s.22

Practitioner # s.22

AUDIT REPORT

FOR THE PERIOD
JULY 1, 2006 to JUNE 30, 2011

Ministry of Health
Audit and Investigations Branch
Billing Integrity Program

s.22

Audit Report
For the period July 1, 2006 to June 30, 2011

A. INTRODUCTION

Practitioner Background

s.22 is a registered Ophthalmologist (practitioner number s.22) with medical practices at:

- s.22
-
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During this audit period, patients booked for cataract surgeries with s.22 were given the choice of non-foldable (hard) lens or foldable (soft) intraocular lens. At that time, the costs for a non-foldable lens were publicly funded, at no charge to beneficiaries, whereas beneficiaries choosing a foldable lens were privately charged for it by s.22

As well, for cataract surgeries done at the s.22 charged a private facility fee to the patient.

The Medical Services Plan (MSP) paid s.22 for the following fee-for-service billings during the five year audit period, July 1, 2006 to June 30, 2011:

Audit Scope Period Per 12 months	Number of Services	Paid Amount
July 1, 2006 to June 30, 2007	28,594	$1,548,194.86
July 1, 2007 to June 30, 2008	29,877	$1,747,685.97
July 1, 2008 to June 30, 2009	29,368	$1,807,363.27
July 1, 2009 to June 30, 2010	28,135	$1,998,834.64
July 1, 2010 to June 30, 2011	28,081	$1,903,907.09
Total	144,055	$9,005,985.83

s.22 received no publicly funded alternative payment program payments during the audit period.

Practitioner Flags and Audit Decision

In response to an anonymous complaint received by the Billing Integrity Program (BIP), s.22 was issued an education letter by BIP in June 2008 advising him that he must be physically present for services billed under Fee Item 02042 (Quantitative Perimetry exam) and Fee Item 22067 (Comprehensive Retinal Nerve Fibre Layer Photography). Following that educational letter, s.22 2009 practitioner profile was reviewed by the BIP Medical Consultant in 2010.

MSP prepares standard practitioner profiles that compare totals and ratios pertaining to patients, services, and costs, to peer group averages. In order to facilitate easier comparisons of individual practitioner statistics to peer group statistics, flags are raised when certain statistical parameters exceed specified values.

Based on the BIP Medical Consultant's review of the 2009 practitioner profile, s.22

- ranked in the top 4 of his peers under fee items: 22118 (Post Laser follow-up), 22114 (Laser Tabeculoplasty), 22115 (YAG Laser Capsulotomy), 02043 (Comprehensive Quantitative Perimetry), and 22067 (Comprehensive Retinal Nerve Fibre Layer Photography), in terms of services, costs, and number of patients; and
- stood 2 to 6 standard deviations above the average of his colleagues billing the above fee items.

Additionally, a review of his 2009 Daily Distribution of Services by the BIP Medical Consultant showed some days where very high volumes of patients were seen, notably:

- 9 days where greater than 150 patients were seen
- a peak day when 170 patients received services.

For these high volume days, many of the MSP billings were for services which could be delegated by s.22 to an assistant, (Fee Item 02043 and Fee Item 22067) subject to him being physically present when these procedures were performed.

Accordingly, based on the above flags, s.22 was referred by the BIP Medical Consultant to the Audit and Inspection Committee (AIC) in December 2010.

As a result of that referral, the AIC directed in January 2011 that an on-site audit should be undertaken of s.22 billing practices, to include, but not be limited to, the medical necessity, accuracy of billing and frequency of:

- Service Code 28 (Miscellaneous and other visits) – includes Fee Item 22118;
- Service Code 43 (Surgery – Excisional, Major) – includes Fee Item 22114 and Fee Item 22115; and
- Service Code 89 (Diagnostic Ophthalmology) – includes Fee Item 02043 and Fee Item 22067

Objectives

The audit was performed under the authority of Section 36 of the *Medicare Protection Act* and the general direction of MSP. The objectives of the audit were to determine whether:

1. Medical records existed to support that services were rendered for the dates of service that claims paid were paid;
2. Complete and legible medical records were maintained by the medical practitioner;
3. Services rendered were benefits and otherwise claimable under the *Medicare Protection Act*;
4. Fee items claimed were consistent with the services described in the medical records;
5. Services claimed were provided by the practitioner;
6. Services claimed did not overlap with alternate, provincially-funded payment arrangements;
7. Beneficiaries were not extra billed for, or in relation to, benefits under the *Medicare Protection Act;*
8. Potential quality of care concerns existed; and
9. Patterns of practice or billing (including service frequency) were justifiable.

Audit Methodology and Scope

The audit was carried out in order to achieve the objectives outlined above and employed random dollar-unit sampling methodology. Dollar-unit sampling is a standard method used in financial auditing in which individual dollars, rather than individual patients, are the sampling unit. Samples that are based on dollar-unit sampling generally produce more precise results than samples in which patients are the sampling unit.

Under this methodology, a sampled dollar is traced back to the patient to whom it corresponds, and all claims arising from that patient are reviewed. Because there are usually many dollars corresponding to the same patient, it is possible that different sampled dollars may trace back to the same patient. Sampling with replacement is applied and is mathematically dealt with using the appropriate statistical formula. Therefore, the fact that an individual may be selected more than once introduces no bias into the estimate of proportion of errors.

The sample was selected from all billings paid to s.22 by MSP during the period of July 1, 2006 to June 30, 2011. The initial dollar unit sample was comprised of 44 patients (no repeat patient samples) with 838 services, totalling $59,379.48.

Audit Team

The audit team was comprised of two inspectors: s.22 an Ophthalmologist, and s.22 Senior Auditor, BIP.

s.22 was responsible for examining the medical charts. s.22 was responsible for the overall planning, fieldwork, and reporting of the audit.

Audit Co-operation

The on-site audit of s.22 billings was conducted from July 27 to 29, 2011. During the visit, we found s.22 and his staff to be helpful and co-operative. We were given immediate access to all available records requested and s.22 provided the audit team with an overview of his practice. s.22 office manager was helpful in retrieving the patient files requested and in providing explanations and locating additional information to support services billed to MSP and privately to patients. s.22 was also available at the end of the visit for an exit interview to discuss the preliminary findings.

On September 23, 2011 BIP provided s.22 with a list of 146 possible billing errors and asked for any additional medical records with respect to them to be provided within 30 days. We received a response from s.22 on October 31, 2011.

Upon review of s.22 response documents on December 2, 2011, BIP requested further explanation on the private billing facility fees and intraocular lens fees indicated. s.22 responded promptly with a letter received on December 15, 2011.

In the interim BIP sent a letter to s.22 on June 14, 2012 requesting sample invoices on his purchases of intraocular lenses to determine mark-up on the supply cost of the intraocular lens. Subsequently, we received the sample invoices from Harper Grey (on behalf of s.22) on July 13, 2012. s.22 examined s.22 response in September 2012. All the information submitted by s.22 has been considered for the purpose of the audit report.

The final error list was compiled in February 2013.

B. FINDINGS AND CONCLUSIONS

The table below provides a summary of the services included in the sample of 44 patients by service code.

Service Code	Fee Item – Description	# Service Units	$ Value
22	Consultation (Full minor repeat specialist)	57	4,920.99
28	Miscellaneous and other visits	24	781.44
43	surgery (non-minor, excisional)	144	31,308.06
89	Diagnostic Ophthalmology	1534	18,274.42
All Other Service Codes		79	4,094.57
	TOTAL	**838**	**$59,379.48**

OBJECTIVE 1: To determine whether medical records existed to support that services were rendered for the dates of service that claims were paid.

We identified three service units billed with a total value of $42.31, where a medical record was not found to substantiate the billing. As no medical record was found to substantiate the billing, all three service units were deemed not to have been rendered.

The service units deemed not rendered are summarized as follows by fee item:

Fee Item	Fee Item Description	# of Service Units Not Rendered	$ Value of Services Not Rendered
02019	Tonometry	3	$42.31

OBJECTIVE 2: To determine the extent to which complete and legible medical records were maintained by the medical practitioner.

We identified three service units, with a total value of $70.82, where the medical records were incomplete to substantiate the billing under any fee items.

As the requirements of the *MSC Payment Schedule* were not met to substantiate the billing, the services were deemed not to have been rendered.

We found that the medical records were not very legible and were only able to accept the billing as not being in error after s.22 supporting response to the preliminary error list.

The services deemed not rendered are summarized as follows by fee items:

Fee Item	Fee Item Description	# of Service Units Not Rendered	$ Value of Services Not Rendered
02015	Eye Examination (Refraction, Opthalmoscopy)	1	48.90
02146	Trichiasis	2	21.92
	Total	**3**	**70.82**

Additionally, we noted where the medical records were frequently sparse in terms of:

- comment on the results of visual field tests (Fee Item 02043) or optic nerve imaging (Fee Item 22067)
- no practitioner initials to confirm review of the imaging and visual field reports
- measurements of corneal thickness (Fee Item 22016 - pachymetry)
- no chart record of:
  - pre treatment patient complaints or visual acuities
  - post treatment visual acuities except auto refraction, in regards to Fee Item 22115 - Laser Capsulotomy.

OBJECTIVE 3: To determine whether the services were benefits and otherwise claimable under the *Medicare Protection Act.*

We did not identify any billed services which were not benefits and otherwise claimable under the *Medicare Protection Act.*

OBJECTIVE 4: To determine whether fee items claimed were consistent with the services described in the medical records.

We identified one service where the fee items claimed were not consistent with the services described in the medical records. This resulted in a total error of $48.90, before making any necessary adjustments to account for alternate fee items which should have been claimed instead. After such adjustments the total net error (dollars overpaid) was $22.27. In this instance, the service recorded in the medical records did not meet the requirements of the *MSC Payment Schedule* for the fee item billed.

The following table summarizes the claims in error by fee item:

Fee Item	Fee Item Description	# of Service Units Billed Improperly	$ Value of Services Billed Improperly
02015	Eye Examination (Refraction, Opthalmoscopy)	**1**	**$22.27**

OBJECTIVE 5: To determine whether the services claimed were provided by the practitioner making the claim.

With the permissible exception of the delegated procedures performed by other staff members, we found no evidence to suggest that anyone other than s.22 provided the services that were billed to MSP under his practitioner number.

With regard to those delegated procedures, we determined that s.22 was on-site at the time of the diagnostic tests.

OBJECTIVE 6: Services claimed did not overlap with alternate provincially funded payment arrangements;

We identified where s.22 received no alternate provincially funded payments in the audit period.

OBJECTIVE 7: Beneficiaries were not extra billed for, or in relation to, benefits under the *Medicare Protection Act.*

We identified 55 instances of extra billings totaling approximately $18,155 in conjunction with our audit sample of 44 patients.

The extra billings are summarized as follows:

- 44 instances of intraocular soft lens upgrades being charged a mark-up from supply cost of between approximately 73% and 187%, depending on the type of soft lens. After allowing for a recovery of the supply costs, plus, a 10% overhead applied to that cost, we estimated an extra billing of $13,726 and;

- 11 instances of facility fees charged for eye surgeries performed at s.22 totaling $4,430.

Minute 95-1147 of the Medical Services Commission permits only material upgrades in relation to rendering a benefit to be charged on a cost recovery basis, versus a profit basis. That minute also expressly prohibits the charging of facility fees

s.22 explained that the facility fee:

- covers the cost of performing the surgeries at his private surgery facility s.22 s.22 including nurses and support staff salaries, building rent, College licensing fees, equipment purchase and maintenance, medications and cataract surgery disposables, and
- increased from $350 to $450 in September 2008 due to cost increases.

OBJECTIVE 8: To determine whether potential quality of care concerns existed.

With the exception of the missing, incomplete, or difficult to read medical records referred to under Objectives 1, and 2, we found no other potential quality of care concerns with respect to s.22 practice.

Based on those exceptions, the ability of a similarly qualified practitioner to assume care of s.22 patients could be significantly compromised.

OBJECTIVE 9: To determine whether the pattern of practice or billing (including service frequency) were justifiable.

We identified where s.22 pattern of practice and billing was not justified in terms of the nature and extent of:

- medical record errors and expenditures reported under Objectives 1 and 2;
- the extra billings reported under Objective 7; and
- nine unnecessary service units billed and paid less than five different fee items, with a total value of $547.55.

These nine services are summarized as follows by fee item:

FEE ITEM	FEE ITEM DESCRIPTION	# OF SERVICE UNITS NOT BENEFITS	$ VALUE OF SERVICES NOT BENEFITS
00094	YAG LASER TRAY SERVICE FEE	1	61.57
22115	CAPSULOTOMY	3	313.17
22067	COMPUTERIZED RETINAL NERVE FIBRE LAYER PHOTOGRAPHY	2	127.84
02038	KERATOMETRY	1	15.33
02019	Tonometry	2	29.64
TOTAL		9	**$547.55**

The four services billed under Fee Item 00094 or Fee Item 22115 served to maximize billing costs to MSP without either:

- changing risk or improving patient safety; or
- there being a documented need

The two service units billed under Fee Item 22067 were reportedly performed on one patient, even though the test was technically poor for them.

The one service unit billed under Fee Item 02038 for Keratometry test was not necessary, as it was performed 19 days earlier on the patient.

The two service units billed under Fee Item 00219 were performed too frequently.

B. CONCLUSIONS

The examination of the medical records of 44 patients with 838 claims totaling $59,379.48 resulted in the identification of inappropriate billings for 16 services with a net error value of $682.95.

The table below identifies the inappropriate MSP billings by audit objective:

OBJECTIVE	# OF SERVICE UNITS	DOLLAR VALUE
1 – Services Not Rendered	3	42.31
2 – Records Incomplete & Illegible	3	70.82
4 – Billed Inappropriately	1	22.27
9 – Pattern of Practice or Billing including service frequency not justified	9	547.55
Total Sample Error	**16**	**$682.95**

The total error percentages in the sample testing based on services is 1.91% (16/838) and on dollars is 1.15% ($682.95/$59,379.48).

Additionally, significant extra billings were identified in conjunction with the 44 sample patients.

s.22 s.22

Medical Inspector

Date: March 13, 2013

Senior Auditor

Date: March 21/2013

s.22

Practitioner # s.22

General Practitioner

Audit Report
For The Period

August 1, 2007 to July 31, 2012

Billing Integrity Program
Audit and Investigations Branch
Ministry of Health

A. INTRODUCTION

Practitioner Background

s.22 (practitioner #s.22) is a general practitioner, with a medical practice, scheduled seven days a week, in Vancouver BC. He does not share a practice with any other physician. s.22 has no disciplinary actions by the College of Physicians and Surgeons of BC.

The Medical Services Plan (MSP) paid s.22 for the following fee-for-service billings during the five-year audit period August 1, 2007 to July 31, 2012:

Audit Scope Period Per 12 Months	# of Service Units	MSP Paid Amount
08-01-2007 to 07-31-2008	20,968	639,891.87
08-01-2008 to 07-31-2009	23,861	749,737.72
08-01-2009 to 07-31-2010	26,366	836,535.91
08-01-2010 to 07-31-2011	26,343	899,384.46
08-01-2011 to 07-31-2012	25,834	895,491.21
TOTAL:	**123,372**	**$4,021,041.17**

There is no record of s.22 having received funding from the Ministry of Health under the Alternative Payment Program or other public bodies.

Practitioner Flags and Audit Decision

s.22 came to the attention of the Billing Integrity Program (BIP) as a result of a project undertaken by the BIP Research Officer, ranking him fourth among general practitioners for MSP billings in 2011. As a result, the BIP Medical Consultant reviewed s.22 2010 practitioner profile and Daily Distribution of Services Report.

MSP prepares standard practitioner profiles that compare totals and ratios pertaining to patients, services, and costs, to peer group averages. In order to facilitate easier comparisons of individual practitioner statistics to peer group statistics, flags are raised when certain statistical parameters exceed specified values.

Regional Examinations

s.22 2010 practitioner profile flagged for Service Code 01, Regional Examinations (regular office visits), ranking out of 4,233 practitioners as follows:

- Number one for services provided and costs; and
- Number 115 for number of patients receiving the service.

High-volume Practice

s.22 ; billed a very large volume of office visits (21,993) in 2010. A review of the diagnostic codes associated with the office visits showed that 4,856 or 19.0 percent were associated with diagnostic code 460 - common cold or 477 - allergic rhinitis.s.22 practice appears to be a high volume, low intensity type. He does relatively very few complete physical examinations or prolonged counselling visits (155 and 83 respectively in 2010).

s.22 Daily Distribution of Services Report shows that he usually works a seven-day week, seeing a large volume of patients per day and taking very few days off during the year. As an example, in January 2010, s.22 billed for seeing patients every day of the month and saw an average of 69 patients per day, with a peak volume of 79 patients seen on Friday, January 15, 2010.

Based on the above flags, s.22 was referred by the BIP Medical Consultant to the Audit and Inspection Committee (AIC) in May 2012.

As a result of that referral, the AIC directed that an on-site audit should be undertaken of s.22 billing practices, to include, but not be limited to, the medical necessity, accuracy of billing and frequency of Service Code 01 – Regional Examinations (regular office visits).

Following audit approval and the on-site audit a complaint was received alleging a wide range of inappropriate MSP billing practices by s.22 as well as quality of care concerns. The complaint did not provide specific service examples to test but the concerns raised have been taken into account for purposes of this audit report.

Audit Authority and Objectives

The audit was performed under the authority of Section 36 of the *Medicare Protection Act (the Act).*

The objectives of the audit were to determine whether:

1. Medical records existed to support that services were rendered for the dates of service that claims were paid;
2. Complete and legible medical records were maintained by the medical practitioner;
3. Services rendered were benefits under *the Act*;
4. Fee items claimed were consistent with the services described in the medical records;
5. Services claimed were provided by the practitioner;
6. Services claimed overlapped with alternate, provincially-funded payment arrangements;
7. Beneficiaries were extra billed for, or in relation to, benefits under *the Act;*
8. Potential quality of care concerns existed; and
9. Patterns of practice or billing (including service frequency) were justifiable.

Audit Methodology and Scope

The audit was carried out in order to achieve the above objectives and employed a random dollar-unit sampling methodology. Dollar-unit sampling is a standard method used in financial auditing in

which individual dollars, rather than individual patients, are the sampling unit. Samples that are based on dollar-unit sampling generally produce more precise results than samples in which patients are the sampling unit.

Under this methodology, a sampled dollar is traced back to the patient to whom it corresponds, and all claims arising from that patient are examined. Because there are usually many dollars corresponding to the same patient, it is possible that different sampled dollars may trace back to the same patient. Sampling with replacement is applied and is mathematically dealt with using the appropriate statistical formula. Therefore, the fact that an individual may be selected more than once introduces no bias into the estimate of proportion of errors.

The sample was selected from all billings paid to s.22 by MSP during the period of August 1, 2007 to July 31, 2012. The initial dollar-unit sample was comprised of 50 patients (no repeats) with 1,804 services, totalling $68,421.65.

Audit Team

The audit team was comprised of two inspectors: s.22 a general practitioner and s.22 BIP Senior Auditor.

s.22 was responsible for examining the medical charts. s.22 was responsible for the overall planning, fieldwork, and reporting of the audit.

Audit Co-operation

The on-site audit of s.22 billings was conducted on November 21 to 23, 2012. During the audit visit, we found s.22 to be helpful and co-operative. We were given immediate access to all available records requested and s.22 provided the audit team with an overview of his practice. s.22 was also available at the end of the on-site visit for an exit interview to discuss the preliminary findings. s.22 office manager was helpful in retrieving the patient files requested and in providing explanations and locating additional information to support services billed to MSP and privately to patients.

In February 2013, BIP provided s.22 with a list of possible billing errors and asked for any additional medical records to support the errors to be provided within 30 days. In March 2013, BIP received a response from s.22 office manager, on his behalf, unsigned. The information submitted under that response was examined by s.22 and has been considered for the purpose of the audit report.

B. FINDINGS

High-Volume Practice

A review of the Daily Distribution Service Report for the audit period indicates that there were 1,662 dates where s.22 exceeded daily service limits, after excluding Service Code 07 (Institutional Visit) services. Accordingly, some discounts to MSP payments (referred to as Total Daily Relative Value Discounts) would be expected to have applied under the following service unit thresholds:

	Discount Rate	Payment Rate
• 51 to 65	50%	50%
• 66 and greater	100%	0%

During the on-site interview, s.22 explained to the inspectors that his high-volume practice is mainly driven by being located in an under-serviced urban area. s.22 frequently exceeds the Daily Volume Payment Limitations.

During the on-site visit at s.22 clinic, inspectors found:

- The clinic includes three patient rooms, one minor surgery room, one lunch room, one office room and one patient waiting room; and
- The staffs in the clinic complained about the high volume.

Sample

The table below provides a summary of the services included in the sample of 50 patients by fee item and Service Code 01, as identified in the AIC audit approval.

FEE ITEMS	DESCRIPTION	# OF SERVICE RENDERED	$ VALUE OF SERVICE RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
00100	VISIT IN OFFICE (AGE 2 - 49)	476	11,989.67
15300	VISIT IN OFFICE (AGE 50-59)	122	3,687.00
16100	VISIT IN OFFICE (AGE 60-69)	398	12,353.63
17100	VISIT IN OFFICE (AGE 70-79)	328	10,938.03
18100	VISIT IN OFFICE (AGE 80+)	96	4,021.27
OTHER FEE ITEMS		14	584.74
OTHER SERVICE CODES			
00010	INJECTION, INTRAMUSCULAR	31	314.70
00015	INJECTION, INTRA-ARTICULAR - ALL OTHER JOINTS	12	188.01
00044	MINI TRAY FEE	3	14.50
00090	MAJOR TRAY	16	468.36
00117	ECG INTERPRETATION ONLY G.P.	22	211.30
00120	INDIVIDUAL COUNSELLING IN OFFICE (AGE 2-49)	3	127.80
06069	EXCISION OF TUMOR OR SMALL SCAR - FACE	2	144.88
13005	TELEPHONE ADVICE ABOUT A PATIENT IN COMMUNITY CARE	37	543.39
13136	ANNUAL COMPLEX CARE BLOCK FEE (AGE 60-69)	1	192.48
13611	MINOR LACERATION/FOREIGN BODY REQUIRING ANAES.	3	186.76
13620	EXCISION TUMOR OF SKIN/SCAR UP TO 5CM	9	548.75
13621	EXCISION ADDITIONAL TUMOR OF SKIN/SCAR UP TO 5CM	2	62.16
14030	MAJOR COMPLEX CARE PLAN	1	100.00
14033	ANNUAL COMPLEX CARE MANAGEMENT FEE	47	14,805.00
14050	GP ANNUAL CHRONIC CARE BONUS - DIABETES MELLITUS	39	4,875.00
14560	ROUTINE PELVIC EXAM INCLUDING PAP	3	88.18
15100	GLUCOSE - SEMIQUANTITATIVE	75	260.08
15120	PREGNANCY TEST, IMMUNOLOGIC, URINE	16	167.50
17120	INDIVIDUAL COUNSELLING IN OFFICE (AGE 70-79)	1	67.06
18101	COMPLETE EXAMINATION IN OFFICE (AGE 80+)	1	99.29
OTHER FEE ITEMS		46	1,382.11
TOTAL		1,804	$68,421.65

OBJECTIVE 1: To determine whether medical records existed to support that services were rendered for the dates of service that claims were paid.

We identified 58 service units, with a total value of $1,094.30, where a medical record was not found to substantiate the services. As no medical record was found to substantiate the services, in all 58 instances the services were deemed not to have been rendered.

The services deemed not rendered are summarized as follows, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
00100	VISIT IN OFFICE (AGE 2 - 49)	3	59.59
15300	VISIT IN OFFICE (AGE 50-59)	1	16.30
16100	VISIT IN OFFICE (AGE 60-69)	2	68.12
17100	VISIT IN OFFICE (AGE 70-79)	3	56.41
OTHER SERVICE CODES			
00015	INJECTION, INTRA-ARTICULAR - ALL OTHER JOINTS	3	45.13
00117	ECG INTERPRETATION ONLY G.P.	19	182.19
13005	TELEPHONE ADVICE ABOUT A PATIENT IN COMMUNITY CARE	2	29.62
14030	MAJOR COMPLEX CARE PLAN	1	100.00
14033	ANNUAL COMPLEX CARE MANAGEMENT FEE	1	315.00
14050	GP ANNUAL CHRONIC CARE BONUS - DIABETES MELLITUS	1	125.00
15100	GLUCOSE - SEMIQUANTITATIVE	19	66.40
15120	PREGNANCY TEST, IMMUNOLOGIC, URINE	3	30.54
TOTAL		**58**	**1,094.30**

Visit in Office

The nine Visit-in-Office fee item errors related to missing chart entries, as opposed to missing charts. For the nine errors, there were no billings for a patient's family member on the same date, and two sample patients were recorded on the appointment book.

A concurrent Service Verification Audit (SVA) was conducted for 42 out of 50 sample patients who had MSP services claimed by s.22 in the period of August 11, 2011 to July 31, 2012. Of the 20 usable returns, no irregularities were identified. For the nine errors identified above, two were covered by the service verification conducted but generated no usable return due to letter not being deliverable.

Complex and Chronic Care

The complex and chronic care fee item errors relate to missing care plans and flow charts.

ECG Interpretation and Glucose, Semi-quantitative

The ECG interpretation fee item errors related to billings with no ECG interpretation on record. The glucose fee item errors related to billings not supported by blood sugar results.

OBJECTIVE 2: To determine the extent to which complete and legible medical records were maintained by the medical practitioner.

Completeness

With the possible exception of the missing records identified under Objective 1, and records not supporting rendering of a benefit under Objective 3, we otherwise found the records were complete enough to support a claim under MSP.

Legibility

We identified two service units, with a total value of $34.07, where the medical records were not legible to substantiate billing under any fee items. As the requirements of the *Medical Services Commission (MSC)Payment Schedule* were not met to substantiate the billing, the services were deemed not to have been rendered.

The services deemed not rendered because the medical records were not legible are summarized as follows, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
17100	VISIT IN OFFICE (AGE 70-79)	1	19.26
OTHER SERVICE CODES			
13005	TELEPHONE ADVICE ABOUT A PATIENT IN COMMUNITY CARE	1	14.81
TOTAL		**2**	**$34.07**

OBJECTIVE 3: To determine whether the services were benefits under *the Act*.

We identified 71 service units, with a total value of $9,233.07, where the billed services described in the medical records were not benefits under *the Act*.

The services deemed not benefits are summarized as follows, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
00100	VISIT IN OFFICE (AGE 2 - 49)	1	28.90
13136	ANNUAL COMPLEX CARE BLOCK FEE (AGE 60-69)	1	192.48
18100	VISIT IN OFFICE (AGE 80+)	1	44.67
OTHER SERVICE CODES			
00090	MAJOR TRAY	7	203.63
06069	EXCISION OF TUMOR OR SMALL SCAR - FACE	2	144.88
13005	TELEPHONE ADVICE ABOUT A PATIENT IN COMMUNITY CARE	28	411.50
13620	EXCISION TUMOR OF SKIN/SCAR UP TO 5CM	5	300.77
13621	EXCISION ADDITIONAL TUMOR OF SKIN/SCAR UP TO 5CM	1	31.24
14033	ANNUAL COMPLEX CARE MANAGEMENT FEE	25	7,875.00
TOTAL		**71**	**$9,233.07**

The fee items identified as errors are mainly because the records do not support a benefit claimable under *the Act* in terms of:

- Incorrect diagnostic codes indicated (Fee Item 14033 claims)
- No pathology reports (minor surgery and tray fee claims)
- Patients not in community care (Fee Item 13005 claims)

For example, in regard to incorrect diagnostic codes indicated under the Fee Item 14033 - Annual Complex Care Management Fee, we noted instances of s.22 specifying a congestive heart failure plus diabetes condition where the patient medical records indicated the conditions of hypertension and diabetes.

OBJECTIVE 4: To determine whether fee items claimed were consistent with the services described in the medical records.

We identified seven service units where the fee items claimed were not consistent with the services described in the medical records. This resulted in a total error of $268.82, before making any necessary adjustments to account for alternate fee items which should have been claimed instead. After such adjustments the total net error (dollars overpaid) was $130.69. When applicable, Total Daily Relative Value Discounts were taken into account. In all instances, the services recorded in the medical records did not meet the requirements of the *MSC Payment Schedule* for the fee items billed.

The following table summarizes the claims in error, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE RENDERED	$ VALUE OF SERVICE IN ERROR	LESS CORRECTED VALUE ADJUSTMENTS	$ VALUE OF SERVICE OVERPAID
SERVICE CODE 1, REGIONAL EXAMINATIONS					
00100	VISIT IN OFFICE (AGE 2 - 49)	1	29.79	10.20	19.59
OTHER SERVICE CODES					
00015	INJECTION, INTRA-ARTICULAR - ALL OTHER JOINTS	3	47.52	30.30	17.22
00120	INDIVIDUAL COUNSELLING IN OFFICE (AGE 2-49)	1	25.16	14.45	10.71

17120	INDIVIDUAL COUNSELLING IN OFFICE (AGE 70-79)	1	67.06	38.51	28.55
18101	COMPLETE EXAMINATION IN OFFICE (AGE 80+)	1	99.29	44.67	54.62
TOTAL		**7**	**$268.82**	**$138.13**	**$130.69**

The inappropriate billings identified above notably included medical records only supporting:

- An office visit, where counseling or a complete examination had been claimed; and
- An injection (intramuscular), where an injection (intra-articular) had been claimed.

OBJECTIVE 5: To determine whether the services claimed were provided by the practitioner making the claim.

We identified 16 service units, with a total value of $453.20, where someone other than s.22 provided the services that were billed to MSP under his practitioner number.

The following table summarizes the claims in error, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
00100	VISIT IN OFFICE (AGE 2 - 49)	9	253.22
15300	VISIT IN OFFICE (AGE 50-59)	3	81.88
17100	VISIT IN OFFICE (AGE 70-79)	1	38.70
18100	VISIT IN OFFICE (AGE 80+)	1	44.67
OTHER SERVICE CODES			
00044	MINI TRAY FEE	1	4.94
14560	ROUTINE PELVIC EXAM INCLUDING PAP	1	29.79
TOTAL		**16**	**$453.20**

The medical record entries for the above services were not made in s.22 handwriting. Per the response to the possible billing errors submitted by s.22 office manager, on his behalf, these entries were made by a medical student under s.22 supervision and then co-signed by s.22 When comparing the medical records scanned on-site to the copies submitted with the error response, we found subsequent changes made to the medical records as follows:

- Additional clinical notes were added for one of the items also inconsistent with s.22 handwriting; and
- s.22 apparent initials were added for five of the sixteen error items.

Our findings under Objective 5 are in part corroborated by a complaint received that persons under s.22 mentorship see patients alone without his supervision.

All 14 of the Visit in Office fee item errors identified above were covered by the concurrent SVA conducted. Ten were confirmed by the beneficiaries that the services were rendered by s.22 and four were unverifiable with three undeliverable and one no return.

The question asked by the SVA was: "Did you receive this service by s.22 ?"

OBJECTIVE 6: To determine whether services claimed overlapped with provincially funded alternate payment arrangements;

We found no evidence that s.22 received other provincial funding as an alternative to MSP fee-for-service.

OBJECTIVE 7: To determine whether beneficiaries were extra billed for, or in relation to, benefits under *the Act*.

We found one service unit, with total value of $10.20, where the medical record showed that beneficiary was billed for $10, either for, or in relation to, the benefit under *the Act*.

The following table summarizes the claims in error, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 44, MINOR SURGERY, MINOR THER. PROCEDURES			
00010	INJECTION, INTRAMUSCULAR	1	10.20
TOTAL		**1**	**$10.20**

The error was found per a notation in the medical record without supporting description. s.22 did not respond to this exception when responding to the list of the possible errors.

OBJECTIVE 8: To determine whether potential quality of care concerns existed.

We determined that potential quality of care concerns existed in terms of:

- The nature and extent of missing medical records, as noted under Objectives 1 and 3;
- Medical services being apparently rendered by a medical student without supervision by s.22 at the time, as noted under Objective 5;
- Apparent subsequent altering of the medical records in response to our audit findings, as noted under Objective 5;
- Delegating of vaccine injections to unqualified staff members;
- The limited amount of scheduled service, typically five minutes per patient as per the appointment book, under a high-volume practice; and
- A complaint received corroborating much of the above matters.

OBJECTIVE 9: To determine whether the pattern of practice or billing (including service frequency) were justifiable.

We found s.22 pattern of practice and billing were not fully justifiable in terms of the medical records missing or not supporting fee item claimed and services rendered by someone other than himself, as identified under Objectives 1, 3 and 5, respectively.

Additionally, in terms of frequency, we identified six service units, with a total value of $147.69, where the same patient was seen by s.22 multiple times within two to six days with no clear basis for the repeated visits.

The following table summarizes the claims in error, based on over frequency, by fee item:

FEE ITEM	DESCRIPTION	# OF SERVICE NOT RENDERED	$ VALUE OF SERVICE NOT RENDERED
SERVICE CODE 1, REGIONAL EXAMINATIONS			
00100	VISIT IN OFFICE (AGE 2 - 49)	5	131.07
16100	VISIT IN OFFICE (AGE 60-69)	1	16.62
TOTAL		**6**	**$147.69**

C. CONCLUSIONS

The examination of the medical records of 50 patients with 1,804 service units totaling $68,421.65 resulted in the identification of inappropriate billings for 161 service units with a net error value of $11,103.22.

The table below identifies the inappropriate billings by audit objective:

Objective	# of Service Units	MSP Paid Amount
1 – Services Not Rendered	58	1,094.30
2 – Records Not Legible	2	34.07
3 – Not MSP Benefits	71	9,233.07
4 – Billed Inappropriately	7	130.69
5 – Service Not Provided by the Practitioner	16	453.20
7 – Extra billed for MSP Benefits	1	10.20
9 – Pattern of practice/billing, Service Frequency	6	147.69
Total Sample Error	**161**	**$11,103.22**

The total error percentages based on service units is 9 percent (161/1,804) and on dollars is 16 percent ($11,103.22/$68,421.65).

Overall, we found s.22 **pattern of practice and billing were not fully justifiable in terms of the nature and extent of errors identified under Objective 1, 3, and 5. As well, we identified some potential quality of care concerns as outlined under Objective 8.**

s.22

Medical Inspector

Date: 23 Oct 2013

s.22

Senior Auditor

Date: 31 Oct 2013

s.22

PRACTITIONER # s.22

OPHTHALMOLOGIST

AUDIT REPORT

FOR THE PERIOD
MARCH 1, 2009 to FEBRUARY 28, 2014

Billing Integrity Program
Audit and Investigations Branch
Ministry of Health

s.22

Audit Report
For the period March 1, 2009 to February 28, 2014

A. INTRODUCTION

Practitioner Background

s.22 is an ophthalmologist, practicing in s.22 BC. His two listed addresses are s.22

The Medical Services Plan (MSP) paid s.22 for the following fee-for-service (FFS) billings during each 12 months of the five-year audit period, March 1, 2009 to February 28, 2014:

Year	# of Service Units	FFS Value
March 1, 2009 to February 28, 2010	18,389	$1,228,984.74
March 1, 2010 to February 28, 2011	18,879	1,218,738.13
March 1, 2011 to February 28, 2012	18,506	1,235,845.50
March 1, 2012 to February 28, 2013	15,004	1,064,662.88
March 1, 2013 to February 28, 2014	15,443	1,016,510.05
Total:	**86,221**	**$5,764,741.30**

s.22 total MSP payments by payee breakdown as follows for the audit period:

Payee Number	Payee Name	# of Service Units	FFS Value
s.22	s.22	86,144	$5,760,467.93
s.22	s.22	77	$4,273.37
	Total:	**86,221**	**$5,764,741.30**

Other Provincial Funding

For the audit period s.22 also received other Ministry of Health funded or administered payments, as follows:

- Interior Health of $10,677.21, for the Medical On-Call Availability Program, an administration stipend and diagnostic payments;
- WorkSafe BC of $1,502.56; and
- Insurance Corporation of BC of $91.51.

Practitioner Flags and Audit Decision

2011 Service Verification Audit

s.22 came to the attention of the Billing Integrity Program (BIP) in 2011 as a result of a routine monthly Service Verification Audit of beneficiaries covering the October 1, 2010 to January 31, 2011 period. Of the 42 usable letters returned, 12 (28.6 percent) reported an irregularity. Five responses raised concerns regarding s.22 billing practices for Fee Item 02007 - Office Visit, in conjunction with the surgery Fee Item 02188 - Cataract Linear Extraction, Congenital, Traumatic. Two of those five responses indicated that the office visit was done the same day as the surgery. For every one of these five beneficiaries, s.22 billed Fee Item 02007 as occurring on the following day.

The Preamble to the *Medical Services Commission (MSC) Payment Schedule* does not permit post-operative visits to be claimed on the same day as a surgery.

Supporting records requested from s.22 for these five responses substantiated the date of service for Fee Item 02188 claimed but did not substantiate an office visit for the subsequent day billed.

As a result of the above concerns, the BIP Medical Consultant reviewed s.22 2010 practitioner profile and FFS billing data.

2010 Practitioner Profile

MSP prepares standard practitioner profiles that compare totals and ratios pertaining to patients, services, and costs, to peer group averages. In order to facilitate easier comparisons of individual practitioner statistics to peer group statistics, flags are raised when certain statistical parameters exceed specified values.

s.22 2010 practitioner profile flagged for the following Fee Items in terms of ranking with his peer group and standard deviations from the group average:

Fee Item	# of Pracs	Ranking			Standard Deviations		
		Services	Cost	Patient	Services	Cost	Patient
02149 - Meibomian Gland Evacuation	73	1	1	1	5	5	6
02035 - Colour Vision Assessment	71	2	2	3	5	5	4
02049 - Potentiometry	85	9	9	7	2	2	2

Billing Data – Fee Item 02007

A review of FFS billing data identified an anomalous increase for Fee Item 02007, between fiscal years 2009/10 and 2010/11, as follows:

Fiscal Year	Number of Service Units
2008/09	3
2009/10	8
2010/11	1,054

Audit Referral and Decision

Based on the above flags, s.22 was referred by the BIP Medical Consultant to the Audit and Inspection Committee (AIC) in October 2011. As a result of the referral, the AIC directed that an on-site audit be undertaken of s.22 billing practices, to include, but not be limited to, the medical necessity, and accuracy of billing and frequency of Fee Items:

- 02007 - Office Visit - Ophthalmology
- 02149 - Meibomian Gland Evacuation
- 02035 - Colour Vision Assessment
- 02049 - Potentiometry

B. AUDIT METHODOLOGY

Authority and Objectives

The audit was performed under the authority of Section 36 of the *Medicare Protection Act ("the Act").*

The objectives of the audit were to determine whether:

1. Medical records existed to support that services were rendered for the dates of service that claims were paid;
2. Complete and legible medical records were maintained by the medical practitioner;
3. Services rendered were benefits under *the Act*;
4. Fee items claimed were consistent with the services described in the medical records;
5. Services claimed were provided by the practitioner;
6. Services claimed overlapped with alternate, provincially-funded payment arrangements;
7. Beneficiaries were billed for, or in relation to, benefits contrary to *the Act;* and
8. Patterns of practice or billing (including service frequency) were justifiable.

Testing Procedures

The audit was performed to meet the above objectives and applied the following testing procedures:

- Review of websites where s.22 practiced;
- Visit to s.22 clinic;
- Interviews with s.22 Office Manager regarding his medical and non-medical practices, including MSP and private billing procedures;
- Review of the billing pattern of Fee Item 02007 paid claims, extending from the audit referral work in this area and changes to the *MSC Payment Schedule*; and
- Under a random dollar-unit sample:
    - Request and exam available medical, and private charge records and, where warranted, the associated appointment/day sheet and supply cost records;
    - Perform an analysis of repeat consultations under fee item 2010; and
    - Seek additional information regarding the nature of services covered under some private charge descriptions.

Random Dollar-Unit Sample

The audit employed a random, dollar-unit sampling methodology without stratification of the paid FFS billing population. Dollar-unit sampling is a standard method used in financial auditing in which individual dollars, rather than individual patients, family groups of patients, or dates of service, are the sampling unit. Samples that are based on dollar-unit sampling generally produce more precise results than samples in which patients are the sampling unit.

Under this methodology, a sampled dollar is traced back to the patient, family group or date of service to which it corresponds, and all claims arising from that trace are examined. Because there are usually many dollars corresponding to the trace, it is possible that different sampled dollars may repeat back to the same patient, family group or date of service. Sampling with replacement is applied and is mathematically dealt with using the appropriate statistical formula. Therefore, the fact that an individual, family group or date of service may be selected more than once introduces no bias into the estimate of proportion of errors.

The sample was selected from all billings paid to s.22 by MSP during the period of March 1, 2009 to February 28, 2014 and each dollar-unit was traced back to a patient. The dollar-unit sample comprised 125 (1 repeat) patients, totalling 2700 service units and $191,622.22, summarized as follows by paid fee item:

Fee Item	Fee Item Description	Service Units	Value
02005	Emergency Visit - Ophthalmology	9	$792.90
02007	**Office Visit - Ophthalmology**	**108**	**3,088.55**
02010	Consultation - Ophthalmology	334	30,339.36
02014	Orthoptic Evaluation	32	1,318.16
02035	**Color Vision Assessment**	**27**	**744.71**
02043	Comprehensive Quantitative Perimetry Examination	205	11,713.83
02049	**Potentiometry**	**87**	**1,888.92**
02090	Intravitreal Injection or Vitreous Paracentesis	92	12,130.20
02149	**Meibomian Gland Evacuation**	**41**	**504.16**
02188	Cataract Linear Extraction, Congenital, Traumatic	116	47,149.33
02190	Introcular Lens Implant - Primary	116	12,497.46
22047	Anterior Segment Gonioscopy	129	932.59
22067	Computerized Retinal Nerve Fibre Layer Photography	413	22,153.94
22114	Laser Trabeculoplasty, Per Eye	62	7,807.04
22115	Capsulotomy - YAG Laser, Per Eye	73	7,620.47
22399	Ophthalmic A-Scan to Determine Length	112	7,068.32
All Other Fee Items		744	23,872.28
	Total:	**2700**	**$191,622.22**

The fee items in bold above represent those flagged in the BIP Medical Consultant's referral to the AIC and were included in their decision to audit s.22 billing practices. The use of bold is repeated in the tables that follow.

None of the patients included in the audit sample overlapped with those reporting irregularities under the 2011 SVA.

Audit Team

The audit team was comprised of four members: s.22 ophthalmologist, s.22 BIP Senior Auditors and s.22 BIP Audit Manager.

s.22 was responsible for examining the medical records. s.22 was responsible for the overall planning, fieldwork, and initial private charge testing and report drafting, up and to his departure from BIP in s.22 and pending s.22 examination of an overdue response to preliminary errors received from s.22 . Following s.22 departure, s.22 helped finalize the audit file and report.

All work completed was done under the supervision of s.22

C. OVERVIEW OF s.22 MEDICAL AND NON-MEDICAL PRACTICES

s.22 practices at three main locations:

- s.22
-
-

Additionally, he has hospital privileges at s.22 and had assigned small amount of FFS payments to s.22

s.22

s.22 is one of two ophthalmologists working at this clinic which is operated on an appointment basis. s.22 performs ophthalmologic services there, exclusive of cataract surgeries.

s.22

s.22 is a community care facility operated by Interior Health. s.22 performs cataract surgeries there.

s.22

Private charge, aesthetic services are provided at this location. The website advertises: s.22
s.22

D. MEDICAL SERVICES PLAN CHANGES

Post-operative Care

Effective April 1, 2010, the Preamble to the *MSC Payment Schedule* changed with respect to surgeries.

Specific to post-operative care, the post-operative period was reduced from 42 days to 14 and made only applicable to in-hospital visits. Accordingly, in-hospital visits relating to post-operative care became eligible to be claimed after 14 days had elapsed and, by default, visits outside of a hospital were eligible to be claimed starting one day following the surgery.

On June 7, 2010, an e-mail sent by the Executive Officer of the BC Society of Eye Physicians and Surgeons advised its members that eligible post-operative care under the above Preamble change could be submitted under Fee Item 02007, retroactive to April 1, 2010.

Intraocular Lenses for Cataract Surgery

Effective June 4, 2012, MSP announced a policy change regarding intraocular lenses. Under the change, the intraocular lenses were to be supplied by the public hospitals and health centres where the cataract surgeries were being rendered, versus by the ophthalmologist.

The policy change specified that beneficiaries opting for the intraocular, foldable monofocal lenses would not be charged for such by the public hospital, on the basis that these lenses had become insurable under MSP. Alternatively, beneficiaries opting for specialty lens would be charged at the supply cost difference between the foldable monofocal lens and specialty lens.

The policy communication also stated that "*If you choose a non-insured (specialty) lens: ...Specific assessments/education, beyond what is provided and covered by MSP in the initial consultation for cataract surgery, are not benefits of MSP and may be billed directly the patient.*"

E. FINDINGS

Audit Co-operation

The on-site audit of s.22 billings was conducted on June 9 to 13, 2014, in s.22 BC.

During the visit to s.22 we were given timely access to most records requested and s.22 provided the audit team with an overview of his practice. s.22 was also available at the end of the on-site visit for an exit interview to discuss the preliminary findings. s.22 Office Manager was helpful in retrieving the patient files requested, providing explanations and locating additional information to support services billed to MSP and privately to patients.

For services claimed by s.22 as rendered at s.22 and s.22 s.22 we requested and obtained the supporting records directly from these facilities. We sent a follow-up request to s.22 on January 8, 2015, seeking three patient chart files that were not present at the time of the audit visit, as well as further details regarding types of private charges. On January, 29, 2015, s.22 legal counsel requested an extension on his behalf to February 20, 2015, for responding to these requests and BIP granted the request. s.22 responded on February 25, 2015.

Preliminary Error List – Medical Records Examination

On May 6, 2015, BIP provided s.22 with a list of possible billing errors, based on the examination of medical records. We asked him to provide any additional medical records to address these matters within 30 days.

On June 5, 2015, BIP received a letter from s.22 legal counsel requesting an extension of the response date, given he had staffing and computer issues and a family scheduling conflict. An extension was granted to July 20, 2015.

On September 24, 2015, BIP received the overdue response from s.22 The response primarily included medical records for OCT (Computerized Retinal Fibre Layer Photography) tests.

We understand these OCT test records were maintained on a separate computer server to which access was not supplied to s.22 during the on-site audit.

The information submitted under s.22 response was examined by s.22 and has been considered for the purpose of this audit report.

Preliminary Error List – Private Charges Examination

On October 22, 2015, BIP provided s.22 with a list of possible billing errors, based on the examination of 48 private charges associated with MSP claims. We asked him to provide any additional documentation that might have a bearing on our private billing assessment within 14 days. On November 6, 2015, BIP received a letter from s.22 legal counsel requesting an extension of the response date, on the basis that more time was required to respond and that a 30 day, versus 14 day timeframe was customary. An extension was granted to November 23, 2015. As of the date of this report, BIP has not received a response to this second preliminary error list.

Appointment and Medical Records

Prior to October 2011, all appointment records were kept electronically at s.22 under a system by Osler and the patient medical records were handwritten on paper charts.

In October 2011, s.22 practice adopted the Accuro electronic medical record (EMR) system for recording both patient appointments and encounters electronically.

Patients seen by s.22 after the implementation of the Accuro EMR had their old paper chart records scanned into the EMR.

s.22 explained that appointment records from the Osler system were not kept after the change to Accuro. In addition, more recent appointment records under the Accuro EMR, entitled as "day sheets" were only available during our on-site audit in June 2014, from October 30, 2012 onwards.

The bylaws of the College of Physicians and Surgeons of British Columbia (CPSBC) required that prior to June 1, 2013 appointment, or equivalent, daily records be retained for a minimum period of seven years and then 16 years subsequently.

Fee Item 02007 Billing Pattern

s.22 paid FFS billings for Fee Item 02007 – Office Visit was as follows by government fiscal year:

Fiscal Year	Number of Service Units
2008/09	3
2009/10	8
2010/11	1,054
2011/12	892
2012/13	662
2013/14	675
2014/15	581

The significant rise and peak in paid claims for 2010/11 started with dates of service in April 2010 and corresponds to the *MSC Payment Schedule* change taking effect April 1, 2010, which permitted post-operative care visits outside of a hospital to begin to occur one day after the surgery.

We discuss our findings and further observations with respect to this fee item under Objectives 1, 2, 4, 5 and 8 below.

Repeat Consultations under Fee Item 02010

Under the random dollar-unit sample, we identified 283 out of a total of 334 service units which constituted multiple billings for respective patients under Fee Item 02010 - Consultation - Ophthalmology.

Of these 283 service units with multiple billings, we identified 46 where a subsequent consultation was billed within 14 days following the six-month anniversary date from the last such consultation for the same condition.

The *MSC Payment Schedule* states that where "*a consultation is repeated for [the] same condition within six months of the last visit to the consultant, or where in the judgment of the consultant the consultative service does not warrant a full consultative fee, a 02011 fee code should be billed.*"

An MSP claim for Fee Item 02011 - Repeat or Limited Consultation - Ophthalmology is about half the cost of a Fee Item 02010 claim.

We discuss our findings and further observations with respect to Fee Item 02010 under Objectives 1, 2, 4, 5 and 8 below.

Refractive and Lens Implant Private Charges

Subsequent to the Ministry policy change taking effect in June 4, 2012, regarding the supply of intraocular lenses in connection to cataract surgeries, s.22 implemented private charges for "Refractive Services" or "Lens Implant and Refractive Services" depending on the lens type opted for by a beneficiary.

These private charges were levied under the name of s.22 and categorized as follows, based on both template and actual invoices we obtained for purposes of determining private billing practices:

- "Premium Pre-operative Refractive Services" (applying to intraocular foldable monofocal lens implants)
- "Toric Intraocular Lens Implant and Refractive Services"
- "Multi focal Intraocular Lens Implant and Refractive Services"

<u>Premium Pre-operative Refractive Services</u>

For beneficiaries choosing the MSP-insured, foldable monofocal lens, s.22 charged $200 per eye, itemized as follows by invoice:

- **"Invoice for Premium Pre-Operative Refractive Services"**
  Refractive Service
  - Laser Axial Length Interpretation* $100.00
  - Pachymetry $25.00
  - Pre-operative Corneal Topography* $75.00

  The above pre-operative refractive interpretation services are beyond the standard measurements for non-insurable foldable lens. These services are all inclusive and cannot be selected individually.

  "*Cognitive services are not listed individually"

Additionally, the invoice listed: "Lens Cost: $N/C (covered by hospital where surgery is performed)."

Based on the above, we noted:
- The explanation to the beneficiary that the lens being opted for under the service is "non-insurable" is incorrect; and
- The three itemized "refractive interpretation services" bear an apparent strong relationship to the respective Fee Items of:
  - 22399 - Ophthalmic A-scan for Determination of Axial Length;
  - 22016 – Pachymetry – Extra (when billed with other eye examinations); and
  - P22075- Computerized Corneal Topography.

<u>TORIC Intraocular Lens Implant and Refractive Services</u>

For beneficiaries choosing the specialty, TORIC intraocular lenses, s.22 charged between $650 and $750.00 per eye, under the description of "**Invoice for Toric ® Intraocular Lens Implant & Refractive Services**".

Each invoice, per eye, listed or explained services similar to the foldable monofocal lens above, with the following differences noted:
- The itemized services:
  - Started with the proviso that each of the listed services may be included in the charge but do not provide charge subtotals by service;
  - Additionally listed services as:
    - Small Incision cataract surgery interpretation*
    - Astigmatic wound location selection*
    - IOL Selection*
    - Possible IOL exchange at no charge*
    - Possible Laser Refractive touch-up (at cost)*
    - Possible AKs and LRIs*
    - Astigmatic Counselling*
    - Astigmatic Wound Analysis*
    - Astigmatic Vector Analysis*
    - Intraoperative Corneal Wound Marking*
    - Intraoperative IOL Positioning*
    - The note: "*Cognitive services are not listed individually"

- The listed lens cost to the beneficiary included a dollar amount, followed by "payable to hospital where surgery is performed".

Multi focal Intraocular Lens Implant and Refractive Services

For beneficiaries choosing the multi focal intraocular lens, s.22 charged between $975 to $1,100 per eye, under the description of "**Invoice for Multi focal Intraocular Lens Implant & Refractive Services**".

Each invoice, per eye, listed or explained services similar to the Toric Lens above but with the following added services included:

- Presbyopic interpretation*
- Multifocal IOL interpretation*
- NeuroAdaption Training*

We discuss our further findings with respect to the above private charges and whether these were contrary to *the Act* under Objective 7 below.

OBJECTIVE 1: **To determine whether medical records existed to support that services were rendered for the dates of service that claims were paid.**

We identified 326 service units, with a total value of $8,912.44, where a medical record was not found to substantiate the service for the date of service claimed, summarized as follows by paid fee item:

Fee Item	Fee Item Description	Service Units	Value
00094	Major Tray	1	$62.19
02007	**Office Visit – Ophthalmology**	**8**	**226.46**
02009	Home Visit – Ophthalmology	1	45.46
02010	Consultation - Ophthalmology	4	365.28
02011	Limited Consultation - Ophthalmology	3	143.67
02014	Orthoptic Evaluation	24	965.58
02017	Oculo-Motor Function Test	19	427.14
02018	Biomicroscopy	10	249.63
02019	Tonometry	27	421.20
02035	**Colour Vision Assessment**	**4**	**120.76**
02038	Keratometry	5	53.67
02043	Comprehensive Quantitative Perimetry Examination	17	1,001.38
02048	Exophthalmometry	2	13.20
02049	**Potentiometry**	**50**	**1,136.40**
02090	Intravitreal Injections or Vitreous Paracetesis	3	395.55
02120	Punctum Dilation and Syringing Sac	3	50.11
02146	Trichiasis - Epilation (Forceps)	1	10.96
02149	**Meibomian Gland Evacuation**	**31**	**361.68**
02171	Pterygium or Limbus Tumor Excision	2	124.50

Fee Item	Fee Item Description	Service Units	Value
22016	Pachymetry - Extra (When Billed with Other Eye Exams)	2	20.00
22046	Posterior Segment Contact Lens Exam	17	93.50
22047	Anterior Segment Gonioscopy	60	424.55
22067	Computerized Retinal Nerve Fibre Layer Photography	9	435.77
22114	Laser Trabeculoplasty, Per Eye	3	377.76
22115	Capsulotomy-YAG Laser, Per Eye	3	313.17
22399	Ophthalmic A-Scan to Determine Axial Length	17	1,072.87
	Total:	**326**	**$8,912.44**

s.22 provided no explanation for the missing records.

In the absence of appointment records, prior to October 30, 2012, we were not always in a position to determine if there otherwise had been a service scheduled and, if so, under what date. Our discussion under Fee Item 02007 below provides a further illustration.

Fee Item 02007

For seven of the eight service unit errors under Fee Item 02007, we noted where there was corresponding surgery Fee Items 02188 and 02190 with dates of service claimed and supported by the medical records which were dated one or two days before that claimed under Fee Item 02007.

For three of those seven service unit errors under Fee Item 02007, we noted from the medical records where a post-operative assessment was documented as instead performed on the same day as the cataract surgery. This same type of issue is also identified under Objectives 2 and 4.

For another of those seven service unit errors, we identified a $35 private charge to the beneficiary for a "Same Day Post-op" with respect to a cataract eye surgery. Alternatively, we noted from the available appointment record (entitled "Day Sheet") where the post-op cataract service described there indicated a date of service occurring one day after the surgery.

Given this private charge for a post-operative service did not have a supporting medical record, we could not determine whether it was for, or in relation to, the cataract surgery benefit.

Fee Item 02014

For the 24 service unit errors under Fee Item 02014, it was observed that there was either no record of orthoptic testing or no record of service in the medical records. These 24 errors represent 75 percent of the total audit sample for this fee item. In addition, 19 of those 24 errors lacked a clinical indication or evidence of medical necessity in the medical records.

Fee Item 02035

For all four service unit errors under Fee Item 02035 there were no records to support that testing was done on the date of service. For two of the errors there was also either a question of clinical indication or no clinical indication for warranting the test, according to the available medical records.

Fee Item 02049

For the 50 service unit errors under Fee Item 02049, there was no record of service provided on the date of service billed. For two service unit errors, the medical records indicated that the service was provided on an earlier date. Additionally, one service unit error had medical records indicating that all other billed services to this patient were provided by s.22 associate.

Fee Item 22399

For the 17 service unit errors under Fee Item 22399, we noted where it was s.22 common practice to bill for the Ophthalmic A-scan Biometry for each patient eye on separate days, when the examination of each eye occurred on the same day. This same type of issue is also addressed under Objective 4.

OBJECTIVE 2: To determine the extent to which complete and legible medical records were maintained by the medical practitioner.

We identified 67 service units, with a total value of $4,325.94, where the medical records were not complete or legible enough to substantiate billing under any fee item, summarized as follows by paid fee item:

Fee Item	Fee Item Description	Service Units	Value
02007	**Office Visit – Ophthalmology**	**2**	**$56.16**
02010	Consultation – Ophthalmology	24	2,161.71
02014	Orthoptic Evaluation	2	94.02
02015	Eye Examination (Refraction, Opthalmoscopy, etc.)	1	48.90
02017	Oculo-Motor Function Test	1	33.84
02018	Biomicroscopy	2	62.66
02035	**Colour Vision Assessment**	**2**	**40.26**
02043	Comprehensive Quantitative Perimetry Examination	4	243.50
02048	Exophthalmometry	2	13.20
02049	**Potentiometry**	**2**	**46.07**
02090	Intravitreal Injections or Vitreous Paracetesis	1	131.85
02149	**Meibomian Gland Evacuation**	**2**	**21.92**
02188	Cataract Linear Extraction Congenital Traumatic	2	845.04
02190	Intraocular Lens Implant – Primary	2	222.42
10001	Specialist Telephone Advice - Response Within 2 Hours	1	60.00
22016	Pachymetry - Extra (When Billed With Other Eye Exams)	5	50.00
22046	Posterior Segment Contact Lens Exam	6	33.00
22047	Anterior Segment Gonioscopy	4	34.36
22067	Computerized Retinal Nerve Fibre Layer Photography	1	63.92
22399	Ophthalmic A-Scan to Determine Axial Length	1	63.11
	Total:	**67**	**$4,325.94**

We found that legibility of the medical records was an issue on those patient charts that were handwritten, prior to s.22 adopting an EMR system in November 2011.

Fee Item 02007

For one of the two service unit errors under Fee Item 02007, we noted where the original recorded date on the medical record coincided with the date of service for the associated cataract surgery recorded there. This was a handwritten medical record which had the date manually overwritten to indicate a next day of service in support of the date of service claimed of MSP under Fee Item 02007. The overwritten date was not initialled or signed for.

For the other service unit in error, the legibility of the medical record was too poor to substantiate a billing under any fee item. In this case there was not an associated cataract surgery claim.

Fee Item 02010

Of the 24 service unit errors under Fee Item 02010, 16 were because there were no consultation letters and 8 because the notes were incomplete or not legible.

For one service unit error under Fee Item 02010, there were minimal chart notes and the chart notes did not support the billing of a full consultation visit for the same problem when the patient had a known stable status and the visit was just over six months past the previous consultation.

Fee Item 02035

For one of two service unit errors under Fee Item 02035, there was no record of test results or interpretation. For the other error, the chart record indicated the service was rendered a week earlier.

Fee Item 02049

For the two service unit errors under Fee Item 02049, there was either no record of, or reference to, a Pinhole Acuity Meter test.

Fee Item 02149

For the two service unit errors under Fee Item 02149, there was either poor medical record legibility and no reference to the service, or the medical record was not complete enough to substantiate a billing under any fee item.

Fee Item 22047

For the four service unit errors under Fee Item 22047, the records were either not legible or complete enough to substantiate a billing under any fee item.

OBJECTIVE 3: To determine whether the services were benefits under *the Act*.

To the extent that medical records were available and complete, we determined that there were no billed services that were not benefits under *the Act*.

OBJECTIVE 4: To determine whether fee items claimed were consistent with the services described in the medical records.

We identified 105 service units where the fee items claimed were not consistent with the services described in the medical records. This resulted in a total error of $5,291.38, before making any necessary adjustments to account for alternate fee items which should have been claimed instead. After such adjustments the total net error (dollars overpaid) was $4,938.45. In all instances, the services recorded in the medical records did not meet the requirements of the *MSC Payment Schedule* for the fee items billed and paid. The following table summarizes the claims in error by paid fee item:

Fee Item	Fee Item Description	Service Units	Total Value Before Adjustments	Adjustment Value	Net Dollars Error Value
02005	Emergency Visit - Ophthalmology	8	$704.80	-	$704.80
02007	**Office Visit – Ophthalmology**	**24**	**667.66**	**165.48**	**502.18**
02010	Consultation - Ophthalmology	7	638.64	-	638.64
02011	Limited Consultation-Ophthalmology	1	47.89	-	47.89
02012	Special Consultation-Ophthalmology	1	119.20	91.51	27.69
02014	Orthoptic Evaluation	3	141.03	33.84	107.19
02017	Oculo-Motor Function Test	1	33.84	-	33.84
02043	Comprehensive Quantitative Perimetry Examination	1	59.65	-	59.65
02049	**Potentiometry**	**5**	**107.50**	-	**107.50**
02171	Pterygium or Limbus Tumor Excision	1	62.25	-	62.25
22016	Pachymetry-Extra (When Billed With Other Eye Exams)	1	10.00	-	10.00
22046	Posterior Segment Contact Lens Exam	3	16.50	-	16.50
22047	Anterior Segment Gonioscopy	7	49.08	-	49.08
22067	Computerized Retinal Nerve Fibre Layer Photography	2	108.94	54.47	54.47
22399	Ophthalmic A-Scan to Determine Axial Length	40	2,524.40	-	2,524.40
	Total:	**105**	**$5,291.38**	**$345.30**	**$4,946.08**

Fee Item 02005

The eight service unit errors under Fee Item 02005 resulted from patient chart notes indicating that the patient was accommodated within the regular office schedule, representing an 88.9 percent sample error rate for this fee item, based on service units.

Fee Item 02007

For the 24 service unit errors under Fee Item 02007, 18 related to post-cataract operation assessments billed one day or more after the actual operation date. However, the medical records indicate that the post-operative assessment was recorded and performed on the same day as the surgery.

For all 24 errors we attempted to match the date of service reported under the billing to the appointment records but were unable to do so because all preceded October 30, 2012, when appointment records were no longer available.

We also describe errors for Fee Item 02007 under audit Objectives 1 and 2 where there was evidence to indicate that office visit occurred on the same day as the surgery but was billed to MSP as being on a subsequent day.

Fee Items 02010, 02011, 02012

Of the nine errors under these consultation fee items, six of them resulted from there being no evidence of a consultation letter being produced. For one of the nine errors, a full consultation (Fee Item 02010) was also billed again and paid for the same problem as previously billed and paid 15 days earlier with/without a consultation letter on file.

Fee Item 02049

All five of the errors under Fee Item 02049 were the result of the medical records indicating that a Pinhole Acuity Test was performed instead of a Potentiometry. This is not considered adequate to justify billing Fee Item 02049. No alternate fee item was applied because Pinhole Acuity Testing is not considered to be a billable service.

Fee item 22047

The seven service unit errors under Fee Item 22047 resulted from either the medical records lacking clinical indication for the Gonioscopy Test, or insufficient justification for the test, including questions of service frequency in the case of one sample patient where the test was claimed on three separate occasions during the audit period.

Fee Item 22067

The two errors under Fee Item 22067 resulted from the medical records lacking clinical indication for the test or that the medical records lacked evidence for the medical necessity of the procedure.

Fee Item 22399

The 40 errors under Fee Item 22399 resulted from the medical records indicating that Ophthalmalic A-scan Biometry was performed on both eyes on the same day, versus them being billed individually on separate dates of service. We have accepted the earlier date of service billing when both eyes were measured, and deemed the subsequent billing of this fee item as an error with no alternate fee item applicable.

OBJECTIVE 5: To determine whether the services claimed were provided by the practitioner making the claim.

We identified 56 service units, with a total value of $3,705.33, where someone other than s.22 provided the services that were billed to MSP under his practitioner number, summarized as follows by paid fee item:

Fee Item	Fee Item Description	Service Units	Value
02007	Office Visit – Ophthalmology	3	$89.38
02010	Consultation – Ophthalmology	16	1,464.16
02018	Biomicroscopy	4	78.34
02019	Tonometry	1	15.67
02035	Colour Vision Assessment	2	60.38
02043	Comprehensive Quantitative Perimetry Examination	9	527.85
02048	Exophthalmometry	1	6.60
02146	Trichiasis – Epilation (Forceps)	1	10.96
02188	Cataract Linear Extraction Congenital Traumatic	1	332.49
02190	Intraocular Lens Implant – Primary	1	87.51
22047	Anterior Segment Gonioscopy	4	29.44
22067	Computerized Retinal Nerve Fibre Layer Photography	8	435.76
22114	Laser Trabeculoplasty, Per Eye	4	503.68
22399	Ophthalmic A-Scan to Determine Axial Length	1	63.11
	Total:	**56**	**$3,705.33**

For all 56 errors, the chart records indicated that the services were performed by another ophthalmologist working in the same office as s.22

OBJECTIVE 6: To determine whether services claimed overlapped with alternate provincially-funded payment arrangements.

We identified where s.22 received only minor, alternate provincial funding for health-related services, according to health authority and Ministry of Health, Physician Compensation Branch reporting sources. As a result, we did not exam further for any possible overlaps with FFS.

OBJECTIVE 7: To determine whether beneficiaries were billed for, or in relation to, benefits, contrary to *the Act*.

We identified 20 service units where beneficiaries were billed for or in relation to benefits, contrary to *the Act* for a total MSP paid claim value of $5,507.29 and private charge value of $9,450.00, summarized as follows by fee item:

Fee Item	Fee Item Description	Service Units	MSP Value	Private Charge Value
02187	Glaucoma – Filtering Procedure, Microscopic	2	$1,263.66	$3,000.00
02188	Cataract Linear Extraction, Congenital, Traumatic + sample #79	9	3,290.14	6,450.00
02190	Intraocular lens Implant – Primary + sample #79	9	953.49	
	Total:	**20**	**$5,507.29**	**$9,450.00**

In terms of private charge types, the 20 service unit errors are summarized as follows:

- 16 related to material upgrades charged on a profit basis, contrary to MSC Minute #1147 which allows for some private charge exemptions under *the Act*, but only on a cost-recovery basis; and
- 4 related to refractive services under a lens type which became insurable after the June 4, 2012 policy change.

Additionally, we noted one service unit error under Objective 1 where there was an associated private charge to the beneficiary, as further described under the Fee Item 02007 subtitle of that objective. In the absence of a medical record to substantiate a benefit in this instance, we could not determine whether the private charge was for, or in relation to one claimed by s.22

Material Upgrade Charges on a Profit Basis

For the 16 service units in error related to material upgrades charged on a profit basis, 10 concerned lens upgrades supplied by s.22 prior to MSC's new lens policy of June 4, 2012, and 6 to iStents supplied by s.22 irrespective to that policy change. The mark-ups on cost are summarized as follows by type of material upgrade:

Material Upgrade Description	Private Charge to Beneficiaries, Per Eye	Supply Cost to s.22	Approximate Mark-up On Supply Cost	Total Associated Service Units
Foldable Monofocal Lens	$350	$215*	63%	0
Toric Monofocal Lens	$950	$550*	73%	6
ReStor Multifocal Lens	$1,900	$1,240*	53%	4
iStents	$1,500	$1,000 (approximate)	50%	6
			Total:	**16**

* *At January 2012*

Once the Health Authority assumed responsibility of supplying intraocular lenses to patients, starting June 4, 2012, the cost mark-up was significantly less than this 15 percent maximum for each lens.

Pre-operative Refractive Service Charges – Insured Lens

We identified four service units where a beneficiary was charged in relation to lens implant and cataract surgery benefits for foldable monofocal lenses, subsequent to the June 4, 2012 policy change. The private charges were $200 per eye under the general description of "Premium Pre-operative Refractive Services."

The invoice to the beneficiary incorrectly justified the service charges on the basis that the lenses were not insured by MSP.

OBJECTIVE 8: To determine whether the pattern of practice or billing (including service frequency) were justifiable.

We found s.22 pattern of practice and billing was, overall, not reasonably justifiable, based on the nature and extent of errors noted under Objectives 1, 2, 4, 5 and 7. In particular we are concerned about s.22 recurring pattern to:

- Claim incorrect dates of service in order to circumvent billing rules under Fee Item 02007, (as further summarized under Section F below, and Fee Item 22399, where tests performed on both patient eyes occurred during the same visit;
- Not retaining appointment records, contrary to CPSBC bylaws and relating to the above errors;
- Claim emergency visits under Fee Item 02005 where a patient was able to be accommodated within the office regular schedule, (88.9 percent sample error rate based on service units);
- Billings for orthoptic testing under Fee Item 02014, either being over utilized or legitimate indications and results being not commonly available or clear from the medical records (90.6 percent sample error rate based on service units);
- Not having medical records which supported a Potentiometry claimed under Fee Item 02049, as further summarized under section F below;
- Privately charge beneficiaries in relation to cataract surgery benefits, contrary to *the Act* and not documenting any clear separation between consultations covered under MSP, versus non-insured services for these latter to be permissible;
- Frequently bill Fee Items 02014, 02019 22016, 22046, and 22047, without medical justification for the service; and
- Bill for services that were performed by another ophthalmologist under a wide range of fee items.

Fee Item 22046

The error pattern observed was s.22 billed both Fee Item 22067 - Computerized Retinal Nerve Fibre Layer Photography and Fee Item 22046 - Posterior Segment Contact Lens Examination in high frequency on the same visit. When Computerized Retinal Nerve Fibre Layer Photography is done under Fee Item 22067, it is redundant to perform a Posterior Segment Contact Lens Exam under Fee Item 22046.

Scheduling of Repeat Consultations – Fee Item 02010

In addition, the 51 service units in cumulatively in error under Objectives 1, 2, 4 and 5, and in conjunction with our billing data analysis for repeating consultations, we have concerns regarding the frequency or medical necessity of Fee item 02010 paid claims. It was noted that s.22 was sometimes billing consultations for re-referrals of stable patients just outside the allowable six months.

End Stage Glaucoma

We noted one case under Fee Items 02188 - Cataract Linear Extraction and 2190 - Intraocular Lens Implant claimed, the cataract surgery was done on an end stage glaucoma patient and the optional Toric transplant lens was inserted. Based on the patient's condition, the medical necessity of the patient to undertake the surgical operation and to select the higher-priced implant lens over the basic monofocal foldable lens was questionable.

F. AIC SUMMARY

As directed by the AIC, BIP conducted an on-site audit of s.22 billing practices, which included, but was not limited to Fee Items 02007, 02035, 02049 and 02149.

Sample error rates under each of the fee items ranged between 29.6 and 80.5 percent, based on service units. The following table provides a breakdown by fee item:

Fee Item	Fee Item Description	Sample Service Units	Service Unit Errors	Sample Error Rate
02007	Office Visit - Ophthalmology	108	37	34.3%
02035	Color Vision Assessment	27	8	29.6%
02049	Potentiometry	87	57	65.5%
02149	Meibomian Gland Evacuation	41	33	80.5%

Fee Item 02007

Our audit testing confirmed the concern raised under the 2010 Service Verification Audit and the BIP Medical Consultant's referral that s.22 was incorrectly stating dates of service under Fee Item 02007. These misstatements of date, in effect, circumvented billing rules which do not permit billing the office visit for post-operative follow-up the same day as a hospital surgery, as described under Objectives 1, 2 and 4.

Fee Item 02035

Our audit testing identified missing, incomplete or inadequate records to support the billing of this fee item and evidence that someone other than s.22 provided the services that were billed to MSP under his practitioner number, as described under Objectives 1 and 2.

Fee Item 02049

Our audit testing identified missing, incomplete or inadequate records to support the billing of this fee item. Where there were records available, it was noted that the actual service provided was Pinhole Acuity testing instead of the Potential Acuity Meter testing. Pinhole Acuity testing does not equate to the Potential Acuity Meter test and it should not be billed as such, as described under Objectives 1, 2 and 4.

Fee Item 02149

Our audit testing identified missing, incomplete or inadequate records to support the billing of this fee item, as described under Objectives 1 and 2.

G. CONCLUSIONS

The examination of the medical records of 125 patients with 2700 service units totaling $191,622.22 resulted in the identification of inappropriate billings for 574 service units with a net error value of $27,397.08.

The table below identifies the inappropriate billings by audit objective:

Objective	# of Service Units	MSP Paid Amount
1 – Services Not Rendered	326	$8,912.44
2 – Records Incomplete & Illegible	67	4,325.94
3 – Not MSP Benefits	0	0
4 – Billed Inappropriately	105	4,946.08
5 – Service Not Provided by the Practitioner	56	3,705.33
7 – Extra billed	20	5,507.29
Total Sample Error	**574**	**$27,397.08**

The total error percentages based on service units is 21.26 percent (574/2700) and on dollars is 14.3 percent ($27,397.08/$191,622.22).

s.22 s.22

Medical Inspector

Date: Jan 15, 2016

Audit Manager

Date: Jan. 15, 2016