s.22

Practitioner # s.22

OTOLARYNGOLOGY

AUDIT REPORT

FOR THE PERIOD
April 1, 2008 to March 31, 2013

Billing Integrity Program
Audit and Investigations Branch
Ministry of Health

s.22

Audit Report
For the period April 1, 2008 to March 31, 2013

A. INTRODUCTION

Practitioner Background

s.22 (practitioner number s.22) is an otolaryngologist (ear, nose, and throat), practicing at the following sites:

- s.22
-
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Medical Services Plan Payments

The Medical Services Plan (MSP) paid s.22 for the following fee-for-service billings during the five-year audit period of April 1, 2008 to March 31, 2013:

Audit Scope Period Per 12 Months	# of Service Units	MSP Paid Amount
April 1, 2008 to March 31, 2009	13,828	704,975.46
April 1, 2009 to March 31, 2010	16,727	824,092.27
April 1, 2010 to March 31, 2011	12,902	761,210.37
April 1, 2011 to March 31, 2012	12,311	745,041.64
April 1, 2012 to March 31, 2013	12,993	774,529.48
TOTAL:	**68,761**	**$3,809,849.22**

Other Payment Sources

Additionally, during the audit period s.22 received:

- $109,688.04 in Medical On-Call/Availability Program payments distributed through the Vancouver Coastal Health Authority;
- At least $33,278.00 from s.22 in 2011, as a s.22 s.22 exceeding the minimum $25,000 per annum public-reporting threshold for vendors; and
- Private payments for services rendered at s.22 and any profit shares or sale of business interests there.

s.22

Up and to March 2013, we understand that s.22 was a shareholder of s.22

As of June 20, 2014, s.22 advertises its privately charged services as follows:

> "...The surgical procedures offered at s.22 are private and not covered by the Medical Services Plan of British Columbia. It is possible that extended health insurance plans may cover certain procedures..."

Consistent with the above advertising, we understand from s.22 that for any medical services he renders to beneficiaries at s.22 no claims are made by him to MSP.

Practitioner Flags and Audit Decisions

Random Service Verification Audit (SVA) – June 2008

s.22 came to the attention of the Billing Integrity Program (BIP) as a result of a random monthly SVA in June 2008. This SVA indicated four irregularities out of 32 usable responses, concerning Fee Item 13620 - Excision of Tumour of the Skin/Scar, up to 5 cm.

Select SVA – October 2008

In response to the irregularities found under the random SVA, a select SVA was initiated by BIP in October 2008, specific to Fee Item 13620. That SVA resulted in 31 irregularities out of 80 useable responses, summarized as follows:

- one patient not knowing s.22
- one patient not seeing s.22 and seeing another practitioner instead while s.22 was away on holidays; and
- 29 patients having sutures/packing removed and/or a follow-up visit rendered instead.

First Practitioner Profile Review

As a result of the two SVAs, the BIP Medical Consultant reviewed the latest available practitioner profile for s.22

MSP prepares standard 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 2007 practitioner profile flagged as being high for Fee Item 13620 - Excision of Tumour of the Skin/Scar, up to 5 cm. In turn, the BIP Medical Consultant referred s.22 to the Audit and Inspection Committee (AIC) in January 2009.

First Audit Decision

As a result of that referral, the AIC directed that an audit inspection should be undertaken of s.22 practice, to include, but not be limited to, the medical necessity and accuracy of billing:

- Fee Item 13620 - Excision of Tumour of Skin or Subcutaneous Tissue or Small Scar Under Local Anaesthesia – up to 5cm;
- Fee Item 00090 - Major Tray Service; specifically in regard to the fact that "tray fees are only applicable where the costs are actually incurred by the physician" and "tray fee are not applicable when the service is performed at a funded facility"; and
- Service Code 43 - Surgical Procedures.

At that time, and up to 2013, BIP did not have a Medical Inspector with the otolaryngology speciality in order to commence the audit. Consequently, a second practitioner profile review was conducted by BIP Medical Consultant in 2013.

Second Practitioner Profile Review

In 2013, a follow-up review of s.22 most recent available practitioner profile was performed by the BIP Medical Consultant.

s.22 2011 practitioner profile flagged for the following fee items where he ranked in the top three, relative to his peer group:

Service Code	Fee Item Description	Rankings			
		# of Practitioners	Services	Cost	Patients
43 – Surgery (Non-Minor, Excisional	02308 – Naso-antral Window – Bilateral	44	2	3	2
43 – Surgery (Non-Minor, Excisional	02331 – Submucous Turbinectomy – Bilateral	45	2	2	2
44 – Minor Surgery, Minor Ther. Procedures	02325 – Antral Lavage – Bilateral	17	1	1	1
44 – Minor Surgery, Minor Ther. Procedures	13620 – Excision Tumour of Skin/Scar up to 5 cm	45	2	2	1
98 – Other (Needle Biopsies, 0X99, etc.)	00907 – Endoscopic Exam of Nose and Nasopharynx	79	1	1	2

Fee Items 02308, 02331 and 02325 (Double or Bilateral Procedures)

A further follow-up by the BIP Medical Consultant for the double or bilateral procedure fee items of 02308, 02331 and 02325 indicated billing anomalies relative to single or unilateral procedures. More specifically:

- 118 of Fee Item 02308 were billed, versus 15 of Fee Item 02307 - Naso-antral Window - Single;
- 138 of Fee Item 02331 were billed, versus 10 of Fee Item 02330 - Submucous Turbinectomy - Unilateral; and
- 5,297 of Fee Item 02325 were billed, versus 3 of Fee Item 02324 - Antral Lavage - Unilateral.

Fee Item 13620

The BIP Medical Consultant noted where Fee item 13620 is listed under the Plastic Surgery section of the *Medical Services Commission (MSC) Payment Schedule* and that the billing of it could be considered unusual for an ENT specialist.

Fee Item 00090

The BIP Medical Consultant noted where Fee item 00090 can only be billed for procedures rendered in a private, non-funded facility, and not in a public hospital setting, where s.22 primarily practices.

Second Audit Decision

Based on the 2011 practitioner profile flags, s.22 was again referred by the BIP Medical Consultant to the AIC in February 2013.

As a result of the referral, the AIC again directed that an on-site audit be undertaken of s.22 billing practices, to include, but not be limited to, the appropriateness, accuracy of billing and frequency of:

- Fee Item 13620 - Excision of Tumour of Skin or Subcutaneous Tissue or Small Scar Under Local Anaesthesia – up to 5cm;
- Fee Item 00090 - Major Tray Service; specifically in regard to the fact that "tray fees are only applicable where the costs are actually incurred by the physician" and "tray fee are not applicable when the service is performed at a funded facility"; and
- Service Code 43 - Surgical Procedures.

Audit Authority and Objectives

The audit was performed under the authority of Section 36 of the *Medicare Protection Ac ("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 claimable 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 did not overlap 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

Random Dollar-Unit Sample

The audit was carried out in order to achieve the objectives outlined above and primarily 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, 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 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 April 1, 2008 to March 31, 2013 and each dollar-unit was traced back to a patient. The dollar-unit sample was comprised of 44 patients (one repeat) totalling 2,661 service units, and $138,098.21.

Additional Records Review

Selective Follow-up of SVA Irregularities

In addition to the random dollar-unit sample, three further sample patient files with a specific date of service were selected for examination as a follow up to the 31 SVA billing irregularities identified under the 2008 select SVA.

The selection of these three samples was based on the following:

- two patients with follow-up visits billed to MSP when the associated surgery was performed at s.22 These two samples were comprised of 61 service units totalling $2,333.11; and
- one patient stated that they were not seen by s.22 These services were reviewed under Objective 5 (i.e. Services claims were provided by the practitioner).

Audit Team

The audit team was comprised of two inspectors: s.22 an otolaryngologist, and s.22 BIP Senior Auditor. s.22 was responsible for examining the medical records. 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 June 19 to 21, 2013 at s.22

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 visit for an exit interview to discuss the preliminary findings.

All records requested and received during the on-site for services billed to MSP were located at s.22 s.22 and related to services rendered there. No MSP billings we tested covered services rendered at s.22 consistent with s.22 explanation to us that he does not bill MSP for medical services rendered at this location.

s.22 Medical Office Assistant at his clinic in s.22 was helpful in retrieving the patient files requested and in providing explanations and locating additional information to support services billed to MSP. s.22 records staffs were also helpful in retrieving patient files not located at the clinic.

On December 20, 2013, we provided s.22 with a list of 1,138 possible billing errors (one repeat) under the random, dollar-unit sample and asked him to provide any additional medical records to address these matters within 30 days.

Additionally, on April 11, 2014, we provided s.22 with a list of 29 possible billing errors from the additional two-patient select sample and asked him to provide any additional medical records within 30 days.

To date we have not receive a response from s.22 under either of the two error lists.

B. FINDINGS

Random Dollar-Unit Sample

The table below provides a summary of the services included in the sample of 44 patients by fee item. The fee items in **bold** in all of the tables represent those flagged in the BIP Medical Consultant's audit referral and the AIC audit decision.

Fee Item	Fee Item Description	# Service Units	MSP Paid Amount
00090	**Major Tray**	**518**	**15,060.89**
00907	**Endoscopic Exam of the Nose and Nasopharynx (SC 98 - Other (Needle Biopsies, 0X99, Etc**	**616**	**19,954.68**
02308	**Naso-Antral Window – Bilateral (SC 43 – Surgery (Non-Minor, Excisional)**	**18**	**1,563.23**
02321	Sinus Sphenoidotomy (Intranasal)	18	2,342.84
02325	**Antral Lavage – Bilateral (Operation Only) (SC 44 - Minor Surgery, Minor Ther. Procedures)**	**1,247**	**61,004.80**
02331	**Submucous Turbinectomy - Bilateral (SC 43 – Surgery (Non-Minor, Excisional)**	**18**	**2,233.21**
02343	Septal Reconstruction	20	3,717.32
02359	Spheno- Ethmoidotomy/Intranasal/Endoscopic/Revision	7	3,357.50
02347	Osteoplastic Frontal Flap Operation – External	3	2,686.87
02358	Sinusotomy – Frontal – Endoscopic – Revision	7	1,579.12
02361	Ethmoidotomy-Intranasal-Posterior-Bilateral	19	9,876.06
02510	Consultation – Otolaryngology	28	2,077.19
02507	Subsequent Office Visit – Otolaryngology	27	788.47
13620	**Excision Tumor of Skin/Scar up to 5cm (SC 44 – Minor Surgery, Minor Ther. Procedures)**	**49**	**3,041.93**
25310	Endoscop Trans-Nasal Repair CSF Leak Frm Ant Skull	2	1,898.84

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Fee Item	Fee Item Description	# Service Units	MSP Paid Amount
25315	Primary Frontal Sinusotomy	21	4,626.14
All Other Fee Items		43	2,289.12
TOTAL:		**2,661**	**$138,098.21**

Additional Records Review

Two-Patient Select Sample

The table below provides a summary of the services included in the select sample of two patients tested under all objectives and dates of service, by fee item.

Fee Item	Fee Item Description	# Service Units	MSP Paid Amount
00090	Major Tray	12	346.04
00907	**Endoscopic Exam of the Nose and Nasopharynx**	**23**	**743.49**
02324	**Antral Lavage – Unilateral (Operation Only)**	**1**	**16.05**
02325	Antral Lavage – Bilateral (Operation Only)	18	882.00
02507	Subsequent Office Visit – Otolaryngology	3	86.52
02510	Consultation – Otolaryngology	1	73.49
13620	**Excision Tumor of Skin/Scar up to 5cm**	3	185.52
TOTAL:		**61**	**$2,333.11**

One-Patient Reviewed Under Objective 5

The table below provides a summary of the services included in the select sample for this one patient tested under a date of service and by fee item.

Fee Item	Fee Item Description	# Service Units	MSP Paid Amount
00090	**Major Tray**	**1**	**28.55**
00907	**Endoscopic Exam of the Nose and Nasopharynx**	**1**	**32.13**
13620	**Excision Tumor of Skin/Scar up to 5cm**	**1**	**61.84**
TOTAL:		**3**	**$ 122.52**

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

Random Dollar-Unit Sample

We identified 141 service units, with a total value of $7,533.61, where a medical record was not found to substantiate the service summarized, as follows, by paid fee item:

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Fee Item	Fee Item Description	Service Units	Value
00907	**Endoscopic Exam of the Nose and Nasopharynx**	**22**	**712.26**
02325	**Antral Lavage – Bilateral (Operation Only)**	**79**	**3,826.76**
02331	**Submucous Turbinectomy – Bilateral**	**1**	**125.12**
02343	Septal Reconstruction	1	187.68
02359	Spheno-Ethmoidotomy/Intranasal/Endoscopic/Revision	2	1,040.94
02507	Subsequent Office Visit – Otolaryngology	3	87.02
02510	Consultation – Otolaryngology	4	295.53
10001	Specialist Telephone Advice-Response Within 2 Hrs	1	60.00
10003	Specialist Telephone Patient Mgmt/Follow-up	18	360.00
13620	Excision Tumor of Skin/Scar up to 5cm	8	$496.58
25315	Primary Frontal Sinusotomy	2	341.72
TOTAL:		**141**	**$7,533.61**

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

Random Dollar-Unit Sample

We identified 54 service units, with a total value of $4,288.66, where the medical records were incomplete to substantiate billing under any fee item summarized as follows, by paid fee item:

Fee Item	Fee Item Description	Service Units	Value	Explanation
00907	**Endoscopic Exam of the Nose and Nasopharynx**	**9**	**290.97**	**Procedure not documented/very incomplete record**
02308	**Naso-Antral Window - Bilateral**	**1**	**85.35**	**Not documented in O.R. report**
02321	Sinus Sphenoidotomy (Intranasal)	3	394.14	Not documented in O.R. report
02325	Antral Lavage – Bilateral (Operation Only)	5	243.17	Procedure not documented/Post OPP/specifically stated "not done"
02330	Submucous Turbinectomy - Unilateral	1	79.99	Not documented in O.R. report
02331	**Submucous Turbinectomy - Bilateral**	**5**	**619.20**	**Not documented in O.R. report**
02343	Septal Reconstruction	4	745.93	Not documented in O.R. report
02510	Consultation – Otolaryngology	4	298.38	No consult note found or very incomplete record
13620	**Excision Tumor of Skin/Scar up to 5cm**	**21**	**1,303.72**	**Procedure not documented /Post OPP/Spacers removed**
25315	Primary Frontal Sinusotomy	1	227.81	Not documented in O.R. report
TOTAL:		**54**	**$4,288.66**	

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

Random Dollar-Unit Sample

We identified 518 service units, with a total value of $15,060.89, where the billed services described in the chart notes were not benefits under *the Act,* summarized as follows:

Fee Item	Fee Item Description	Service Units	Value
00090	Major Tray Service	518	$15,060.89
TOTAL:		518	$15,060.89

Fee Item 00090 - Major Tray Service has a number of requirements including:

- tray fees are only applicable where the costs are actually incurred by the physician; and
- tray fees are not applicable when the service is performed at funded facility (e.g. Hospital, D&T Centre, Psychiatric Institution etc...).

All 518 service units were rendered at the publicly-funded s.22 and therefore, billing Fee item 00090 was not allowable.

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

Random Dollar-Unit Sample

We identified 425 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 $22,307.92, 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 $9,270.07. 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	Value Adjustments	Net Dollars Error Value
02308	Naso-Antral Window - Bilateral	1	87.58	56.30	31.28
02325	Antral Lavage – Bilateral (Operation Only)	408	20,018.82	12,003.06	8,015.76
02324	Antral Lavage – Unilateral (Operation Only)	4	128.66	115.61	13.05
02331	Submucous Turbinectomy – Bilateral	2	244.99	79.99	165.00
02343	Septal Reconstruction	2	370.57	0	370.57
02359	Spheno-				

	Ethmoidotomy/Intranasal/Endoscopic/ Revision	1	520.47	455.43	65.04
02361	Ethmoidotomy-Intranasal-Posterior-Bilateral	1	538.00	162.64	375.36
02510	Consultation - Otolaryngology	2	150.48	58.56	91.92
13620	**Excision Tumor of Skin/Scar Up To 5cm**	**4**	**248.35**	**106.26**	**142.09**
TOTAL:		**425**	**$22,307.92**	**$13,037.85**	**$9,270.07**

For 421 of the 425 service units listed in error above, a lower value fee item applied instead. For the remaining four service units, no fee item applied.

Fee Item 02325 (Antral Lavage – Bilateral)

For 382 of the 408 Fee Item 02325 errors, an office visit applied instead. For the remaining 26 errors a unilateral fee item applied instead.

Fee Item 02308 and 02331 (Naso-Antral Window-Bilateral and Turbinectomy-Bilateral)

For two of the three Fee Item 02308 and 02331 errors, a unilateral fee item applied instead. For the remaining one, no fee item applied.

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

With the possible exception of missing medical records noted under Objective 1, we identified no errors under this objective for the random dollar-unit sample.

OBJECTIVE 6: To determine whether services claimed overlapped with alternate, provincially-funded 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 some indications that beneficiaries were extra billed for surgeries that would ordinarily be benefits under *the Act*. Two such exceptions were noted under the two-patient select sample where the patients identified that they had privately paid for the surgeries at s.22 One of the two-patient select sample identified the price paid for the surgery was $5,000.00.

There remains a possibility that additional exceptions of this type may have occurred under our random dollar-unit sample, where MSP was billed for post-surgery types of benefits but not the surgery itself. We noted some instances of surgeries not billed to MSP. Some of these surgeries may relate to s.22 s.22 having purchased surgery time at s.22

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

We found no potential quality of care concerns with respect to s.22 practice.

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

We found s.22 patterns of practice, was not reasonably justifiable given the nature and extent of billing errors noted under Objectives 1 to 4, and most notably his systematic billing for:

- Fee Item 00090 - Major Tray, where not eligible to do so when rendering services at a publicly-funded hospital; and
- Fee Item 02325 - Antral Lavage Bilateral (Operation Only), where a lesser value fee item applied instead.

Additionally, we have concerns about s.22 involvement with extra billing of beneficiaries for surgeries rendered at s.22 (i.e surgery that would have been covered by MSP).

C. ADDITIONAL RECORDS REVIEW

Two-Patient Select Sample

Objective 2

We identified one service unit, with a total value of $61.84, where the medical records were incomplete to substantiate billing. As the requirements of the *MSC Payment Schedule* were not met to substantiate the billing, the following service was deemed not to have been rendered:

Fee Item	Fee Item Description	Service Units	Value	Explanation
13620	Excision Tumor of Skin/Scar up to 5cm	1	61.84	Procedure not documented
TOTAL:		1	$61.84	

Objective 3

We identified 12 service units, with a total value of $346.04, where the billed services described in the chart notes were not benefits under *the Act*, summarized as follows by paid fee item:

Fee Item	Fee Item Description	Service Units	Value
00090	Major Tray Service	12	346.04
TOTAL:		12	$ 346.04

Objective 4

We identified 16 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 $788.50, 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 $337.21. 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	Value Adjustments	Net Dollars Error Value
02324	Antral Lavage – Unilateral (Operation Only)	1	16.05	14.42	1.63
02325	**Antral Lavage – Bilateral (Operation Only)**	**13**	**637.12**	**379.19**	**257.93**
02510	Consultation - Otolaryngology	1	73.49	28.84	44.65
13620	Excision Tumor of Skin/Scar Up To 5cm	1	61.84	28.84	33.00
TOTAL:		**16**	**$ 788.50**	**$ 451.29**	**$ 337.21**

One-Patient Select Sample

Objective 5

We identified three service units, valued at $122.52 where someone other than s.22 provided the service that was billed to MSP and paid under his practitioner number. More specifically, it was determined that on the date of service s.22 was not scheduled for the surgery and was out of the country.

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

Fee Item	Fee Item Description	# Service Units	MSP Paid Amount
00090	**Major Tray**	**1**	**28.55**
00907	**Endoscopic Exam of the Nose and Nasopharynx**	**1**	**32.13**
13620	**Excision Tumor of Skin/Scar up to 5cm**	**1**	**61.84**
TOTAL:		**3**	**$ 122.52**

D. CONCLUSIONS

Random Dollar-Unit Sample

The random sample examination of the medical records of 44 patients with 2,661 service units totaling $138,098.21 resulted in the identification of inappropriate billings for 1,138 service units with a net error value of $36,153.23.

The table below identifies the inappropriate billings by audit objective:

Objective	# of Service Units	MSP Paid Amount
1 – Services Not Rendered	141	7,533.61
2 – Records Incomplete & Illegible	54	4,288.66
3 – Not MSP Benefits	518	15,060.89
4 – Billed Inappropriately	425	9,270.07
Total Sample Error	**1,138**	**$36,153.23**

The total error percentages based on service units is 42.8 percent (1138/2661) and on dollars is 26.2 percent ($36,153.23/$138,098.21).

Additional Records Review

The select sample examination of the medical records of three patients covering one or more days of service and comprising 64 service units totaling $2,455.63 resulted, in the identification of inappropriate billings for 32 service units with a net error value of $867.61.

The table below identifies the inappropriate billings by audit objective:

Objective	# of Service Units	MSP Paid Amount
2 - Records Incomplete & Illegible	1	61.84
3- Not MSP Benefits	12	346.04
4- Billed Inappropriately	16	337.21
5 - Service Not Provided by the Practitioner	3	122.52
Total Sample Error	**32**	**$ 867.61**

Pattern of Billing

Overall, our testing under the both the random and select samples identified a pattern of billing by s.22 which was not justifiable, given the nature and extent of errors noted under Objectives 1 to 5 and his apparent involvement with extra billing beneficiaries at s.22

s.22 s.22

Medical Inspector

Date: 19 / July / 2014

Senior Auditor

Date: July 28/14