Guide to Scheduling an Audit

1. BIP Director, Medical Inspector, and Audit Manager assign the Senior Auditor an audit

2. The Senior Auditor is formally notified by an email from the Audit Manager, who also c.c's the Audit Assistant, BIP Director, Program Assistant, Records Custodian, Contract Administrator.

3. The Senior Auditor then asks the Contract Administrator for a Medical Inspector if one has not been previously assigned by the BIP Medical Consultant, Audit Manager, and BIP Director. (Medical Inspectors are generally assigned on a rotation basis). The Contract Administrator ensures the Medical Inspector has sufficient funds in his or her contract before assigning to an audit.

4. The Senior Auditor contacts the Medical Inspector and gets two sets of dates that they are available (up to a full week dependent on the MI schedule). The Medical Inspector is contacted by telephone to discuss the highlights of the audit issues, determines if any conflict of interest exists, and informs the medical inspector that an information package will be sent to them prior to the onsite.

5. The Senior Auditor contacts the Medical Inspector to confirm dates and to discuss the audit and any potential issues/concerns the Medical Inspector may have (eg: certain fee codes to look at)

6. The Senior Auditor notifies the Audit Assistant with a ***c.c. to the Audit Manager*** to send the Auditee the **AIC** Audit Notification Letter
   a. Audit Assistant notifies the Senior Auditor when the Auditee has **received the AIC letter and will print out the letter and POD for the auditor's audit binder.**

7. Senior Auditor contacts the Auditee by telephone (**after AIC letter confirmation of receipt**) to notify of the on-site audit dates and conducts the telephone interview with the auditee.

8. The Senior Auditor notifies the Audit Assistant to send the Auditee the **BIP** Audit Notification Letter (the Audit Manager will assign an second senior audit if necessary). The following is the email template to notify the Audit Assistant.

9. Senior Auditor sends an email as follows:
   Hi *Audit Assistant*,

   I have scheduled an on-site audit for Month/Day/Year, in City. Listed is the information for the BIP letter notification for the auditee:

   Auditee:
   Address:
   Specialty:
   Location:
   Onsite Dates:
   Medical Inspector:
   Senior Auditor:

   Advance Notice to auditee (Y/N)
   Second Senior Audit requested (Y/N)

August 11, 2016 - GW

- Please schedule a post-on-site debrief meeting with senior management within one week from on-site end-date month/day/year. I am back in the office day, month/day/year.

- **Please prepare and send the information package and letter for the medical inspector.** ***

Thank you!
Senior Auditor

***The letter and package to the medical inspector are to be completed and sent to the medical inspector at the same at the BIP–Auditee Notification Letter. The MI package will be sent via courier or via SharePoint.**

The MI information package includes: the AIC referral, the minute excerpt, the practitioner mini-profile, an expense claim form, and BIP notification letter.

Address the e-mail as follows;
To: *Audit Assistant* (Christine Groat); *Audit Manager* (Gayle Wilson)
Cc: *BIP Director* (Evan Machin); *Medical Consultant* (Shiroy D.); *LSB Lawyers and LSB support staff at LSB*; *Program Assistant* (Jackie Hucal); *Contract Administrator* (Vanessa Starskey)

10. Senior Auditor completes the Audit Plan, Audit Plan Attachments, and Sample Analysis on the Auditee's billings. In addition, contact the Records Custodian (John Longhurst) to request any archived practitioner files (including SVA audits). The Records Custodian also request records from HIBC at the start of the audit and will save those records to the audit file on the LAN.

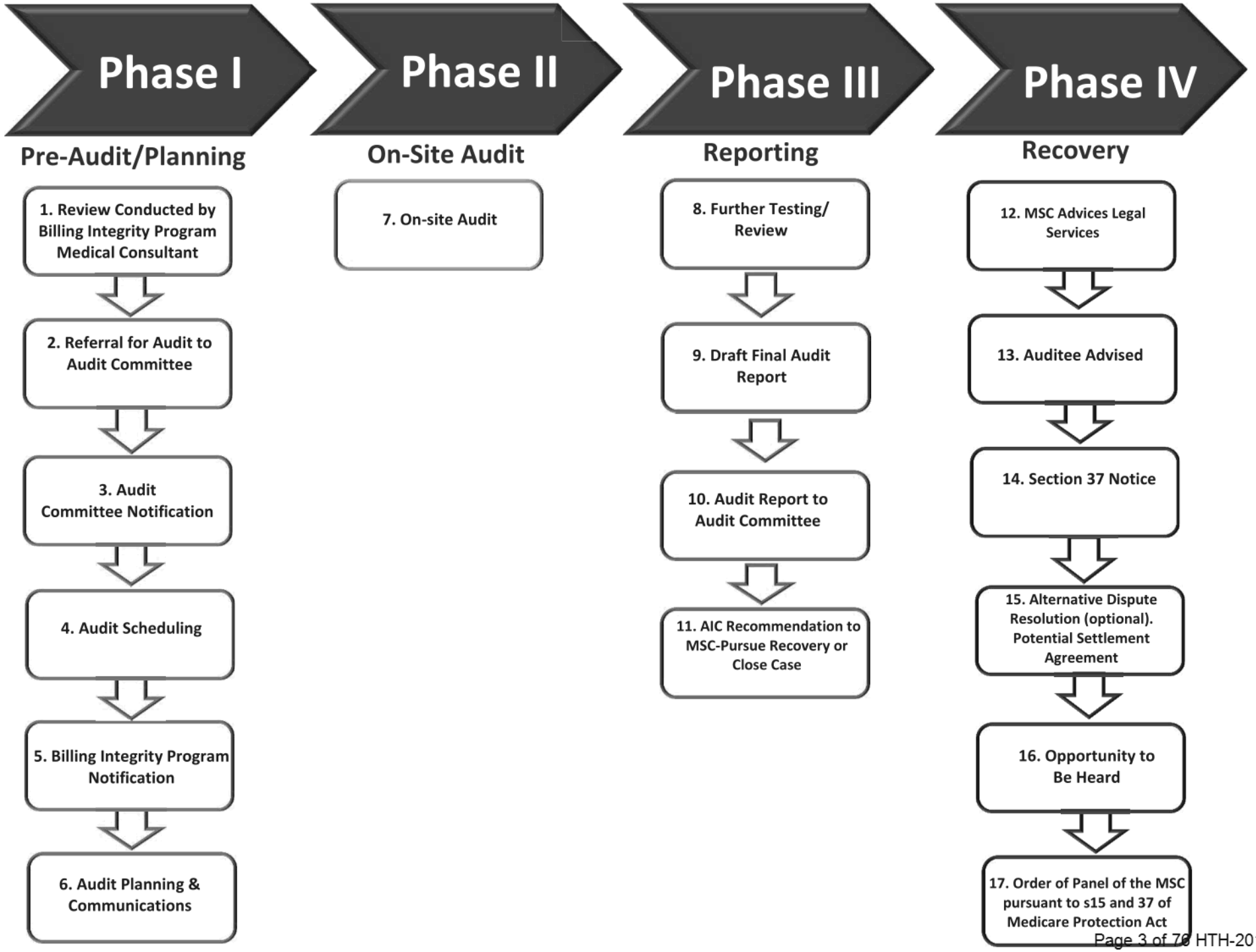
11. Senior Auditor schedules a meeting with the BIP Director, Audit Manager and Medical Consultant to discuss the Audit Plan (APM), Attachments, graphs, and referral. Once the Audit Plan and sampling has been approved, the Senior Auditor prepares the clinical audit worksheets.

12. BIP Director, Audit Manager and Medical Consultant approve the APM, the Audit Manager signs the document.

    Note: Please have your APM and planning documents (Audit Plan Attachments, Outlier graph and any other graphs, and BIP Consultant Referral to AIC) to the Management Team at least 4 days prior to your APM meeting so that they can prepare and contribute to the planning meeting.

    The Audit Cost Estimate (Budget) must be prepared prior to the onsite audit.
    The approval process is as follows: Audit Manager, BIP Director, Executive Director, ADM and back; therefore, you must have your budgets completed at least 2.5 weeks prior to your onsite. You can make reservations (hotels, ministry car), but you cannot make any purchases without prior budget approval.
    For estimates for air flights and car rentals, we have a travel agent at Marlin Travel, Karen Rixrath.
    Once the budget is approved you can book the air flights which are under the Program's Assistant BTA (business travel account)

Billing Integrity Program – Audit Process



GUIDE TO AUDIT PROCESS CHECKLIST

	Prac Name: **Prac #:** **Audit Period:** **Sr. Auditor:**	**(√) Actioned**	**Sign-Off**	**W/P Ref**
I - AUDIT PLANNING & BACKGROUND				
Audit Background				
1	Medical Consultant's audit referral letter to AIC/HCP			
2	AIC Minutes to authorize the audit HCPSC Minutes to authorize the audit			
3	Request the SVA files from the records clerk for the past 10 years, see email template for request			
4	Email John and cc Graham to inform them to start the process with HIBC when you are reading to start planning your audit			
4	Research the Auditee on the CPSBC/CTCMA			
5	Google/News Media Check the Auditee			
4	Other (describe):□			
Scheduling				
5	Medical/Healthcare Inspector assigned by Audit Manager and Medical Consultant. Medical Inspectors are generally assigned on a rotation basis. Confirm with the Contract Administrator that the Medical Inspector has sufficient funds in his or her contract before contacting to an audit			
6	If necessary, schedule a meeting with the Medical Consultant to discuss further particulars of the referral and any customized audit procedures warranted to address high risk areas			
7	Contact Medical/Healthcare Inspector by email to see if they are available for a telephone call:			
	a Introduce yourself and ask if they are available to do an audit			
	b Discuss highlights of the audit issues			
	c Determine if any conflict of interest between the Medical Inspector and the auditee			
	d Get two sets of tentative dates (preferable a 4-5 days for medical practitioners, 3 days for healthcare practitioners)			
	e Informs medical /Health Care Inspector that an information package will be sent to them prior to the onsite			
8	Once MI dates have been set, Email Audit Assistant and C.C. the Audit Manager to send AIC/HCP Notice to Auditee (See guide to scheduling an audit)			
9	Once Audit Assistant confirmes that Auditee has received the AIC Notice,			
	a call that Auditee to inform the scheduled onsite audit			
	b conduct the telephone interview with the auditee			
10	BIP Audit Nofitication Letter - Send email request to Audit Assistant and Office Manager, and C.C. Branch Administrator, Contract Admin, BIP Director, and three LSB Lawyers. - the email also notify Audit Assistant to send background information to Medical/Healthcare Inspector			
11	Schedule an APM Meeting 6 weeks prior to the on-site Note - CAWs only preapred once APM approved.			
12	Complete Audit Cost Estimate at least 6 weeks (minimum 2.5 weeks) prior to on-site, because it requires Audit Manager, Director, Exe Director and ADM approvals. *The approval email should be saved in the "Email" folder of the audit file			
13	Schedule post-on-site debrief meeting with management within one week from on-site end-date.			

GUIDE TO AUDIT PROCESS CHECKLIST

	Prac Name: **Prac #:** **Audit Period:** **Sr. Auditor:**	**(√) Actioned**	**Sign-Off**	**W/P Ref**
14	Reserve a ministry vehicle, if applicable.			
15	Book flights, make an accommodation arrangement, etc., considering whether accommodation is needed by MI - if flights and car rentals are needed, our travel agent is Karen Rixrath at Marlin Travel ensure you receive email confirmations (You can only book air flights once your budget is approved)			
16	Other (describe):			
Practitioner Profiles				
17	Email Sarah for recent two years of the practitioner's profiles, she will place PDFs in the practitioner folders.			
18	Review and file details of the practitioner's profile, specifically:			
	a Reported salaried, sessional and/or other APP payments in lines 155 to 162 - this is prelimiary indentification of possible APP			
	b RRP payments are included in line 190			
19	Look at the Health Authority Supplier Statements for any payments to the physician (APP-sessional/service)			
20	Other (describe):			
Practitioner Background				
21	Review and file:			
	a Current registration status per governing body website (including any discipline and restrictions)			
	b Internet Search for any media coverage on practitioner, including search on locations and addresses			
	c Education letters, Pattern of Practice Orders by governing body			
	d Complaints or tips received by AIB			
22	If warranted, request APP details from Physician Compensation Branch for the audit period.			
23	Run the DDS Report from MicroStrategies and save it in the "MicroStrategies and Calculations" folder as an Excel and PDF (LSB Requirement)			
24	Other (describe):			
Data Extraction and Sampling- conduct 4 weeks after audit period end date to ensure capture of adjustments				
25	Determine the audit period using the AIC/HCPSC minutes as a guide and remember 90 day rule for submitting/changing billings			
	a Run "Payment Category Breakdown" to see how much the Auditee gets from each category			
	b Click "Create MSP Audit Population", run "MSP Audit Population", and export it to Excel. (The total MSP paid should agree to MSP			
	c If there are outliers, repeat step b, to exclude outliers from the population to get random sample population			
	d Determine sample size: office minimum is 60 PHNs - Consider date of service for basis of sample; confer with colleagues if unsure			
	d Click "Create MSP Audit Sample", and run "MSP Audit Sample Claims" to get Sample PHNs, and export it to Excel. Count how many repeats in the sample. Re-run sample if there are too many repeats.			
	e Run "Audit Sample Population", and export it to Excel			
	f Add repeats to the sample population for quantification purpose			
	g Confirm that sample is representative of the population for Service Codes and Fee Items, increase sample size if needed. * use Audit Plan Attachments [office minimum is 3%] .			

GUIDE TO AUDIT PROCESS CHECKLIST				
	Prac Name: **Prac #:** **Audit Period:** **Sr. Auditor:**	**(√) Actioned**	**Sign-Off**	**W/P Ref**
26	Other (describe):			
	* Print total service units and dollar value for each population and sample, and file them in the binder			
Prepare Audit Planning Memo				
27	Apply information collected per preceding steps and using Audit Plan template and audit cost attachment template to prepare an Audit Planning Memo			
28	Establish if special circumstances warrant a change for number of days for a site visit			
29	Have a APM Approval meeting with the Director, Audit Manager and Medical Consultant to discuss the Audit Planning Memo/Audit Planning Risk and Sample Analysis - usually 6 weeks before the on-site			
30	Distribute Audit Planning Memo and Analysis to the management 4 business days before the APM meeting - analysis should include audit summery, graphs (including outliers), and referral - analysis may also include ICD and fee item summaries identified in Referral and any other highlighted issues.			
31	Audit Manager signs the APM prior to the onsite			
32	Other (please describe):			
Confirm Scheduling Arrangements [for medical inspector(s) & auditee]				
33	Contact the Medical/Healthcare Inspector:			
	a Confirm the audit dates and number of onsite days and where the preliminary meeting to occur			
	b Make arrangements for preliminary meeting to discuss expectations on audit and documentation requirements. This is done prior to arrival at the auditee's office.			
	c discuss any potential issues/concerns regarding audit (e.g.: specific fee codes to review)			
34	Confirm flights, cars, and hotel arrangement, and make ferry reservation if needed.			
35	Other (describe):			
Prepare CAWs				
36	From sample data created above, use the Clinical Audit Worksheets template spreadsheet to develop working papers for the Medical/Healthcare Inspector to record audit findings by patient on each date of service for each fee item billed.			

AUDIT COMPLETION CHECKLIST

Prac Name:	0	(√) Actioned	Sign-Off	W/P Ref
Prac #:	0			
Audit Period:	0			
Sr. Auditor:	0			
II ON-SITE AUDIT PREPARATION				
Prepare: Documents to Bring during On-Site Audit				
37	Print copies of relevant payment schedules and descriptions of relevant fee items included in audit sample			
38	Print a copy of Medicare Protection Act for reference			
39	Print a copy of MI Comment Form x2			
40	Prepare and print following letters if applicable:			
	a Practitioner record request letter/ and sample list to hand in during on-site audit			
	b Facility request for records and sample list (preferable 6 weeks prior to onsite) Note: for publicly funded nursing homes, it maybe necessary to enquire with the local health authority if the information is not available on MaxPath.			
41	Prepare and print following documents/Working paper:			
	a Temporary removal of patient records			
	c Practitioner Onsite Interview			
	d MOA Onsite Interview if applicable			
	e Practitioner Exit Interview			
	f nursing home interviews if applicable			
42	Other (describe):			
	^ Include file path, filename and, as appropriate Worksheet name on all Excel Worksheet printouts			
Final Preparations for On-site Audit				
43	Copy and file MSC Appointments for each inspector of audit team			
44	Take Scanner, Kingston Secure USB stick, and get Christine to request a Spare laptop for your MI.			
45	Test laptop, scanner, USB key and cell phone message recall for workability.			
46	Copy audit file to secure drive of your laptop hard drive and onto encrypted USB stick for backup			
47	If not travelling with Medical/Healthcare Inspector, confirm initial meeting place and time.			

AUDIT COMPLETION CHECKLIST

Prac Name:	0	(√) Actioned	Sign-Off	W/P Ref
Prac #:	0			
Audit Period:	0			
Sr. Auditor:	0			
III - AUDIT FIELDWORK				
48	*a* Conduct initial interview, wiith the Medical/Healthcare Inspector *b* Conduct interview at nursing homes if applicable			
49	Medical/Healthcare Inspector hands over list of patients for on-site audit and asks any questions they may have about auditee's practice and patient records.			
50	Medical/Healthcare Inspector officially receives all requested patient records and Senior Auditor tracks records received, scanned, reviewed, and returned.			
51	Medical/Healthcare Inspector examines patient charts, notes, reports, and all documents made available for the list of patients provided to the auditee.			
52	Medical/Healthcare Inspector completes on-site Clinical Audit Worksheets with additional notes and comments			
53	Obtain copies of the appointment books / daysheets for the audit period * impacts missing medical/clinical records and vloume analysis			
54	Scan paper medical/clinical records or obtain copies of electronic medical/clinical records with the auditee MOA assistance.			
55	Conduct interview MOA, particularly on billing procedures with MOA * take sample copies if needed			
56	If extra billing or private billing analysis determined at the planning stage, obtain invoices or billing records applicable.			
57	Ensure all Clinical Audit Worksheets are clear and fully completed by Medical/Healthcare Inspector and returned back to the auditor. Make sure that each page of the working paper contains a signed off and dated by the Medical/Healthcare Inspector at end of each day.			
58	Ensure that all on-site documents are removed from auditee's office and kept in hotel room every night.			
59	Back up scanned documents and electronic CAWs to USB at the end of each day.			
60	Medical/Healthcare Inspector provides written comments in overview of the audit summary report.			
61	With the Medical/Healthcare Inspector, conduct exit interview, including confirm missing patient records and ensure that the auditee gain an understanding of the major findings during the onsite audit and audit report will be written based on those findings.			
62	Return on-site audit documents back to the office and copy to LAN			
63	Copy USB scanned documents to audit folder in LAN, and after you confirm documents are on the LAN, then **delete** USB contents			
64	Return spare laptop to Christine to return to the helpdesk			

AUDIT COMPLETION CHECKLIST

Prac Name:	0	(√) Actioned	Sign-Off	W/P Ref
Prac #:	0			
Audit Period:	0			
Sr. Auditor:	0			
IV - REPORTING & FILE COMPLETION				
Error List				
65	Prepare the Error list using Error List Template			
66	Ensure the DSS Fee Item Information pages relating to any Objective 4 errors are on file for the correcting fee item rate used to calculate the net error, or automatic formula by importing all related Fee Item in Excel			
67	Ensure the Error list is peer reviewed for accuracy. *Save the reviewer email in the "Email" folder to indicate the completion of peer review.			
	^ Include file path, filename and, as appropriate Worksheet name on all Excel Worksheet printouts			
Quantify Errors				
68	Complete quantification of errors.			
69	Prepare schedule of supplemental information (quantification summary)			
70	Ensure quantification is reviewed by a peer to ensure accuracy. *Save the reviewer email in the "Email" folder to indicate the completion of peer review.			
	^ Include file path, filename and, as appropriate Worksheet name on all Excel Worksheet printouts			
Record Completion				
71	Review, index and reference all working papers, including supporting correspondence.			
72	Review Local Area Network (LAN) to ensure all relevant records are printed and formatted in audit files for the purpose of LSB Disclosure.			
Finalize Audit Report				
73	Use reporting template to draft audit report. Ensure all figures and findings are cross-referenced to supporting working papers.			
	Perform final check and review for completeness and accuracy of the draft audit report and audit file.			
74	Submit cross-referenced audit report, quantification, and the entire supporting audit file binder to a peer for review of accuracy of the numbers, readability and text/table formatting. *Peer should also review auditee's folders to ensure proper documents and folders are prepared. *Save the reviewer's email in the "Email" folder to indicate the completion of peer review.			
75	Revise draft report, quantification, and audit file , as necessary based on the peer review.			
76	Print the draft audit report for your binder and submit to Audit Manager for review. Ensure the "DRAFT" watermark is on every page			
77	Revise draft report, quantification, and audit file , as necessary based on Audit Manager's review.			

78	With Audit Manager approval, submit final audit report and quantification to Audit Assistant for formatting and upload to eapproval by Management. Once completed it will be set to Medical/Healthcare Inspector for review and approval.			
79	Sign final audit report after approved by Medical/Healthcare Inspector			
80	Signed Audit Report is presented at the AIC meeting (medical practitioners) for approval or to the Chair of the Health Care Practitioner's Special committee (health practitioners)			

AUDIT COMPLETION CHECKLIST

Prac Name:	0	**(√) Actioned**	**Sign-Off**	**W/P Ref**
Prac #:	0			
Audit Period:	0			
Sr. Auditor:	0			
V - LEGAL RECOVERY AND DISCLOSURE				
81	With an audit committee recovery decision, prepare the file in advance for anticipated legal disclosure, by:			
	a Obtaining confirmation of full document disclosure by the Medical Inspector, using template			
	b Ensuring a complete and typed up file index (no handwritten notations)			
	c Ensuring all relevant documents/records are placed appropriately in their respective working paper section			
82	Upon receiving a LSB Request for Disclosure:			
	a make any further necessary arrangements\			
	b confirm Audit Costs with Contract Admin			

BRITISH COLUMBIA

DR. FIRST NAME LAST NAME (all capitals)
Practitioner
SPECIALITY

AUDIT PLAN

For the Period:
Month Day Year to Month Day Year

Prepared by: _____

Approval by:

_____ _____
Jordan Monteiro, A/Audit Manager **Date**

Billing Integrity Program
Audit and Investigations Branch
Ministry of Health

Dr. First Name Last Name (Upper and lower case)
Audit Plan
For the period Month Day Year to Month Day Year

A. INTRODUCTION

Dr. NAME (practitioner number) is a SPECIALTY, practicing at CLINICS/INSTITUTIONS in CITY(IES), BC. (w/p ref. __) Dr. NAME stated he/she also regularly visits ABC Hospital (acronym) and the following long-term care facilities: (w/p) *(delete if not applicable)*

- ABC Care Home
- DEF Care Centre
- HIJ Nursing Home

Dr. Name is the medical director for the following facilities:…….. (w/p)

Medical Services Plan

The Medical Services Plan (MSP) paid Dr. NAME for the following fee-for-service (FFS) billings and Rural Retention Program (RRP) premiums *(delete if not applicable)* during the audit period:

Audit Period	Service Days	Service Units	FFS Value	RRP Premium Value	Total Value	W/P Ref.
**All tables should be in regular 12 point Times New Roman -*	*(add this column if*		$	$	$	
Caps at start, balance lower case Format tables consistently.	*FFS per year*					
ex: January 1, 2016 to December 31, 2016	*averages above*					
January 1, 2017 to December 31, 2017	***$500,000***					
Total:			**$0.00**	**$0.00**	**$0.00**	

If a GP, otherwise remove: During the audit period Dr. Name sometimes billed office-based fee items (visits, counselling and complete examinations) in excess of 50 service units under the Daily Volume Payment Rules.

Furthermore, for # days out of # total possible billing days, Dr. Name billed MSP for over 50 patients per day (all of these patients were not necessarily billed fee item which are limited under the Daily Volume Payment Rules). For # of those days Dr. s.22 billed between 51 and 65 patients per day and on # days for over 65 patients per day. The highest day had # patients.

Rural Retention Program Premiums **(delete if not applicable)**

RRP benefits are paid to physicians working in eligible communities covered under the Rural Practice Subsidiary Agreement (RSA). The incentive program was designed to enhance the supply and stability of

physicians in RSA communities.

The Program

- A physician's individual premium is determined by the number of isolation points assigned to his or her community.
- Isolation point ratings are based on a number of factors including the number of physicians in the community and the distance of the community from a major medical community.
- If a physician lives in a RSA community, but practices in a different RSA community, he or she will receive the fee premium and flat sum premium for the community in which he or she practices.

Eligibility

- Physicians must reside and practice in an eligible RSA community for at least nine months per year.
- Physicians must bill equal to or greater than $65,000 in the previous calendar year.

Use the following when there is more than one payee:
Dr. NAME's total MSP payments including the RRP premiums, by payee, as follows for the audit period:

Payee	Payee Name	MSP Paid	Period of billings		Location
Total					

(w/p ref. __)

OR use the following when only one payee:

Dr. Name's total MSP billings including RRP Premiums totalled $ which he/she received under her/his own payee number for the audit period. (w/p ref.)

Ministry of Health Funding

For the audit period, we are not aware of Dr. NAME receiving any Alternate Payment Program (APP) payments under sessional contracts.
or
For the audit period Dr. NAME received other Ministry of Health funded payments, as follows, *(delete as applicable)*:

- Medical On-call Availability Program of $; (w/p ref. __)
- Rural Retention Plan Annual Flat Premium of $; and (w/p ref. __)
- salary/sessional/service contract(s) administered by the NAME HEALTH AUTHORITY for $ and RRP premiums of $ totalling $. (w/p ref. __)

Dr. Name's sessional services were…..provided at…….

Other Public Funding Sources

Health Insurance BC

For the audit period Dr. NAME received the following provincial funding:

- Insurance Corporation of British Columbia (ICBC); (w/p ref.)
- Out-of-province reciprocal payments $; (w/p ref.)
- BC Employment and Income Assistance (MEIA) $; (w/p ref.)
- Office of the Superintendent Motor Vehicle (OSMV) $; and, (w/p ref.)
- WorkSafe (WSBC) $. (w/p ref.)

University NAME

An internet search of Dr. NAME found that he is listed as a Professor under the Department of Pathology and Laboratory Medicine at ABC. There was no record of Dr. NAME receiving funding from ABC, above publicly reportable annual thresholds.

Practitioner Flags and Audit Decision

(This section is completed by copying the relevant sections from the BIP Medical Consultant's referral to AIC. Reference each fact and number)

Dr. NAME came/first came/again came to the attention of the Billing Integrity Program (BIP) in YEAR because of DESCRIBE *i.e. Service Verification Audit, complaint/referral from.., analysis of high billers by…* (w/p ref. __)

As a result of this/these concerns, the BIP Medical Consultant reviewed Dr. NAME's YEAR practitioner profile and DESCRIBE

Practitioner Profile (REMEMBER PROPER TENSE i.e. RANKED)

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.

Dr. NAMEs YEAR practitioner profile flagged for the following service codes and fee items, in terms of peer group ranking and/or number of standard deviations above the group average:

Service Code	Fee Item	#of Pracs	Rank			Standard Deviations		
			Services	Cost	Patient	Services	Cost	Patient
	Include description							

(w/p ref. __)

Billing Data

For Fee Item…..(w/p ref. __)

For Fee Item….(w/p ref. __)

For Fee Item….(w/p ref. __)

Audit Referral and Decision

Based on the above flags, Dr. NAME was referred by the BIP Medical Consultant to the Audit and Inspection Committee (AIC) in MONTH YEAR. (w/p ref. __)

As a result of that referral on MONTH YEAR the AIC directed that an/ a short-notice/ an unannounced on-site audit should be undertaken of Dr. NAME's billing practices, to include, but not be limited to, the medical necessity, accuracy of billing and frequency of Service Codes /Fee Items:

- SERVICE CODES/FEE ITEMS (as exactly described in minute)

(w/p ref. __)

B. AUDIT METHODOLOGY

Authority and Objectives

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

The objectives of the audit are 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;*
8. Patterns of practice or billing (including service frequency) were justifiable; and,
9. Pattern of Practice Order dated date has been complied with. *(delete if not applicable)*

Testing Procedures

The audit will be performed to address the above objectives and includes the following procedures: *(delete if not known or not applicable)*

- Search the Internet for:
    - the auditee's clinic, location, and background information;
    - the College of Physicians and Surgeons of British Columbia website to determine practitioner status, any disciplinary action and background information.

- Interview Dr. NAME and his/her Office Manager/Medical Office Assistant to:
    - obtain clinic background on: office hours, the office EMR system, paper medical records, possible hospital privileges, care homes visits, locums and, work locations
    - to determine any payments from the Division of Family Practice;
    - understand the process of initiating and reviewing GPSC billings and all other MSP billings.
- Visit the PRACTICE/CLINIC/INSTITUTION NAME(S) where Dr. Name has the majority of his practice.
- Under the audit sample(s) conduct,
    - one hundred percent testing of a select sample of the # patients flagged in the AIC referral where anomalies were identified with respects to Fee Items # and #
    - one hundred percent testing of patient outliers greater than $; and,
    - random dollar unit sampling of the remaining FFS population after excluding the patient outlier sample and the select sample.
- Request and examine available medical records:
    - from the clinic/care homes/hospitals where the services claimed by Dr. NAME were indicated as rendered;
    - to determine medical necessity of high frequency billings of fee items identified in the AIC Referral;
- Request private billing records from clinic/care homes;
- Request appointment records or day sheets from Dr. NAME to reconcile to billings without a supporting medical record if necessary. *Do not include this line if you do not report on in the Audit Report.*
- Examine the audit findings to determine whether adequate medical records have been made and maintained in accordance with the Preamble Clause C.10 of the *Medical Services Commission (MSC) Payment Schedule*.

(ADDITIONAL PROCEDURES IF REQUIRED, DELETE IF NOT NECESSARY)

- Perform a billing population/sample data analysis for the purpose of quantifying total daily service hours being claimed and paid under FFS to determine wither these exceeded 12 hours.
    - The above daily threshold was based on Dr. NAME's stated schedule during the interviews. The analysis of total daily service hours was based only on fee items with minimum required times, as specified in the *MSC Payment Schedule.*
    - The daily service time estimates did not attempt to factor in any service times for fee items without a minimum time requirement, physical breaks by Dr. NAME, or travel between service locations.

OR

- Perform an analysis of Dr. NAME's:
    - Pattern of billing for GPSC fee items to determine that the billings did not exceed the permitted frequencies described in the *Medical Services Commission (MSC) Payment Schedule*;
    - Daily claims of office visits, complete examinations, and counselling visits, to determine if daily volume payments rules and discounts were reached;
    - Daily volume of patients seen each day in relation to total possible number of billing days; and
    - Daily volume of billing fee items with minimum time requirements as stated in the MSC

Payment Schedule.

(RRP procedure – delete if not required)

From the patient medical records, compare the actual location of services to the location codes for RRP premiums to ensure the location is appropriate for the premium paid.

(CONTRACT IDS/FAMILY IDS –DELETE IF NOT REQUIRED)

- Identify x family members with concurrent dates of service claimed by Dr. NAME;
- examine medical records of x family members with concurrent dates of service claimed by Dr. NAME, reconciled to scheduled appointments;
- Perform a concurrent service Verification Audit on X patients included in Samples A and B of the onsite audit.

Delete / modify/ add to the following, as appropriate)

We will request and examine available alternative payment records, including patient encounter information, contracts, billing submissions, work schedules and access logs.

OR

We will not examine Dr. NAME's: *(*ALTERNATIVE PAYMENT CONTRACT NAME funding in relation to FFS paid claims because that alternative funding was not significant;

- OTHER – DESCRIBE.

Population Stratification and Sampling *(or* **Population and Sampling** *delete the term "Stratification" if no stratification used)*

The audit will employ random dollar unit sampling with/without stratification of the paid FFS billing population.

Population Stratification

No Stratification

The billing population for the audit period totals # service units and $ in paid FFS claims. Random dollar-unit sampling was conducted on this population and the resulting sample was labelled Sample A.*OR*

Stratification

The billing population for the audit period was stratified into # sub-populations for audit testing.

The first sub-population was stratified based on all patients *(family contract identification numbers)* with total MSP paid claims greater than $, each representing statistical outliers. This sub-population totalled # service units and $, which is comprised of $ in paid FFS claims and $ in RRP premiums. All services in this sub-population were tested, and this was labelled Sample A. (w/p ref.)

The second and final sub-population constitutes all remaining FFS claims not included in the preceding stratification. This sub-population totalled # service units and $, which is comprised of $ in paid FFS claims and $ in RRP premiums. Random dollar-unit sampling was conducted on this sub-population, and the resulting sample was labelled Sample B. (w/p ref.)

Sample A – Outliers 100 percent testing

The first sub-population consists of # patients that were deemed as outliers and were tested against all the audit objectives. A patient was deemed to be an outlier if the total services billed by Dr. NAME during the audit period exceeded $.

The outliers are comprised of # patients totalling # service units and $, which is comprised of $ in FFS claims and $ in RRP premiums, summarized as follows by fee item: **(w/p ref)**
Insert tables – Delete RRP Premiums columns if not required)

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref)

**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. Name's billing practices. The use of bold is repeated in the tables that follow in the findings section of this report.*

Sample B - Random Dollar-Unit Sample

A random dollar-unit sample was selected from the second sub-population *(e.g. the remaining population)* with each dollar-unit traced back to a patient/family group/date of service.

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, family groups or dates of service 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. It is possible that different sampled dollars may repeat back to the same patient, family group or date of service because there are usually many dollars corresponding to the trace. 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 random dollar-unit sample is comprised of # patients/family groups/Dates of Service (# repeats), totalling # service units and $, which is comprised of $ in FFS claims and $ in RRP premiums, summarized as follows by service code/ fee item:
Insert table – Delete RRP premium columns if not required

Sample B – Random Dollar-Unit Sample					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium**	**Total Value**

				Value	
			$	$	$
	All other Fee Items				
	Total		$	$	$

(w/p ref)

**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. Name's billing practices. The use of bold is repeated in the tables that follow in the findings section of this report.*

Sample C - Select Sample *(if applicable)*

In addition to the random dollar-unit sample and outliers, we selected the patient flagged under the AIC referral….*or*
…..all billings of PHN/Date of service/Family ID/followed up on YEAR SVA irregularities/selected
describe what, how many, and why for testing against all audit objectives/ audit objectives #s

The select sample covers the audit period DATE to DATE *(if different than audit period)*, and is comprised of # patient totalling # service and $, which is comprised of $ in FFS claims and $ in RRP premiums summarized as follows by fee item:
Insert table*- Delete RRP premium columns if not applicable*

Sample C – Select Sample					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	All other Fee Items				
	Total		$	$	$

(w/p ref)

**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. Name's billing practices. The use of bold is repeated in the tables that follow in the findings section of this report.*

Sample Representation

A comparison by service codes and fee items for the sample to the population for service units and MSP dollars paid can be found in Appendix A.

Attach the Summary by SC and/or Summary by FI

Population Data Testing *(delete if not applicable)*

In addition to the audit sample testing we performed a population data analysis

…to match between any MSP recorded times of service, versus XHA paid times under contract(s)

… to detect any daily/weekly/biweekly/monthly/annual limits being exceeded/minimum thresholds not being met for fee item(s) # - DESCRIPTION

Audit Team

The on-site audit of Dr. NAME billings will be conducted on MONTH DAY to DAY YEAR at LOCATION(S).

The audit team will be comprised of three inspectors: Dr. MI NAME, SPECIALTY, and Mr./Mrs./Ms/ NAME HERE, BIP Senior Auditors.

Dr. MI NAME will be responsible for examining the medical records. AUDITOR NAME will be responsible for the overall planning, fieldwork, and reporting of the audit and conducting extra billing and alternate payments overlap *(delete if not applicable – covers both APP and HA op. funding)* testing. AUDITOR NAME #2 will assist on-site. *(delete if not applicable)*

AUDIT PLAN ATTACHMENTS		APPENDIX A
Prac:	Specialty:	
Pr#	Location:	
Audit Period:	Audit date:	
Auditors:	MI:	

POPULATION BREAKDOWN

12 months of the Audit Period	MSP Population Pd $	Service Units
Total	$0.00	-
5 Year % change	#DIV/0!	#DIV/0!

	Paid $	Service Units
Total Population		

# of PHNs		# of Family IDs	

Exclusions	Pd $	Service Units	% of Total POP $
ICBC			#DIV/0!
MEIA			#DIV/0!
OSMV			#DIV/0!
Out-of-Province			#DIV/0!
WCB			#DIV/0!
MSP Claims			#DIV/0!

Summarized by Payee

Payee#	Payee Name	MSP Paid	Period of billings		Location
Total		$ -			

POPULATION STRATIFICATION AND SAMPLE BREAKDOWN

Population 1 - Outliers > $X,XXX 100% testing

		% of Total MSP POP
MSP Pd $		#DIV/0!
Service Units		#DIV/0!
PHNs		#DIV/0!
Other		

Population 2 - MSP Population Excluding Outliers

		% of Total MSP POP
MSP Pd $		#DIV/0!
Service Units		#DIV/0!
PHNs		#DIV/0!
Other		

Population 1 Outliers 100% testing

Size (Dollar Units):		
		% of POP #1
MSP Pd $		#DIV/0!
Service Units		#DIV/0!
PHNs		#DIV/0!

Population 2 Random Sample - XX PHNS includes X repeats

Size (Dollar Units):		
		% of POP #2
MSP Pd $		#DIV/0!
Service Units		#DIV/0!
PHNs		#DIV/0!

TOTAL # OF CHARTS TO REVIEW:		# of repeats

Reconcilation of Populations to Total MSP Claims

	MSP Paid $	MSP Units
Pop 1		
Pop 2		
Total		

Sample Units and PHNs

	MSP Units	PHNs
Sample A		
Sample B		

Service Code Comparison: Stratified Population to its Sample Population (Outliers excluded; they are 100% Tested) APPENDIX A.1

Prac:	**0**	**Specialty:**	**0**
Pr#	**0**	**Location:**	**0**
Audit Period:	**0**	**Audit date:**	**0**
Auditors:	**0**	**MI:**	**0**

Comparison of the % PAID on SERVICE CODES

Service Code	Service Code Description	Total Population PAID AMT	Total Population % PAID AMT	Total Sample PAID AMT	Sample % PAID AMT	Variance
	Bold service codes that are part of the AIC/HCPSC referral		**#DIV/0!**		**#DIV/0!**	**#DIV/0!**
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
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			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
	All other service codes		#DIV/0!		#DIV/0!	#DIV/0!
Total		**$ -**	**#DIV/0!**	**$ -**	**#DIV/0!**	
		#DIV/0!		**#DIV/0!**		

Comparison of the % UNITS on SERVICE CODES

Service Code	Service Code Description	Total Population # UNITS	Total Population % UNITS	Total Sample # UNITS	Sample %UNITS	Variance
			#DIV/0!			**#DIV/0!**
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
			#DIV/0!			#DIV/0!
	All other service codes		#DIV/0!			#DIV/0!
Total		**0**	**#DIV/0!**	**0**	**0%**	
		#DIV/0!		**#DIV/0!**		

Fee Item Comparison: Stratified Population to its Sample Population (Outliers excluded; they are 100% Tested) **APPENDIX A.2**

Prac: 0	**Specialty: 0**
Pr# 0	**Location: 0**
Audit Period: 0	**Audit date: 0**
Auditors: 0	**MI: 0**

Comparison of the % PAID on FEE ITEMS

Fee Item	Fee Item Description	Total Population PAID AMT	Total Population % PAID AMT	Total Sample PAID AMT	Sample % PAID AMT	Variance
	Bold fee items in the AIC/HCPSC referral		#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
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			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
	All other fee items		#DIV/0!		#DIV/0!	#DIV/0!
Total		**$ -**	**#DIV/0!**	**$ -**	**#DIV/0!**	
		#DIV/0!		**#DIV/0!**		

(This is a summary of referral FI)
Gives a snapshot of total % to POP)

Example: Total Counselling Dollars
Percentage of Population/Sample

Comparison of the % UNITS on FEE ITEMS

Fee Item	Fee Item Description	Total Population # UNITS	Total Population % UNITS	Total Sample # UNITS	Sample %UNITS	Variance
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
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			#DIV/0!		#DIV/0!	#DIV/0!
			#DIV/0!		#DIV/0!	#DIV/0!
	All other fee items		#DIV/0!		#DIV/0!	#DIV/0!
Total		0	#DIV/0!	0	#DIV/0!	
		#DIV/0!		**#DIV/0!**		

Total Counselling Service Units
Percentage of Population/Sample

Categorizing Audit Objectives

1

Billing Integrity Program
Ministry of Health
30 October 2017

Why is it important to categorize correctly?

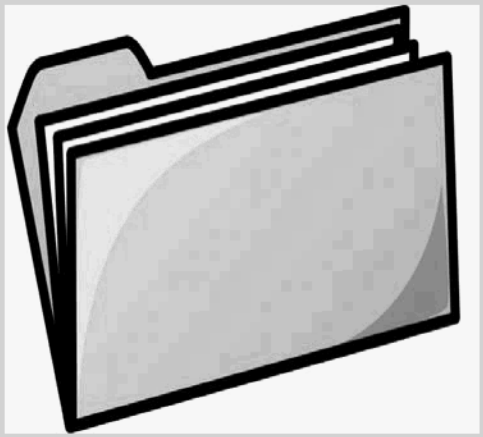
2

- Communicates the reason we consider the billing an error
  - To practitioner – helps to correct practice pattern
  - At hearing – helps the panel understand the different reasons for rejecting a claim
  - Audit process – helps form a Pattern of Practice Order to which the practitioner must comply
- Identifies other possible associated concerns
  - Overall practice patterns, and majority source of errors
- Helps to correctly assess billings
  - Some objective errors have alternate fee items applied, whereas others are collected entirely

Definitions

3

- What is a patient chart vs. a patient record:



Objective 1 Errors

4

- "To determine if medical record entries exist to support whether services were provided on the dates of service when fee items were billed."
- In the comments, please note if there is:
  - "No CHART" whatsoever:
    - Unable to find a physical folder containing any information relating to this patient, or any information in the EMR relating to this patient
  - "No RECORD within chart":
    - Able to find a folder or 'EMR folder' of the patient,
    - But unable to find a record entry for that date of service (DOS)
    - We expect this to be the majority of Objective 1 errors.
  - "No ENTRY for this service on record":
    - Able to find a folder or EMR folder for the patient, AND
    - Able to find a record entry for that date.
    - But, unable to find an entry/notation within the record relating to the service billed
    - This should be rare, and only used when multiple services are billed on the same day, and the record that is seen has already been accepted under a different sample number. If no other services were billed that day, and the billing claim is not consistent with the record available, this should be an Objective 4 error.

Objective 1 Error – Examples

5

Sample #	Patient	DOS	FI billed
6-3	SMITH, John	February 29, 2016	00100
6-4	SMITH, John	February 29, 2016	00015

- "No Chart":
  - No chart for John SMITH is found
- "No Record within chart":
  - You find the chart for John SMITH
  - But you cannot find a record dated Feb 29/16
- "No Entry for this service on record":
  - You find the chart for John SMITH
  - You find a record dated Feb 29/16
  - The dated record shows an office visit (00100), but doesn't show any record of an intra-articular injection (00015).

Objective 1 Errors - Quantification

6

This slide applies to auditors in their compilation of the Error List. It is not relevant to the MI

- Usually Objective 1 errors are rejected and quantified as 100% errors.
- However, in cases where:
  - (1) there is "No CHART," AND
  - (2) the chart would not be expected to be in the physician's control (i.e. the chart was requested from a hospital or LTC facility site)
    - Ideally, the MI will state on the CAW that there was no chart received/found from hospital or LTC facility site
  - Then, the Objective 1 error should still be documented by the MI in the CAW, and by the auditor in the error list, but it should not be quantified (i.e. claim should be accepted as paid)
  - Auditor should count this as a service unit error; but not a dollar error. The claim amount is paid to the auditee and is not included in the quantification.

Objective 2 Errors

7

- To determine whether adequate medical records (complete and legible) were maintained by the practitioner.
- In the comments, please note what aspects of the clinical record make it inadequate. For example:
  - "Illegible" – you cannot determine what was done because the record is illegible.
  - "Scant" or "Incomplete" – the record is so inadequate that it is not sufficient for the claimed billing, nor is it sufficient enough for any other fee item. If it would be sufficient for an alternate fee item, it should be classified as an Objective 4 error.

Objective 2 Error – Examples

8

Sample #	Patient	DOS	FI billed
8-1	DOE, Jane	December 25, 2015	00120

- A chart and record from this DOS is found
- Example 1:
  - The record is barely legible. You cannot determine what, if anything, was done
  - This is an Objective 2 error
- Example 2:
  - The record is partially legible. You can tell there was discussion about hypertension, but certainly no evidence of counselling
  - This is an Objective 4 error (discussed later), NOT an Objective 2 error.

Objective 3 Errors

9

- To determine whether services provided were MSP benefits under the *Medicare Protection Act*.
- There must be a chart, record, and appropriate entry for this DOS.
- However, based on the information in the record/entry, you determine that the service was not a benefit
- In the comments please indicate why the service is not a benefit. For example:
  - "ICBC" – should be billed to ICBC
  - "WSBC" or "WCB" – should be billed to WSBC
  - "Not a benefit" – should have been billed privately

Objective 3 Error – Examples

Sample #	Patient	DOS	FI billed
3-5	JONES, Chris	September 5, 2014	00190

- Medical record states: “freezing wart because patient doesn’t like the look of it.”
- This is an objective 3 error. Comment could state “should be billed privately.”

Objective 4 Errors

- To determine whether the fee items billed were consistent with the services provided, as described in the clinical records.
- This is used when there is a record available for the DOS, but the record is not consistent with the fee item billed/claimed.
- These should almost always have a substitute fee item noted in the comments. If there is no appropriate alternate fee item, then please review to see if this could be better classified under a different objective type.

Objective 4 Error – Examples

Sample #	Patient	DOS	FI billed
7-1	ALLEN, Ashley	September 5, 2014	00120

- There is a medical record for the DOS in question, and it is a benefit, but is not consistent with the service billed/claimed
- Medical record states: "f/up htn. BP 135/85. Stable. Renew hctz."
- Comments could state: "Not sufficient for counselling. Accept as office visit. Substitute FI 00100."

Objective 5 Errors

13

- To determine whether services were provided by the practitioner.
- Used when there is an acceptable record and the service is a benefit, but when the service was not provided by the practitioner.
- Most commonly this occurs when another person provides the service.
- Comments should identify the basis of the error. For example:
  - "Done by resident/trainee" – this is an error if the appropriate criteria were not met for review record/encounter by the billing practitioner
  - "Done by another physician, Dr. _____."
  - "Record appears to show documentation that a service was completed but totality of evidence does not support that the service was provided." Such a claim would also need significant additional details as this is a serious allegation.

Objective 5 Error – Examples

Audit for Dr. Bill Much			
Sample #	Patient	DOS	FI billed
10-2	JAMES, Jennifer	April 4, 2013	00100

- Record was signed by a resident without any co-signing and without any indication on the record that the case was discussed with Dr. Much
- Comments could state: "Done by resident, w/o prac involvement."

Objective 6 Errors

- To determine whether fee items billed overlapped with alternate, provincially-funded payment arrangements.
- These are typically determined by the auditors rather than the MIs, since they have access to the APP contracts.

Objective 6 Error – Examples

Sample #	Patient	DOS	FI billed
13-13	DOUBE, Bill	June 5, 2013 13:15-13:45	00650

- The auditor also has found a contract that the practitioner billed for service on an APP contract from 09:00-16:00 on that DOS.
- Comment could state: "Overlap with APP contract"

Objective 7 Errors

17

- To determine whether there was 'extra billing' for services that would ordinarily be MSP benefits under the *Medicare Protection Act.*
- The audit team must collect invoices from the practitioners to cross-reference with services.
- Comments should identify the basis of the audit finding. For example:
  - "Also billed privately @ $150"

Objective 7 Error – Examples

Sample #	Patient	DOS	FI billed
1-1	XTR, Bill	Jan 3, 2016	00120

- Record states "Meet and Greet"
- Invoice notes that patient was charged $150 for "Intake interview"
- Comments could state:
  - "Not counselling. Should be office visit. But also billed privately @ $150. Primarily Object 7 error."

Challenging situations (1)

- More than one Objective Error applies
  - In this case, please note the most significant and substantial error. If you have marked more than one error type, you MUST leave a comment to indicate the reasons for each error type and which is the primary error.

Challenging Situations (2)

- Multiple services billed, but only 1 medical record found for that DOS.
  - In this case, every service billed that is supported by the medical record must be accepted. Other claims billed but where there is no entry in the medical record, should be classified as Objective 1 with the comment "No ENTRY for this service."
  - This would also apply to FI 14033, which requires an associated office visit to be billed. In this case, as long as there is a chart and record consistent with a visit, the office visit should be accepted. If the criteria for 14033 are not met, this should be an Objective 1 error (if there is no record of a complex care plan) or Objective 2 error (if there is an incomplete record of a complex care plan).

Challenging Situations (3)

- The service claimed does not require a service or record from a particular DOS
  - This applies to fee items such as 14050, 14051, 14052, etc
  - This should be classified as an Objective 1 error only if there is no CHART found.
  - If there is insufficient evidence in the overall chart to meet the criteria of the fee item, then it must be classified as an Objective 2 error.

Challenging Situations (4)

- There is abundant evidence to suggest that a visit that has been documented has not been provided.
  - This would be classified as an Objective 5 error.
  - There should be ample comments to clarify the content of the record and the inconsistencies of the record with the remainder of the chart which led to your conclusion.
  - The possible reasons for this conclusion can be widely varied, but may include:
    - Expected associated procedures were not done. A surgery was billed and an operative report is available, but there is no record of anaesthesia.
    - A procedure was billed and a record is available, but the patient was not in the country at that time.
  - If you conclude this is occurring, please advise the auditor and medical consultant promptly

Challenging Situations (5)

- Multiple procedures were billed on the same day, with some procedures paid at 50%.
  - If some of the procedures are errors, and some are not, we have decided to use the following parameters:
    - If the billing claims being rejected was paid at 100%, in order to account for the fact that the next highest claimed procedure should have been billed at 100% instead of 50%, the claim being rejected should only be reduced by 50% instead of being rejected entirely. (This will result in a slight overpayment to the practitioner)
    - If the billing claim being rejected was paid at 50%, the entire claim can be rejected as normal.
    - If the billing claim is being substituted with a different fee item, the substitute FI must be paid at 50% or 100%, corresponding with the original claim percentage. (This may result in a slight underpayment to the practitioner overall, so must be reviewed along with all other claims on the same day)
    - The MI must advise the auditor of ALL claims requiring 50% adjustments in the comments.

Challenging Situations (6)

- There may be times when Objective 4 appears to be most appropriate, but there is no alternate fee item to be billed
  - This can occur occasionally, and should be discussed with the auditor and/or Medical Consultant.
  - Please bring such cases to the attention of the auditor or Medical Consultant promptly to be advised which audit objective is most appropriate.

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Questions

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BRITISH COLUMBIA

MEDICAL SERVICES COMMISSION AUDIT

Pursuant to the *Medicare Protection Act (the Act)*, the Medical Services Commission (MSC) has legislative authority to audit practitioner records to ensure that the Medical Services Plan (MSP) is paying only for benefits of the Plan, as defined under *the Act*, and that third parties are not being privately billed for such benefits unless such charges are specifically authorized under *the Act* or its regulations.

The following information is provided to assist you in preparing for the on-site audit.

Audit Schedule

The audit team usually requires two or three full working days to examine billing procedures and records (both MSP and non-MSP related), day sheets, appointment books, and medical/clinical records. On occasion, additional time may be required. Your assistance in arranging the scheduling for the on-site audit and providing information as requested will ensure that the audit moves quickly with minimal disruption to your office staff and routine. Please note that the audit process should not require you to make any changes in your normal office routines.

Audit Team

An audit team is typically comprised of one licensed practitioner, appointed by a subcommittee of the MSC, who will examine the clinical records; and one or two Senior Auditors from the Billing Integrity Program who will examine scheduling, and billing procedures and records. Your audit scheduling letter will detail the expected audit team members.

Confidentiality

The MSC is sensitive to concerns regarding confidentiality, and has developed audit protocols which provide strict guidelines to ensure that the process is applied fairly and in accordance with the provisions of the legislation under Section 49 of *the Act*. As indicated above, inspectors hired by the MSC to perform on-site inspections are licensed practitioners who are bound by both their professional Code of Ethics and the legislation to protect patient and practitioner confidentiality. In addition, as employees of the Province of British Columbia, the audit staff have signed an Oath of Employment which requires them to maintain the confidentiality of any information obtained during the course of their employment in the Public Service.

…2

Ministry of Health

Billing Integrity Program
Audit and Investigations Branch

PO Box 9647 Stn Prov Govt
Victoria BC V8W 9P4

Telephone: 250 952-1361
Facsimile: 250 952-2605

Facilities Requirements

We would appreciate if you could arrange for a quiet and private room or area with tables or desks, and electrical outlets, to be available to the audit team. This will facilitate the timely completion of the inspection and ensure the privacy of your patient charts and records. Should you not be able to provide the requested facilities, please advise in advance of the visit so alternate arrangements can be made.

Records Requirements

Patient Charts

The audit team will request patient medical/clinical records supporting your billings to MSP, for the audit period, for a selected sample of patients. As part of that patient sample, you will also be requested to supply records of any private billings. Please ensure that a member of your staff is available to assist with this request including the printing of any records maintained electronically as well as a walkthrough description of your billing procedures.

Billing Records

Other types of medical/clinical records supporting your billings to MSP during the audit period should also be made available. This includes, but is not limited to:

- Out-of-office visits or service records such as rendered at patient's home or an institution;
- Laboratory and x-ray reports;
- Referral letters and consultation reports;
- Information contained in pocket or other personal diaries; and,
- Appointment books and day sheets.

If it is not practical to have these records available in their entirety at the audit site, please ensure that, prior to the on-site audit, you inform the assigned auditor of their existence and assist them in obtaining any records they request relating to specific services, patients or periods of time.

Copies of medical/clinical and billing records will be made at the inspectors' discretion. These copies will be retained by the inspectors and turned over to the Billing Integrity Program along with the working papers when the audit is completed.

Results of Findings

During the on-site audit the inspectors will make arrangements to meet with you at a mutually convenient time in order to discuss and review possible billing errors and other issues identified.

Upon completion of the audit, you will receive a copy of the audit report and the error list.

BRITISH COLUMBIA

DR. FIRST NAME LAST NAME (all capitals)
Practitioner
SPECIALTY

AUDIT REPORT

For the Period:
Month Day Year to Month Day Year

DRAFT

Billing Integrity Program
Audit and Investigations Branch
Ministry of Health

File: 40920-20/12345
40920-25/12345

Dr. First Name, Last Name (Upper and lower case)
Audit Report
For the period Month Day Year to Month Day Year

A. INTRODUCTION

Dr. NAME (practitioner number) is a SPECIALTY, practicing at CLINICS/INSTITUTIONS in CITY(IES), BC. (w/p ref. __) Dr. NAME stated he/she also regularly visits ABC Hospital (acronym) and the following long-term care facilities: *(delete if not applicable)*

- ABC Care Home
- DEF Care Centre
- HIJ Nursing Home

Dr. Name is the medical director for the following facilities:…….. (w/p)

Medical Services Plan

The Medical Services Plan (MSP) paid Dr. NAME for the following fee-for-service (FFS) billings and Rural Retention Program (RRP) premiums *(delete if not applicable)* during the audit period from Month Day Year to Month Day Year.

Audit Period	Service Days	Service Units	FFS Value	RRP Premium Value	Total Value	W/P Ref.
**All tables should be in regular 12 point Times New Roman -*	*(add this column if*		$	$	$	
Caps at start, balance lower case Format tables consistently.	*FFS per year*					
ex: January 1, 2016 to December 31, 2016	*averages above*					
January 1, 2017 to December 31, 2017	***$500,000***					
Total:			**$0.00**	**$0.00**	**$0.00**	

If a GP, otherwise remove: During the audit period Dr. Name sometimes billed office-based fee items (visits, counselling and complete examinations) in excess of 50 service units under the Daily Volume Payment Rules.

Furthermore, for # days out of # total possible billing days, Dr. Name billed MSP for over 50 patients per day (all of these patients were not necessarily billed fee item which are limited under the Daily Volume Payment Rules). For # of those days Dr. s.22 billed between 51 and 65 patients per day and on # days for over 65 patients per day. The highest day had # patients.

Rural Retention Program Premiums (delete if not applicable)

RRP benefits are paid to physicians working in eligible communities covered under the Rural Practice

Subsidiary Agreement (RSA). The incentive program was designed to enhance the supply and stability of physicians in RSA communities.

The Program

- A physician's individual premium is determined by the number of isolation points assigned to his or her community.
- Isolation point ratings are based on a number of factors including the number of physicians in the community and the distance of the community from a major medical community.
- If a physician lives in a RSA community, but practices in a different RSA community, he or she will receive the fee premium and flat sum premium for the community in which he or she practices.

Eligibility

- Physicians must reside and practice in an eligible RSA community for at least nine months per year.
- Physicians must bill equal to or greater than $65,000 in the previous calendar year.

Use the following when there is more than one payee:
Dr. NAME's total MSP payments including RRP premiums, payee, as follows for the audit period:

Payee	Payee Name	MSP Paid	Period of billings		Location
Total					

(w/p ref. __)

Or use the following when only one payee:

Dr. Name's total MSP billings totalled $ which he/she received under her/his own payee number for the audit period. (w/p ref.)

Ministry of Health Funding

For the audit period, we are not aware of Dr. NAME receiving any Alternate Payment Program (APP) payments under sessional contracts.
or
For the audit period Dr. NAME received other Ministry of Health funded payments as follows: *(delete as applicable)*:

- Medical On-call Availability Program of $; (w/p ref. __)
- Rural Retention Plan Annual Flat Fee of $; and (w/p ref. __)
- salary/sessional/service contract(s) administered by the HEALTH AUTHORITY for $ and RRP premiums of $ totalling$. (w/p ref. __)

Dr. Name's sessional services were…..provided at…….

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Other Public Funding Sources

Health Insurance BC

For the audit period Dr. NAME received:

- Insurance Corporation of British Columbia (ICBC) $; (w/p ref.)
- Out-of-province reciprocal payments, $; (w/p ref.)
- BC Employment and Income Assistance (MEIA), $; (w/p ref.)
- Office of the Superintendent Motor Vehicle (OSMV) $; and, (w/p ref.)
- WorkSafeBC (WSBC) $. (w/p ref.)

University NAME

An internet search of Dr. NAME found that he is listed as a Professor under the Department of Pathology and Laboratory Medicine at ABC. There was no record of Dr. NAME receiving funding from ABC, above publicly reportable annual thresholds.

Dr. NAME's Practice

During our initial interview(s) with Dr. NAME we determined that he/she: *(delete/modify/add to the following, as appropriate)*

- primarily practiced at LOCATION NAME up and to MONTH YEAR, before moving to LOCATION NAME
- sees patients on an appointment /walk-in basis
- operates under a typical weekly schedule of SCHEDULE *(insert table if multiple locations to account for)*
- employs manually-prepared/electronic medical records / transitioned from manually-prepared to electronic medical records in MONTH YEAR; and
- privately charges patients for the following types of services: DESCRIBE

Practitioner Flags and Audit Decision
(This section is completed by copying the relevant sections from the BIP Medical Consultant's referral to AIC. Referencing each fact and number)
Dr. NAME came/first came/again came to the attention of the Billing Integrity Program (BIP) in YEAR because of DESCRIBE *i.e. Service Verification Audit, complaint/referral from.., analysis of high billers by…* (w/p ref. __)

As a result of this/these concerns, the BIP Medical Consultant reviewed Dr. NAME's YEAR practitioner profile and DESCRIBE

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.

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Dr. NAME's YEAR practitioner profile flagged for the following service codes and fee items, in terms of peer group ranking and/or number of standard deviations above the group average:

Service Code	Fee Item	#of Pracs	Rank			Standard Deviations		
			Services	Cost	Patient	Services	Cost	Patient
	Include description							

(w/p ref. __)

Billing Data (REMEMBER PROPER TENSE i.e. RANKED)

For Fee Item…..(w/p ref. __)

For Fee Item….(w/p ref. __)

For Fee Item….(w/p ref. __)

Audit Referral and Decision

Based on the above flags, Dr. NAME was referred by the BIP Medical Consultant to the Audit and Inspection Committee (AIC) in MONTH YEAR. (w/p ref. __)

As a result of that referral on MONTH YEAR the AIC directed that an/ a short-notice/ an unannounced on-site audit should be undertaken of Dr. NAME's billing practices, to include, but not be limited to, the appropriateness, accuracy of billing and frequency of Service Codes /Fee Items:

- SERVICE CODES/FEE ITEMS (as exactly described in minute)

(w/p ref. __)

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;*
8. Patterns of practice or billing (including service frequency) were justifiable; and,
9. Pattern of Practice Order dated date has been complied with. *(delete if not applicable)*

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Testing Procedures

The audit was performed to address the above objectives and included the following procedures:
(Delete if not known or not applicable)

- Searched the Internet for:
  - the auditee's clinic, location, and background information;
  - the College of Physicians and Surgeons of British Columbia website to determine practitioner status, any disciplinary action and background information.
- Interviewed Dr. NAME and his/her Office Manager/Medical Office Assistant to:
  - obtain clinic background on office hours, the office procedures, paper medical records, possible hospital privileges, care homes visits, locums and work locations
  - determine any payments from the Division of Family Practice;
  - understand the process of initiating and reviewing General Practice Service Committee (GPSC) billings and all other MSP billings;

OR

- We did not examine General Practice Service Committee (GPSC) fee items not connected to specific patients, because in order for these fee items Dr. NAME would have been pre-qualified to receive the payments.
- Visited the PRACTICE/CLINIC/INSTITUTION NAME(S) where Dr. Name has the majority of his practice.
- In the audit sample(s) conducted:
  - one hundred percent testing of a select sample of the # patients flagged in the AIC referral where anomalies were identified with respects to Fee Items # and #;
  - one hundred percent testing of patient outliers greater than $; and,
  - random dollar unit sampling of the remaining FFS population after excluding the patient outlier sample and the select sample;
- Requested and examined available medical records:
  - from the clinic/care homes/hospitals where the services claimed by Dr. NAME were indicated as rendered;
  - to determine medical necessity of high frequency billings of fee items identified in the AIC Referral;
- Requested private billing records from clinic/care homes;
- Requested appointment records or day sheets from Dr. NAME to reconcile to billings without a supporting medical record if necessary (do include if you do not comment on in the audit report).
- Examined the audit findings to determine whether adequate medical records had been made and maintained in accordance with the Preamble section C.10 of the *Medical Services Commission (MSC) Payment Schedule*.

(ADDITIONAL PROCEDURES IF REQUIRED, DELETE IF NOT NECESSARY)

- Performed a billing population/sample data analysis for the purpose of quantifying total daily service hours being claimed and paid under FFS to determine wither these exceeded 12 hours.
  - The above daily threshold was based on Dr. NAME's stated schedule during the interviews. The analysis of total daily service hours was based only on fee items with minimum required times, as specified in the *Medical Services commission (MSC) Payment Schedule.*
  - The daily service time estimates did not attempt to factor in any service times for fee items

without a minimum time requirement, physical breaks by Dr. NAME, or travel between service locations.

OR

- Performed an analysis of Dr. NAME's:
  - Pattern of billing for GPSC fee items to determine that the billings did not exceed the permitted frequencies described in the *Medical Services Commission (MSC) Payment Schedule*;
  - Daily claims of office visits, complete examinations, and counselling visits, to determine if daily volume payments rules and discounts were reached;
  - Daily volume of patients seen each day in relation to total possible number of billing days; and
  - Daily volume of billing fee items with minimum time requirements as stated in the MSC Payment Schedule.

(RRP procedure – delete if not required)

From the patient medical records, compare the actual location of services to the location codes for RRP premiums to ensure the location is appropriate for the premium paid.

(CONTRACT IDS/FAMILY IDS –DELETE IF NOT REQUIRED)

- Identified x family members with concurrent dates of service claimed by Dr. NAME;
- examined medical records of x family members with concurrent dates of service claimed by Dr. NAME, reconciled to scheduled appointments;
- Performed a concurrent service Verification Audit on X patients included in Samples A and B of the onsite audit.

Delete / modify/ add to the following, as appropriate)

We requested and examined available alternative payment records, including patient encounter information, contracts, billing submissions, work schedules and access logs.

OR

We did not examine Dr. NAME's: (ALTERNATIVE PAYMENT CONTRACT NAME funding in relation to FFS paid claims because that alternative funding was not significant.

- OTHER – DESCRIBE.

Population Stratification and Sampling *(or* **Population and Sampling** *delete the term "Stratification" if no stratification used)*

The audit employed random dollar unit sampling with stratification of the paid FFS billing population.

Population Stratification

No Stratification

The billing population for the audit period totalled # service units and $ in paid FFS claims. Random dollar-unit sampling was conducted on this population and the resulting sample was labelled Sample A.*OR*

Stratification

The billing population for the audit period was stratified into # sub-populations for audit testing.

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The first sub-population was stratified based on all patients *(family contract identification numbers)* with total MSP paid claims greater than $, each representing statistical outliers. This sub-population totalled # service units and $, which is comprised of $ in paid FFS claims and $ in RRP premiums. All services in this sub-population were tested, and this was labelled Sample A. (w/p ref.)

The second and final sub-population constitutes all remaining FFS claims not included in the preceding stratification. This sub-population totalled # service units and $, which is comprised of $ in paid FFS claims and $ in RRP premiums. Random dollar-unit sampling was conducted on this sub-population, and the resulting sample was labelled Sample B. (w/p ref.)

Sample A - Outliers 100 percent testing

The first sub-population consists of # patients that were deemed as outliers and were tested against all the audit objectives. A patient was deemed to be an outlier if the total services billed by Dr. NAME during the audit period exceeded $.

The outliers are comprised of # patients totalling # service units and $, which is comprised of $ in FFS claims and $ in RRP premiums, summarized as follows by fee item: **(w/p ref)**
Insert tables – Delete RRP Premiums columns if not required)

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)
**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. Name`s billing practices. The use of bold is repeated in the tables that follow in the findings section of this report*

Sample B - Random Dollar-Unit Sample

A random dollar-unit sample was selected from the second sub-population with each dollar-unit traced back to a patient/family group/date of service.

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, family groups or dates of service 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. It is possible that different sampled dollars may repeat back to the same patient, family group or date of service because there are usually many dollars corresponding to the trace. Sampling with replacement is applied and is mathematically dealt with using the appropriate statistical formula. Therefore, the fact that an individual,

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family group or date of service may be selected more than once introduces no bias into the estimate of proportion of errors.

The random dollar-unit sample is comprised of # patients/family groups/Dates of Service (# repeats), totalling # service units and $, which is comprised of $ in FFS claims and $ in RRP premiums, summarized as follows by service code/ fee item:
Insert table – Delete RRP premium columns if not required

Sample B – Random Dollar-Unit Sample					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	All other Fee Items				
	Total		$	$	$

(w/p ref.)
**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. NAME`s billing practices. The use of bold is repeated in the tables that follow in the findings section of this report.*

Sample C - Select Sample *(if applicable)*

In addition to the random dollar-unit sample and outliers, we selected the patient flagged under the AIC referral….*or*
…..all billings of PHN/Date of service/Family ID/followed up on YEAR SVA irregularities/selected
describe what, how many, and why for testing against all audit objectives/ audit objectives #s

The select sample covers the audit period DATE to DATE *(if different than audit period)*, and is comprised of # patient totalling # service and $, which is comprised of $ in FFS claims and $ in RRP premiums summarized as follows by fee item:
Insert table- Delete RRP premium columns if not applicable

Sample C – Select Sample					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	All other Fee Items				
	Total		$	$	$

(w/p ref.)
**The fee items in bold in the sample table above represent those flagged in the BIP Medical Consultant's referral to the AIC and included in their decision to audit Dr. NAME`s billing practices. The use of bold is repeated in the tables that follow in the findings section of this report.*

Population Data Testing *(delete if not applicable)*

In addition to the audit sample testing we performed a population data analysis

…to match between any MSP recorded times of service, versus XHA paid times under contract(s)

… to detect any daily/weekly/biweekly/monthly/annual limits being exceeded/minimum thresholds not being met for fee item(s) # - DESCRIPTION

Audit Team

The audit team was comprised of # inspectors: Dr. MI NAME, SPECIALTY, and Mr./Mrs./Ms./ AUDITOR(S), BIP Senior Auditors.

Dr. MI NAME was responsible for examining the medical records. Mr./Mrs./Ms./ AUDITOR was responsible for the overall planning, fieldwork, and reporting of the audit, as well *(add delete modify as appropriate)* performing billing data analysis, and examining private charges and alternative payments. Ms. AUDITOR assisted on-site.

OR:

Ms. Name was responsible for the overall planning, fieldwork, as well as performing billing data analysis. Ms Name assisted with the onsite fieldwork. Mr Name was responsible for the completion of the audit file and report.

OR:

The audit team was comprised of five inspectors: Dr. First and Last Name, Physical Medicine and Rehabilitation, Dr. First and Last Name, Anaesthesiology, Mr. First and Last Name, Ms. First and Last Name, and Ms. First and Last Name, Senior Auditors, BIP.

Dr. Last Name and Dr. Last Name were responsible for examining the medical records. Mr. Last Name was responsible for the overall planning, fieldwork, as well as performing billing data analysis. Ms. Last Name assisted on-site. Ms. Last Name was responsible for completing the audit file and report.

C. FINDINGS

Audit Co-operation

The on-site audit of Dr. NAME's billings was conducted from MONTH DAY to DAY, YEAR at Dr. Name's clinic at LOCATION(S).

Dr. NAME provided/was not available to provide the audit team with an overview (w/p ref. __) of his/her practice at the start of the visit. Dr. NAME was also/was not available at the end of the on-site visit for an exit interview (w/p ref. __) to discuss the preliminary findings.

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Dr. NAME's Office Manager/Medical Office Assistant helped in retrieving the requested patient files, in providing explanations, and locating additional information to support services billed to MSP and privately to patients.

For services claimed by Dr. NAME which were rendered at other clinics/healthcare institutions, we requested and obtained the medical/appointment/and or private charge records directly from these facilities. *Delete or modify as appropriate.*

Audit Objectives

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

In Sample A, OR all samples we identified # service units, with a total value of $, where a medical record was not found to substantiate the service for the date of service claimed, summarized as follows by paid fee item:

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample B – Random Dollar-Unit					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample C - Select					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

For all #service units in error, none of these represented an unaccounted for patient chart. All units in error represented a patient chart without a supporting entry for the dates of service claimed and paid. (w/p ref.)*OR*
All of the remaining # service units in error represented patient charts that were found; however, it did not contain entries for the dates of service claimed and paid. (w/p ref.)

Delete or modify, as appropriate. Private Charge(s)

For # of the # service units in error under Objective 1, we also identified an associated private charge to the beneficiary with the description of "DESCRIPTION" to indicate a patient encounter for the date of service claimed of MSP. Given the medical records were unaccounted for, we could not determine whether the private charge was for or in relation to a benefit. (w/p ref.)

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

Completeness

In Sample A OR under all samples we identified # service units, with a total value of $, where the medical records were too incomplete to substantiate billing under any fee items, summarized as follows by paid fee item:

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample B – Random Dollar-Unit					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample C - Select					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$

DRAFT

	Total		$	$	$

(w/p ref.)

Legibility

Under Objective 2, we found that legibility of the medical records was not an issue OR was an issue for # service units with a total value of $, summarized as follows by paid fee item:

Delete or modify the following as appropriate. For # of the # service units in error under Objective 2, we also identified # service units in error indicated as being rendered by another practitioner.

OR

Delete or modify the following as appropriate. For # of the # service units in error under Objective 2, we also identified an associated private charge to the beneficiary. Given the medical records were not complete/ legible enough to support a claim under any fee item we could not determine whether each private charge was for or in relation to a benefit.

No Errors: delete if not applicable

We identified no service units where the medical records were incomplete or illegible, except for the errors identified under the other objectives in this report.

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

Under Sample A OR under both samples we determined # service units, with a total value of $, where the billed services described in the medical records *delete if not applicable:* or associated private charges to the beneficiary were not benefits under the *Act,* summarized as follows by paid fee item:

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample B – Random Dollar-Unit					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample C - Select

Fee Item	Fee Item Description	Service Units	FFS Value	RRP Premium Value	Total Value
			$	$	$
	Total		$	$	$

(w/p ref.)
Please briefly explain why each did not constitute a benefit.

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

In Sample A *OR* in both samples we identified # 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 $, before making any necessary adjustments to account for alternate fee items which should have been claimed instead. *For GPs only (exclude GP with RRP Premiums-they are not subjective to daily volume payment rules:* **Where Total Daily Volume Payment Rules resulted in reductions for original fee item paid, these were extended to the alternate fee item we applied instead**. After such adjustments the total net error (dollars overpaid) was $. 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.

(If you have negative values in your tables then replace the above section with the section below).

In Sample A *Or* in both samples we identified # 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 $, 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 $.

For services that were under paid, a negative value is shown as the net error. All services which were underpaid are accounted for, in each sample patient. There were no/# patients with a net under payment based on all services assessed.

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, summarized as follows by paid fee item:

Sample A - Outliers			**Value Before Adjustments**		**Adjustment Value**		**Net Dollar Value**
Fee Item	**Fee Item Description**	**Service Unit**	**FFS Value**	**RRP Premium Value**	**FFS Value in Error**	**RRP Value in Error**	

Total			**$**	**$**	**$**	**$**	**$**

(w/p ref.)

Sample B – Random Dollar-Unit			**Value Before Adjustments**		**Adjustment Value**		**Net Dollar Value**
Fee Item	**Fee Item Description**	**Service Unit**	**FFS Value**	**RRP Premium Value**	**FFS Value in Error**	**RRP Value in Error**	
Total			**$**	**$**	**$**	**$**	**$**

(w/p ref.)

Start with the Fee Items highlighted from the AIC Referral. Also you can group like fee items such as counselling and GPSC fee items especially if there are a large number of errors. Please briefly explain why each group is an error and give the alternate fee item that was applied.

Examples:

Fee Item 00120, 15320, 16120, 17120, 18120 – Individual Counselling In Office

For all x service units, we found the records did not meet the requirements of the *MSC Payment Schedule.* Section D.3.3 of the *Preamble to the MSC Payment Schedule* states:

- counselling must be for a medical condition which is recognized as difficult by the medical profession;
- where the medical practitioner's intervention must be over and above the advice which would normally be appropriate for that condition; and,
- where the duration of counselling must last at least 20 minutes.

We found the documentation for these services did not support conditions that were difficult, and/or interventions that were above and beyond a regular visit. There was no evidence of crisis or significant emotional distress, which would have required extensive counselling. Therefore, office visit fee items were alternately applied.

Fee Item 15142 Urinalysis-Complete Diagnostic, Semi-Quant & Micro

For all x service units in error, there was no documentation of a microscope being used and only dipstick results were recorded. Therefore, Fee Item 15130 Urinalysis-Screening was alternately applied.

For All Remaining Fee Items

For the x remaining service units in error the patient medical records did not support the fee items billed and alternate fees were applied.

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

Under Sample A, OR both samples we identified # service units, with a total value of $, where someone other than Dr. NAME provided the services that were billed to MSP under his/her practitioner number, summarized as follows by paid fee items:

Sample A - Outliers					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample B – Random Dollar-Unit					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Sample C - Select					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)

Please briefly explain why each did not constitute a benefit

For # service units in error we found that the service units related to trainees that were working in Dr. Name's clinic. It was not evident from the chronological encounter charts notes that the cases were personally reviewed and signed off by the teaching practitioner, to either confirm or amend the diagnosis and treatment plan.

Example of wording: (delete if not applicable)

While the practitioner may bill for the patients seen by a trainee, the case must be reviewed by the practitioner in order to bill for the service provided. Effective May 1, 2015, the *General Preamble* to the *MSC Payment Schedule* section C.18.f states:

In order to bill for a supervised service the physician must review in person, by telephone or video conferencing the service being billed with the trainee, resident or fellow and have signed off within the next weekday workday on the EMR record, hospital chart, office chart or some other auditable document."

For the five year audit period, #service units were identified totalling $ where it appeared that Dr. Name had not signed office on trainees' chart notes to either confirm or amend the patient diagnosis and treatment plan. On May 1, 2015, the MSC General Preamble to the Payment Schedule was amended to clarify the requirements for payments for services by trainees, residents and fellows and as a result # service units prior to May 1, 2015, have been categorized as errors. The remaining # service units in error occurred after May 1, 2015.

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

Option A - no alternative payments: We did not identify that Dr. NAME received other provincial funding as an alternative to MSP FFS.

Option B - minor alternative payments: We identified where Dr. Name received only minor, alternate provincial funding for health-related services, according to health authority and Ministry of Health, Physician Compensation Branch report sources as outlined under Section A of this report. As a result, we did not exam further for any possible overlaps with FFS.

Option C - significant alternative payments assigned to health authority with full patient encounter report under FFS shadow billing: We identified that payments received by Dr. NAME from ENTITY NAME in their capacity as TITLE likely did not overlap with FFS payments they received. We were able to make this determination based on having patient encounter reporting under each payment model available through the FFS. We did not note any overlapping patient encounters between FFS paid claims assigned by Dr. NAME to ENTITY NAME, versus his own payee name.

We noted where Dr. NAME was paid under an executed/expired/unexecuted agreement with ENTITY NAME.

Option D - significant alternative payments – unable to conclude or only to partially conclude: We were unable to fully determine whether alternative payments received by Dr. NAME from ENTITY NAME overlapped with FFS paid claims for the following main reasons under:

- Under the alternative payments:
  - had services based on availability, versus actual patient encounters, in effect permitting FFS claims for paid available time;
  - no patient encounter reporting;
  - no schedule of patient encounters covering the service location, contrary to the College of Physicians and Surgeons of BC bylaws;
  - no daily start and end time reporting for billings submitted;
  - in the absence of the above, no documented work schedule or access logs to establish service dates and times; and
- under the majority of FFS paid claims had:

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- no required or reported time of service;
- no OR incomplete day sheet/appointment records covering out-of-office patient encounters.

Based on these significant information limitations we identified no/# service units with a total FFS paid claim value of $ where alternative paid dates and times overlapped with FFS claims which had times of service reported/or/determinable.
OR
In Sample A and B we identified # service units, with a total net value of $ where alternate provincially funded payment arrangements with paid dates and times overlapped with FFS claims which had times of service reported. The following table summarizes the overlaps we could identify by fee item:

Sample C - Select					
Fee Item	**Fee Item Description**	**Service Units**	**FFS Value**	**RRP Premium Value**	**Total Value**
			$	$	$
	Total		$	$	$

(w/p ref.)
We noted where Dr. NAME was paid under an executed/expired/unexecuted agreement with ENTITY NAME which included/excluded a FFS billing waiver.

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

We identified no service units where beneficiaries were billed for, or in relation to, benefits, contrary to the *Act*. OR
We identified # service units with a total MSP paid claim value of $ and private charge value of $ where beneficiaries were billed for, or in relation to, benefits, contrary to the *Act*.

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

We found Dr. NAME's pattern of billing was, overall, an unjustified departure from the patterns of billing of practitioners in the practioner' s category, based on the nature and extent of errors noted under Objectives X, X and X.

In particular, we are concerned about Dr. NAME's pattern of DESCRIBE.

Objective 9: To determine whether the Pattern of Practice Order dated DATE has been complied with. *Delete if not applicable.*

We found that Dr. Name has not complied with the Pattern of Practice Order signed Month Day Year. Specifically, he/she did not prepare and maintain an adequate medical record for every insured service in

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accordance with the *Preamble* to the *MSC Payment Schedule*.

D. AIC SUMMARY

As directed by the AIC, BIP conducted an on-site audit of Dr. NAME's billing practices, which included but was not limited to Fee Items:

- SERVICE CODES/FEE ITEMS (as exactly described in minute)
- SERVICE CODES/FEE ITEMS (as exactly described in minute)
- SERVICE CODES/FEE ITEMS (as exactly described in minute)
-
-

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

Fee Item	Sample Total		In Error		Percent in Error	
	Service Units	Value	Service Units	Value	Service Units	Value
Total:		**$**		**$**		

E. CONCLUSIONS

Sample A – Outliers

Under Sample A, the examination of the medical records of # patients with # service units totaling $ resulted in the identification of inappropriate billings for #service units with a net error value of $.

The table below identifies the inappropriate billings by audit objective:
(remove those that have no errors to report)

Sample A – Outliers		
Objective	**Service Units**	**Value**
1 – Services Not Rendered		
2 – Records Incomplete and Illegible		
3 – Not MSP Benefits		
4 – Billed Inappropriately		
5 – Service Not Provided by the Practitioner		
6 – APP Overlap		
7 – Extra billed		
8 – Over Service Frequency		
Total Sample Error:		

The total error percentages based on service units is X percent (#/#) and on dollars is X percent ($/$).

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Sample B – Random Dollar Unit Sample

Under Sample B, the examination of the medical records of # patients with # service units totaling $ resulted in the identification of inappropriate billings for #service units with a net error value of $.

The table below identifies the inappropriate billings by audit objective:
(remove those objectives from the table below that have no errors to report)

Sample B – Random Dollar Unit Sample		
Objective	**Service Units**	**Value**
1 – Services Not Rendered		
2 – Records Incomplete and Illegible		
3 – Not MSP Benefits		
4 – Billed Inappropriately		
5 – Service Not Provided by the Practitioner		
6 – APP Overlap		
7 – Extra billed		
8 – Over Service Frequency		
Total Sample Error:		

The total error percentages based on service units is # percent (#/#) and on dollars is # percent ($/$).

Based on the value of errors in Sample A - Outliers, and the extrapolation of total errors in Sample B - Random sample, for the five year audit period, the estimated value of billings in error is $xxx . Errors determined under Sample A are not extrapolated; they are recovered at 100 percent.

We have concerns that Dr. Name billings show a pattern of:

- Bullet of issue
- Bullet of issue
- Bullet of issue

Dr. MI NAME	AUDITOR NAME	Manager's Name, CPA, CGA
Medical Inspector	Senior Auditor	Audit Manager
Date: _____	Date: _____	Date: _____

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BILLING INTEGRITY PROGRAM PEER REVIEW PROCESS AND DOCUMENTS

DOCUMENTS REQUIRING PEER REVIEW

1. PRELIMINARY ERROR LIST (for audit files prior to June 2016)
2. MEDICAL RECORDS REVIEW-FINAL ERROR LIST
3. QUANTIFICATION OF POSSIBLE INAPPROIATE ERRORS AND SUMMARY
4. INTEREST, SURCHARGE, AND AUDIT COST CALCUATIONS
5. AUDIT REPORT with references
6. SETTLEMENT AGREEMENTS

PROCESS:

1. PRELIMINARY ERROR LIST; AND,

2. MEDICAL RECORDS REVIEW -FINAL ERROR LIST

- Ministry Standard: All documents must be "Times New Roman 12"
- Print FEL for Attachment to Audit Report in Lanscape
- Data printed on both sides of paper
- Headers are aligned and centered
- Dollars are in "currency" formatting, (example $32,459.25)
- Service Units have zero decimals, with commas where applicable (Example 2,123).
- FOOTER must contain page numbering (EXAMPLE – Page 1 OF 20)
- FOOTER must contain: Prepared by: NAME of senior auditor
- Error Listing contains only errors

The Preliminary Error List/Final Error List must be compared to the clinical audit worksheets (CAWs) as completed by the medical inspector. Verify for accuracy all information as listed in the Error Listing headers: Sample #, PHN, Patient Name, Date of Service, Fee Item, Fee Item Description, Units, Paid Amount ICD, Objective error, Comments.

Indicate on the document any errors identified, and return document to senior auditor for correction and updating. As the peer reviewer you must verify the corrections were made correctly by the senior auditor.

After Peer Review is completed forward an email to the senior auditor stating that you have completed the Peer Review. This email must be saved in the "Email" folder of the audit file.

3. QUANTIFICATION OF POSSIBLE INAPPROIATE ERRORS AND SUMMARY

There are three Excel tabs: Quantification with names, Quantification without names, Quantification Summary

All information on the three tabs must be verified so that each cell contains the correct information and is calculating correctly. ENSURE formulas are capturing all required cells for accurate results.

Verify data in tables:

- Practitioner name
- Audit period
- Total number of service units (in MSP population)
- Number of patients receiving service
- Number of services per patient (in MSP population)
- Total cost of the fee items (in MSP population)
- Sample size, n
- Count of Dollar Used as Hooks
- Patient Name
- Billed by Patient
- Number of Dollars in Error

Special Note: when the MSP population has been stratified ensure the quantification has the correct dollars and units for the applicable stratified population for the random samples. This affects the total point estimate.

After Peer Review is completed forward an email to the senior auditor stating that you have completed the Peer Review. This email must be saved in the "Email" folder of the audit file.

4. INTEREST, SURCHARGE, AND AUDIT COST CALCUATIONS

Verify data:

- Practitioner name
- Audit period ending date
- Audit period
- Settlement date
- Audit costs
- CIBC Historical Rates

The senior auditor is to adjust the interest rates and the days/months calculations in the table to the applicable period starting the first day after the audit period end date. For example: Audit period ends January 31, 2017, interest calculations start February 1, 2017

Peer Reviewer is to verify the interest rates and date range calculations.

Peer Reviewer to verify the correct Audit Costs have been entered.

Peer Reviewer must check that the data is populating correctly to the table that is sent to legal services.

Ensure all formulas are calculating correctly.
Reminder: This Excel sheet is never sent to legal counsel; the table is pasted into a word document and disclosed.

After Peer Review is completed forward an email to the senior auditor stating that you have completed the Peer Review. This email must be saved in the "Email" folder of the audit file.

5. AUDIT REPORT with references

The first review of the audit report with references (audit report) is to ensure all numbers and facts are recorded and referenced correctly to supporting source documents. Documents that support the referencing in the audit report should be printed and inserted in your audit binder. All tables with numbers must add and flow correctly throughout the audit report. Rounding errors must be corrected.

The second review of the audit report is to read the content for clarity, accuracy, and concise language. If you do not understand what the report is saying, the user of the audit report will also not understand. Communicate the facts and audit findings clearly.

The third review of the audit report must ensure that all text and tables in the audit report have the same font (Ministry standard of Times New Roman 12 for body and tables), spacing is correct and headers are located on the correct pages followed by content. Page numbers must be correct, no page number on the title page, the next page that follows the title page starts with page 2 of X.

The audit binder must be organized in good form at the time the audit report is peer reviewed so that all references in the audit report are aligned to the referencing in the audit binder. The audit binder index must be updated, completed, and matched to the contents of the audit binder. The audit binder must be fully organized at this stage so that it is ready to submit when LSB disclosure is requested.

Once the audit report has completed the peer and management review, the Branch Administrator creates a clean copy of the audit report without references for signing and filing within the audit file on the local area network. This is the document that is uploaded to e-approval for Managements final approval. The audit report with reference and audit report without reference match in content and are part of the LSB disclosure process.

During your review of the Draft Audit Report you must also do a Peer Review of the audit file folders on the LAN to ensure that all the standardize folders are on the LAN and any "dangling" or "to be deleted" files are cleaned up.

6. SETTLEMENT AGREEMENT

The senior auditor will receive a draft copy of the settlement agreement from our Legal Services Branch after the mediation process. It must be reviewed for accuracy before LSB sends to the auditee's legal counsel. Verify that the numbers and content are correct by matching to your audit file and that opposing counsel has **not** insert a privacy clause. Any adjustments are to be communicated by email to LSB and the original email recipients of the draft settlement agreement.