (qı ality, location), radiating down left arm and left shoulder, while walking (context), for about one hour (duration), was given ASA in field with no relief (modifying factor) . Ext HPI. ROS: no : ɔb (resp), no history of MI (cardiovascular). Past medical history and social. Detailed history,
Exam: Const, Neck, heart, lungs, abdomen, and extremities (comprehensive single system cardiovascular exam).
MDM: Acute chest pain (high acuity presenting problem, poses threat to life), multiple data: labs, ekg, xray. Discussion with cardiology. Treated with Toradol IM (moderate) Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99285	11/18/1998	$501.00	$160.93	R0	R0	99285	$160.93	$0.00

hx: chest pain (location), associated with SOB (signs), pain resolved in ambulance (timing), sharp pain in left shoulder (quality) (Ext Hpi)
ROS: Complete, Past, family and social. Comprehensive history.
Exam: Const, eyes, ENT, Resp, Cardiovascular, musculoskeletal, skin, GU, and neurological. (Comprehensive multi system exam)
MDM: presenting problem- unstable angina (high risk-poses threat to life), multiple data: labs, chest xray, EKG (moderate), Treatment cardiac monitoring, nitropaste, discussion with private physician, decision to admit. (overall high complexity)

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	12/08/1998	$186.00	$66.85	R1.3.2	R1.3.2	99282	$37.19	$29.66

Government downcoded to 99282

Hx: cc: Chills. Brief HPI: Cramps (signs). Pert ROS: no known allergies. Pert social: lives on street. EPF hx.
Exam: Constitutional: WD BB, Psychological : Alert. Respiratory: Lungs clear. Cardiovascular: Sinus rhythm. And Abdomen: neg. Detailed exam.
MDM: Acute uncomplicated illness (URI), no data reviewed, treated with liquids, and discharged. Overall low.

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Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99282	12/25/1998	$109.00	$37.19	R1.2.1	R0	99282	$37.19	$0.00

OAS coded es 99291.

Hx: cc: Injury
HPI: while cooking (context), left hand (location), penetrated deep (severity), no excessive bleeding (signs). Brief HPI. Extended ROS: Tingling (neuro), weakness(muskuloskeletal), allergies. Past medical and social hx. Overall EPF hx.
Exam: Expanded problem focused exam of hand including integumentary system (wound), and musculoskeletal system (ROM intact). EPF exam
Medical decision making: acute uncomplicated Injury, prescription treatment with Augmentin. Overall tow.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99204	03/20/1999	$323.00	$102.07	R1.4.3	R0	99294	$102.07	so.00

Hx: Shakes, dysuria (signs), and frequency (timing), can't hold wins (context). Nursing history- urinary incontinence since this morning (duration), Ext HPI. ROS: Const, cardiovascular, respiratory and GI. (Extended ROS). Pertinent Past. Detailed history.
Exam Constitutional, Eyes. neck, heart, lungs, abdomen, neuro (detailed).
MDM: Multiple data: Labs, EKG,discussion ewith other physician(ID consult). Treatment lvs and prescription md. (overall moderate)

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99203	04/09/1999	$188.00	$66.51	R0	R0	99293	ss6.51	$0.00

Hx: MVA(context), restrained driver (modifying factor), no loc (pert ROS), back pain (location). Brief HPI and Pert ROS (EPF history).
Exam Const, CV. Resp, Back and extremities. Detailed exam
MDM: Acute complicated injury (MVA with dizziness and lumbar strain), Treated with IM torodal, flexeril. (moderate), Overall moderate omplexity.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99283	0510111999	$186.00	$66.51	R1.3.2	R0	99283	$66.51	$0.00

hx: Walking up steps (context), neck with pain (location), No LOC (pert ROS). Past medical. social. EPF hx.
Exam: Const,eye, neck , MS (Shoulder and back), and Neuro (DTR,motor and sensory OK)(Detailed).
MDM: Fracture lumbar spine (acute complicated Injury- moderate), data review xray L-S spine, CT, consult with primary care and ortho, plan to admit (high risk-threat to loss of bodily function). Overall moderate.

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99285	05/17/1999	$501.00	$180.32	R0	R0	99285	$160.32	50.00

Hx: weakness in left leg (location), lasting several minutes (duration), unable to walk (signs), numbness in right hand transient (quality). Ext hpi. ROS: CV. constitutional, respiratory, and all other. Comprehensive
Past medical and social. Overall comprehensive history.
Exam Const, Eyes. ENT. CVS. Resp,GI, neurological, and musculoskeletal. Comprehensive exam
MDM: Acute TIA (high). extensive data: EKG, xray, carotid duplex, and discussion with other physician (high).

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Community Urgent Care Medical Group

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99265	06/17/1999	$501.00	$160.32	RI.52	RI.5.3	99263	86.51	$93.61

Hx: Vomiting x3 days (duration), No diarrhea, no few (Pert ROS). allergic to codeine(ext ROS). RN notes: weak (signs), knee surgery (Modifying factor), unable to ambulate (context). Pert PMH/SH Detailed history.
Exam MS (right knee), GI: heme negative, Const: pulse ox and VS's. (EPF exam)
MDM Knee injury and vomiting (complicate injury-knee injury in patient with previous knee replacement), data multiple: Comparison EKGs,lab, discussion with Dr. * and orthopedics. (multiple- moderate) Overall moderate

Patient Name	CPT Code	Date	Charge Amt.	Allowed	Reviewers CD	CPT CD Rev	Aud CPT	Audited	Difference
*	99284	07/08/1999	$323.00	$102.07	R1.4.3	R2.4.5	99265	$106.32	($4.25)

OAS agreed to allow it as a 99283

Hx: CVA 2 weeks aog (timing), unable to urinate, chronic indwelling foley(modifying factor), mild suprapubic distention (quality, signs/symptoms, and location) no urinary pressure for 6 hours (duration). ROS: No chest pain (CV), SOB (resp), N/v (GI), Fever chills (Const), pain in back/flank (GU). Pert past and social. Detailed history,
Exam Const, Neck. Cardiovascular, Respiratory, GI, GU, Neuro. (Supports comprehensive single specialty GU exam).
MDM: Extensive data (multiple labs. Xrays, EKG). Hi risk presenting problem- patient with UTI that has altered mental status associated with confusion while being treated in the ED. Documented by the attending as needing additional work-up. Overall MDM is hiih complexity.

Attending documentation supports presence during treatment, review of resident's history. exam and contains appropriate revisions to assessment and treatment. All diagnostic studies entered as reviewed by attending. Due to patient's altered mental status and confusion, we believe the history is comprehensive under (he coding rules for 99265 and that the overall level is a 99266.

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MEDICARE
PART B CARRIER

August 9, 2001

Department of Health & Human Services
Office of Inspector General
Region IX
Off ice of Audit Services
801 I Street, Room 285
Sacramento, CA 95814-2510
Attention: Jerry Hurst

RE: Audit Report on Community Urgent Care Medical Group
CIN: A-09-00-00089

Dear Mr. Hurst:

This letter is in response to the draft audit report issued by your office as a result of a review conducted for services billed from January 1, 1995 through July 31, 1999 by Community Urgent Medical Group.

We have reviewed and concur with the findings made,

If we can be of further assistance, please give me a call at (213) 593-6834 or Maria M. Hernandez, at (213) 593-6836.

Sincerely,

Carlos Rivera, Manager
Medical Review Department
Program Integrity