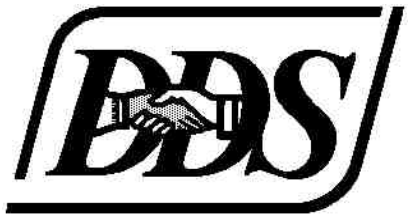

Medicare Compliance Review of the Fee for Services Billing Program for Canyon Springs Community Facility

Review Period of January 1, 2010, through December 31, 2010

Client Financial Services
Department of Developmental Services

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EXECUTIVE SUMMARY

In January 2011, the Department of Developmental Services' (DDS), Client Financial Services (CFS) Section conducted a Medicare Compliance Review at Canyon Springs Community Facility (CSCF). The purpose of the review was to determine compliance with the Office of the Inspector General (OIG) standards for Medicare billings, and to identify missed billings to Medicare to ensure maximum reimbursement for the services provided by DDS. The review focused on Physicians' Progress Notes (PPNs) that are required to support physicians' fee-for-service billings to Medicare. The review found the following:

Compliance with OIG Standards

As shown on the chart below, the reviewers found the Medicare billing compliance rate of 67.6 percent and the payment error rate of 32.4 percent. CSCF did not meet the OIG's expected standard of 97.0 percent compliance with Medicare billing requirements.

Summary of Compliance with OIG Standards
Sample = 15 consumers
Review Period January 1, 2010, December 31, 2010

OIG Standards	Sample = *148 Physician Claims Reviewed
Compliance Rate	67.6%
Payment Error Rate	32.4%
Total	100.0%

** represents documents examined without "Missed Billings."*

- **No Record of Client Being Seen**

  The primary contributing factor leading to the 32.4 percent payment error rate was caused by the medical record not substantiating the provider examined the patient. The consumer's medical record must support the provider performed a face-to-face examination on the patient. This source of error accounted for 40 of the original 148 PPNs reviewed or 27.0 percent of the payment error rate.

Missed Billings

Audit staff also reviewed PPNs to identify errors associated with services which appeared to meet the criteria for billing to Medicare, but were not billed to Medicare. These missed billings represent a loss of potential federal revenue for DDS and California.

Reviewers found a total of 32 PPNs that could have been billed in addition to the original sample of 148 claims reviewed for a total of 180 potential PPNs. Based upon this review, 17.8 percent of eligible services were not billed to Medicare and no federal revenue was received for the services provided by DDS.

Conclusion

A Plan of Correction (POC) is requested from CSCF as the payment error rate is 32.4 percent which significantly exceeds the required OIG standard for billing errors of 3.0 percent.
In addition, the missed billing rate is 17.8 percent which represents a lost opportunity for maximizing federal revenue for the services provided by DDS. We are requesting a POC for both of these items within 60 days of receipt of this report.

PURPOSE OF THE MEDICARE COMPLIANCE REVIEW

This Medicare Compliance Review, conducted by staff of the Department of Developmental Services' (DDS), Client Financial Services (CFS) Section, is part of a series of ongoing, reviews of developmental centers to monitor physicians' and psychologists' compliance with Medicare billing requirements. These reviews are intended to improve compliance with Medicare regulations and laws, to reduce the risk of adverse audit findings by external agencies, assure that the State is maximizing the federal revenues to which it is entitled, and ensure compliance with the Welfare and Institutions Code (WIC), Section 14124.90.
In addition, Audit staff compares the results of each compliance review with the prior reviews to determine if there has been any trend of improvement or decline.

The DDS/DMH Medicare Administrative Manual includes the CFS' Compliance Review Protocol and an overview of the Medicare program and billing responsibilities.

SCOPE AND METHODOLOGY

Audit staff, Gloria Rhodes and Latonia Richardson of Department of Developmental Services, conducted the Medicare Compliance Review from January 27 through January 28, 2011. The review focused on common sources of errors in the documentation of physician services identified by federal studies of the Medicare program. The federal Office of the Inspector General (OIG) audits numerous facilities nationwide, and has determined that the most common areas for errors are:

1. No evidence that the provider conducted a face-to-face examination of the individual;
2. No PPN in the medical record, or the PPN did not substantiate the service;
3. Up-coded or wrong-coded services;
4. Billing for non-covered services; and,
5. Billing for mutually exclusive services.

The DDS' billing system blocks two types of these common errors, billing for non-covered services and mutually exclusive services; therefore, staff did not review for these errors. This review, as in prior reviews, focused on the three remaining common sources of errors found by the OIG.

Auditors also reviewed documents to identify services that would appear to meet the Medicare criteria for billing, but remained unbilled to Medicare. These findings are referred to as "Missed Billings." These errors represent missed opportunities for federal funding and are of concern to DDS, as California strives to maximize federal funding for Medicare eligible services provided by Developmental Centers and the Community Facility.

The Audit staff selected 15 Medicare beneficiaries from the Intermediate Care Facility (ICF) residence, for a total twelve-month time period from January 1, 2010, through December 31, 2010. The consumers represent 100 percent of all Medicare beneficiaries at CSCF. Audit staff selected the physicians' claims for those beneficiaries and reviewed the medical records for PPNs supporting the claims.

Audit staff also examined additional PPNs found in the same sample of files to identify evidence of missed billings. These PPNs met all criteria for billing to Medicare, but were not billed. Audit staff also checked for any other types of errors, concerns, or problems worth noting related to Medicare billing.

The OIG considers a payment error rate of 3.0 percent to be acceptable. Audit staff calculated the rate for each type of error by dividing the number of errors found in the review by the number of PPNs reviewed in the sample, noting if the sum of the three common sources of error identified by the OIG exceeded the acceptable error rate of 3.0 percent. In a federal audit, an error rate above 3.0 percent is cause for the OIG to assess fines and penalties.

At the conclusion of the site visit, Audit staff prepared a spreadsheet summarizing the raw data findings and discussed these findings with staff at CSCF during the exit conference. Audit staff also provided information regarding areas found to be in compliance with Medicare standards, areas where procedures are deficient, and recommendations on how to correct the deficiencies.

Audit staff then developed this written report for the Executive Director of CSCF. Audit staff routed the report for review and approval by CFS management. The Executive Director may provide additional information relative to the findings as outlined in the letter transmitting the report, and if warranted, Audit staff may revise this report. The Executive Director has 60 days to prepare a POC, if one is necessary.

FINDINGS

1. Payment Error Rate

The January 2011 review found that the physicians' payment error rate, as defined by the federal OIG, was 32.4 percent. Of the 148 claims, 100, or 67.6 percent, appeared to have adequate documentation to meet Medicare billing requirements and were submitted for payment. However, 32.4 percent of the PPNs were not correctly billed to Medicare.

The table below shows the error rates for each source of payment error. The formula used to arrive at the payment error rate was the total of the category addressed divided by the total of PPNs reviewed.

Source of Error	Error Rate Percentage of *148 Physician Claims
A. PPN not found in the medical record or documentation of PPN did not substantiate billing of the claim	5.4%
B. Not seen or documentation of PPN did not substantiate billing of the claim	27.0%
Payment Error Rate	**32.4%**

**148 physician claims sampled does not include "Missed Billings."*

Criteria

PPNs must contain evidence that the doctor examines the patient. The documentation of each patient encounter should include: reason for the encounter, physical examination findings, assessment, clinical impression or diagnosis, and plan for care.

The Code of Federal Regulations (CFR), Chapter 42, Section 482.24(c), states, "The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services."

CFR, Chapter 42, Section 483.40(b)(2), requires that physician performing services must: "write, sign, and date progress notes at each visit . . ." In addition, CFR Chapter 42, Section 424.5(a)(6), states, "The provider . . . must furnish . . . to the carrier sufficient information to determine whether payment is due and the amount of payment."

Medicare pays for services based upon the coding descriptions developed by the American Medical Association and published in the Physicians' Current Procedural Terminology Manual (CPT) reference book.

Conditions

Condition 1 – PPN Not Found

Of the 148 physician claims reviewed, 8, or 5.4 percent of the supporting PPNs were billed to as monthly progress and medication reviews, but were not located in the consumers' medical

records, or the documentation located did not substantiate the billing to Medicare for the service.

Cause

The provider is not documenting the medical examination as required by Medicare. In the absence of the medical record, the hospital staff is not ensuring that the medical record is properly documented and filed in the consumer's medical record.

Effect

Without sufficient documentation that records an examination of the patient, it cannot be determined if the hospital has appropriately billed Medicare for services. These services were submitted to Medicare and paid. Medicare must be reimbursed by DDS as the services were billed with the absence of the medical documentation. DDS could be charged for false claims resulting in fines and penalties with the potential loss of eligibility to bill Medicare for services provided by the Community Facility.

Recommendation:

PPNs must meet the criteria for billing to Medicare according to the medical service provided. Complete and thorough notes leave no room for error or doubt regarding the services provided. Consumers' medical record files must be maintained in a manner that allows staff and external auditors to review and locate PPNs for services that have been submitted to Medicare for billing.

Condition 2 – Client Not Seen

Of the 148 physician claims reviewed, 40, or 27.0 percent of the supporting PPNs were billed as monthly progress and medication reviews, but showed no evidence of a face-to-face patient encounter.

Cause

Based upon a review of the medical file, the reviewers concluded that the physician had not documented an examination of the patient and no face-to-face time was spent with the patient. The notes appeared to be a recap of the patient's care plan, not a direct visit with the patient.

Effect

Medical record documentation is used to record pertinent facts, findings and observations about the consumer's health and the services provided. These services were submitted to Medicare and paid. Medicare must be reimbursed by DDS as the services were not performed as billed. This could potentially result in a charge of false claims that carry fines and penalties, as well as the loss of eligibility to bill Medicare for services provided by the Community Facility.

Recommendation:

Proper documentation in the medical record is vital. The primary reason for the medical documentation is to ensure that patient treatment is recorded for quality of care and continuity of

treatment. In addition, proper documentation provides the support for billing to Medicare to ensure that eligible services are appropriately paid. Supervisory review of the medical record should be completed to ensure proper documentation is being completed by the providers. If necessary, training must be provided to the medical staff to ensure that proper documentation of the medical record is completed.

Missed Billings

Criteria

Although, neither the OIG nor Medicare recognizes missed billings in their audits, missed billings, represent a potential loss of federal revenue to the State of California and violates the Welfare and Institutions (W&I) Code, Section 14124.90, which states that Medi-Cal is the payer of last resort. DDS is responsible for maximizing federal reimbursement for the services that are provided by the Developmental Centers and Community Facility.

Missed Billings	PPNs Reviewed *172 PPNs
# of PPNs Supporting Claims not Billed	32
Percentage of Missed Billing	17.8%
Percentage of Overall Correct Claiming (Payment Errors + Missed Billings)	55.6%

**172PPNs = 140 notes supporting the physicians claims plus 32 PPNs identified as "Missed Billings."*

Condition

The review found that 17.8 percent of claims studied showed evidence of missed billings. In the sample reviewed, 32 PPNs, or 17.8 percent met the criteria for billing. DDS is required by law to bill all insurances before billing any other insurance. WIC, Section 14023.7., states, "Any provider of service seeking payment for health care services for a person eligible for these services under this chapter shall first seek to obtain payment from any private or public health insurance coverage to which the person is entitled, where the provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to the department for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by the provider, a claim may be submitted to the department."

Cause

The PPNs reviewed by Audit staff were sufficient documentation to bill the services to Medicare. In some instances, the second level review by facility staff had not been completed on a timely basis, or the service was not entered into the facility system for billing purposes.

Effect

DDS is not in compliance with the law that requires providers to obtain payment from any private or public health insurance and to bill all other sources of insurances the person may be entitled to, including Medi-Cal the payor of last resort. Missed billings impact the ability for DDS

to maximize federal funding for the services that are provided by the Community Facility. When billable services are not billed to Medicare, the charges roll over to Medi-Cal for payment. This is a potential audit finding by the Department of Health Care Services, as all insurances were not billed prior to billing to Medi-Cal. In addition, there may be an affect on the rates established for the procedures performed.

Recommendation:

PPNs that meet the criteria for each CPT code must be billed to Medicare timely for the eligible beneficiaries to ensure maximum federal payment. A review process should be implemented to ensure that missed billings are kept within reasonable and acceptable limits for DDS.

2. Comparisons to Prior Year Compliance Review for 2005

	2005 Compliance Review	2011 Compliance Review
Compliance percentage without missed bills	92.0%	67.6%
Compliance percent with missed bills	88.1%	55.6%

The comparison of the 2005 and 2011 compliance reviews show a significant decline in the compliance percentage.

NEXT STEPS

A Plan of Correction (POC) should be submitted to Gloria Rhodes, Manager, Medicare Unit, Client Financial Services, Department of Developmental Services, within 60 days from the date of receipt of this report. The POC must include a correction for the "Payment Error Rate" findings, and a correction for reducing "Missed Billings." If the CSCF, Client Records Department (CRD), can show why services should not have been billed to Medicare or submit the identified services for billing to Medicare, Audit staff may remove the finding for missed billings.

Additionally, we want to thank the staff at Canyon Springs for accommodating the CFS staff. If you have any questions, feel free to contact either Gloria Rhodes, or Latonia Richardson regarding the compliance review.