

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**FIRST COAST SERVICE  
OPTIONS, INC.:  
AUDIT OF MEDICARE CLAIMS BY  
PODIATRISTS AND OPTOMETRISTS  
FOR COMPREHENSIVE NURSING  
FACILITY ASSESSMENTS FOR  
CALENDAR YEARS 1995  
THROUGH 1998**



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 2000  
A-09-00-00094**

# ***OFFICE OF INSPECTOR GENERAL***

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

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**Office of Audit Services  
Region IX**

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OPTIONS, INC.:  
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ASSESSMENTS FOR CALENDAR YEARS 1995  
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**OAS FINDINGS AND OPINIONS**

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



**JUNE GIBBS BROWN  
Inspector General**

**NOVEMBER 2000  
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Region IX  
Office of Audit Services  
50 United Nations Plaza  
San Francisco, CA 94102

CIN: A-09-00-00094

NOV 21 2000

Ms. Patricia Ainsley  
Vice President of Program Safeguards  
First Coast Service Options, Inc.  
532 Riverside Avenue, Seven Tower  
Jacksonville, Florida 32202

Dear Ms. Ainsley:

The purpose of this letter report is to provide First Coast Service Options, Inc. (First Coast) with the results of our audit of Medicare claims by podiatrists and optometrists in Florida for comprehensive nursing facility (CNF) assessments during Calendar Years 1995 through 1998. Our objective was to determine the extent to which podiatrists and optometrists in Florida inappropriately billed Medicare for CNF assessments.

Our audit disclosed that podiatrists and optometrists submitted claims for CNF assessment services totaling \$3,224,389 and \$68,740, respectively. Of the total amount claimed by podiatrists, First Coast allowed \$2,539,315 and paid \$1,979,769. Of the total amount claimed by optometrists, First Coast allowed \$62,720 and paid \$46,372. The company's payments for services billed by 46 podiatrists represented 60 percent of the paid \$1,979,769, and its payments for services billed by 2 optometrists represented 59 percent of the paid \$46,372. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

We initially contacted First Coast regarding this issue in November 1998. Subsequently, the company initiated an internal review that determined the following provider specialties should not be billing for CNF assessments: podiatry, optometry, oral surgery, and dental. First Coast issued a notice in its March/April 1999 The Florida Medicare B Update! newsletter stating that the CNF assessment codes should not be billed by the podiatry, optometry, oral surgery, and dental provider specialties. The company also installed computer edits on April 19, 1999. We concur with First Coast's actions to prevent payment to these provider specialties for CNF assessments.

Regarding the improper payments that have been made, we request that First Coast not seek recovery of the overpayments at this time because we are still evaluating the issue.

In a written reply to our draft report, First Coast indicated agreement with the accuracy of our report. It also stated that it will comply with our request to not seek recovery of improper payments at this time. First Coast's comments are included in its entirety as an appendix to this report.

## **INTRODUCTION**

### **BACKGROUND**

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

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

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

Medicare Part A, 42 Code of Federal Regulations (CFR) 483.20 and 483.20(b) require SNFs to perform a comprehensive assessment of each resident's functional capacity within 14 days of admission and after significant changes in a resident's condition or at least every 12 months. These resident assessments cover the patient's entire well-being, such as physical functioning, sensory impairments, nutritional requirements, mental and psychosocial status, cognitive status, etc.

The responsibility for completion of the resident assessment lies with the SNF which must assure that appropriate health professionals participate. However, some of the information required to be collected can only be provided by a physician, and, thus, physicians play a crucial role in the assessment process. The 42 CFR 483.40(a) states, "...The facility must ensure that -- (1) The medical care of each resident is supervised

by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable.” (emphasis added) Additionally, 42 CFR 483.40(b) states, “...The physician must -- (1) Review the resident’s total program of care, including medications and treatments, at each visit...” (emphasis added)

The Health Care Financing Administration (HCFA) issued guidance to carriers in a Program Memorandum (Carriers) No. B-93-3, dated August 1, 1993 (the Memorandum), which states that there are three key components in selecting the level of evaluation and management (E&M) service when performing a CNF assessment: (1) a history, (2) a comprehensive examination, and (3) medical decision making that includes either the creation of a new *comprehensive medical care plan* or a review and affirmation of the current *comprehensive medical care plan*. The Memorandum also describes how physicians participating in resident assessments of beneficiaries in nursing facilities are to bill for their services. Physicians should use the Physicians’ Current Procedural Terminology<sup>1</sup> (CPT) codes for CNF assessments (99301-99303) to report E&M services involving resident assessments.

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

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

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

<sup>2</sup> The CPT code examples are from the 1998 version of the American Medical Association’s Physicians’ Current Procedural Terminology.

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

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

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

99302

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

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

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

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

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

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

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

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

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

The creation of a medical plan of care is required.

Physicians typically spend 50 minutes at the bedside and on the patient's facility floor or unit. (emphasis added)

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

For all CNF assessments, the required examination must be a comprehensive examination. The CPT manual defines a comprehensive examination as a general multi-system examination or a complete examination of a single organ system. In addition to the comprehensive examination for CNF assessments, either a detailed interval history or a comprehensive history is required. According to the CPT manual, a detailed history includes, "...chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; and pertinent past, family, and/or social history directly related to

the patient's problems." (emphasis added) The CPT manual states that a comprehensive history includes "...chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family and social history." (emphasis added)

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

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

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

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

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

The Florida State Statutes (the Statutes) restricted podiatrists to treatment and care planning of the foot and leg. Chapter 461.003(5) of the Statutes defines the practice of podiatric medicine as "...diagnosis or medical, surgical, palliative, and mechanical treatment of ailments of the human foot and leg. The surgical treatment of ailments of the human foot and leg shall be limited anatomically to that part below the anterior tibial tubercle. The practice of podiatric medicine shall include the amputation of the toes or other parts of the foot but shall not include the amputation of the foot or leg in its entirety. A podiatric physician may prescribe drugs that relate specifically to the scope of practice authorized herein."

The Statutes restricted optometrists to treatment and care planning of the eye and its appendages. Chapter 463.002(5) of the Statutes defines optometry as "...diagnosis of conditions of the human eye and its appendages; the employment of any objective or subjective means or methods, including the administration of topical ocular pharmaceutical agents, for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and any other means or methods, including topical ocular pharmaceutical agents, for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages."

Limited scope providers (such as podiatrists and optometrists) are not licensed to perform the key medical service components required to bill Medicare for CPT codes 99301-99303, such as preparation of a comprehensive medical care plan that is outside the scope of their specialty. Thus, podiatrists and optometrists should not be billing Medicare for CNF assessments, CPT codes 99301-99303.

## **OBJECTIVES, SCOPE AND METHODOLOGY**

The objective of our audit was to determine the extent to which podiatrists and optometrists in Florida inappropriately billed Medicare for CNF assessments during the Calendar Years 1995 through 1998.

Our review was conducted in accordance with generally accepted government auditing standards. Accordingly, we performed such tests and other auditing procedures as necessary to meet the objectives of our review. We did not review the overall internal control structure of First Coast or of the Medicare program. Our review of internal

controls was limited to obtaining an understanding of First Coast's payment procedures and system edits for processing Florida CNF assessment claims for podiatrists and optometrists. We obtained a general understanding of these procedures and system edits through discussions with First Coast personnel and an analysis of claims data.

We obtained an understanding of the Medicare regulations regarding CNF assessments. We also reviewed the Florida State Statutes to ascertain the scope of medical practice authorized for podiatrists and optometrists.

Our audit included an analysis of First Coast's CNF assessment payments for services billed by Florida podiatrists and optometrists. The data for this payment analysis were obtained from HCFA's National Claims History database. We did not perform an analysis of the procedures used to accumulate the Claims History data nor did we validate the accuracy of the data.

The fieldwork was performed from March 2000 through June 2000 at the Office of Audit Services' San Diego Field Office in San Diego, California.

## **FINDINGS AND RECOMMENDATIONS**

Florida podiatrists and optometrists inappropriately billed Medicare for CNF assessment services totaling \$3,224,389 and \$68,740, respectively, during Calendar Years 1995 through 1998. Of the total amount claimed by podiatrists, First Coast allowed \$2,539,315 and paid \$1,979,769. Of the total amount claimed by optometrists, First Coast allowed \$62,720 and paid \$46,372. The company's payments for services billed by 46 podiatrists represented 60 percent of the paid \$1,979,769, and its payments for services billed by 2 optometrists represented 59 percent of the paid \$46,372. We did not determine if the podiatrists and optometrists performed other, different services and incorrectly claimed CNF assessments.

### **ANALYSIS OF MEDICARE DATA: PODIATRISTS**

We determined that podiatrists submitted claims to First Coast for CNF assessments totaling \$3,224,389 during Calendar Years 1995 through 1998. Of the total claimed amounts, First Coast allowed \$2,539,315 and actually paid \$1,979,769.

Further analysis of the payment data showed that CNF assessments performed by 46 of the 465 podiatrists billing for CNF assessments accounted for 60 percent of the \$1,979,769 in invalid payments. The invalid payments for the 46 podiatrists averaged \$25,701 per provider. In contrast, CNF assessments performed by the remaining 419 podiatrists represented payments of \$797,540, or an average of \$1,903 per provider. The following is a frequency distribution summary of payments for CNF assessments performed by the top 46 providers.

<u>Total Amount Paid</u>	<u>Number of Providers</u>	<u>Percent of Providers</u>
\$10,000 to \$24,999	29	63 %
\$25,000 to \$49,999	14	30
\$50,000 to \$99,999	1	2
\$100,000 and Over	2	5
Totals	46	100%

#### **ANALYSIS OF MEDICARE DATA: OPTOMETRISTS**

We determined that optometrists submitted claims to First Coast for CNF assessments totaling \$68,740 during Calendar Years 1995 through 1998. Of the total claimed amounts, First Coast allowed \$62,720 and actually paid \$46,372.

Further analysis of the payment data showed that CNF assessments performed by 2 of the 37 optometrists billing for CNF assessments accounted for 59 percent of the \$46,372 in invalid payments. The invalid payments for the 2 optometrists averaged \$13,700 per provider. In contrast, CNF assessments performed by the remaining 35 optometrists represented payments of \$18,973, or an average of \$542 per provider.

#### **INSTRUCTIONS AND EDITS**

As a result of a 1999 internal review, First Coast determined that the following provider specialties should not be billing for CNF assessments: podiatry, optometry, oral surgery, and dental. The company issued a notice in its March/April 1999 The Florida Medicare B Update! newsletter stating that the CNF assessment codes should not be billed by the podiatry, optometry, oral surgery, and dental provider specialties. Further, the company informed the providers that it will deny claims submitted by these providers. First Coast also provided us documentation that indicated it installed computer edits (effective April 19, 1999) to prevent payment to podiatrists,

optometrists, oral surgeons, and dentists for CNF assessments. We concur with its actions to prevent payment to these provider specialities for CNF assessments.

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

## **OTHER SERVICES**

For the reasons previously cited, podiatrists and optometrists were not entitled to payment for CNF assessments of beneficiaries in nursing homes. However, it is not known whether the providers performed other, different services and incorrectly claimed CNF assessments. Such a determination could only be made by a detailed review of the providers' records.

## **RECOMMENDATIONS**

We have no recommendations to make because First Coast has already initiated corrective actions. We request that First Coast not seek recovery of the improper payments that have been made. We are still evaluating the recovery issue and will advise First Coast on this matter at a later time.

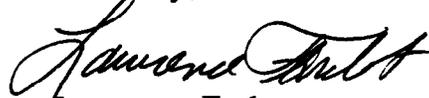
## **FIRST COAST'S COMMENTS**

In a written response to our draft report, First Coast indicated agreement with the accuracy of our report. It also stated that it will comply with our request to not seek recovery of improper payments at this time. First Coast's comments are included in its entirety as an appendix to this report.

Final determination as to actions taken on all matters reported will be made by the Department of Health and Human Services (HHS) action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination. To facilitate identification, please refer to common identification number (CIN) A-09-00-00094 in all correspondence relating to this report.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Lawrence Frelot". The signature is fluid and cursive, written over the printed name below it.

Lawrence Frelot  
Regional Inspector General  
for Audit Services

**Direct Reply to HHS Action Official:**

Rose Crum-Johnson  
Regional Administrator  
Health Care Financing Administration - Region IV  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303

# APPENDIX



**PATRICIA M. AINSLEY**  
VICE PRESIDENT  
MEDICARE PROGRAM SAFEGUARDS

November 3, 2000

Mr. Lawrence Frelot  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Region IX  
50 United Nations Plaza  
San Francisco, CA 94102

CIN: A-09-009-00094

Dear Mr. Frelot:

This letter is in response to your request that we review and comment on your draft report titled, "First Coast Service Options, Inc.: Audit of Medicare Claims by Podiatrists and Optometrists for Comprehensive Nursing Facility Assessments for Calendar Years 1995 through 1998."

We find that your report is accurate and straightforward. The report recognizes the OIG makes no recommendations because FCSO already initiated corrective actions. We also will comply with the OIG request that we not seek recovery of improper payments made during 1995 - 1998. We understand the OIG is still assessing the recovery issue and will advise us at a later date as to the recovery matter.

We appreciate the opportunity to review and comment on the draft report. Please contact us if you need any additional information or commentary.

Sincerely,

Patricia M. Ainsley

cc: P. A. Williams  
L. Rogers

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*FIRST COAST SERVICE OPTIONS, INC.*

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