BEFORE THE ALASKA OFFICE OF ADMINISTRATIVE HEARINGS ON REFERRAL FROM THE COMMISSIONER OF HEALTH AND SOCIAL SERVICES

In the Matter of:	)	
	)	
FAMILY MEDICAL CLINIC	)	OAH No. 10-0095-DHS
	)	

DECISION

I. INTRODUCTION

This case arises from an audit of Family Medical Clinic's Medicaid billings. The audit found overpayments in several different areas and the Division of Health Care Services (Division) sought to recoup those overpayments. While Family Medical Clinic agreed with some of the audit findings, it disagreed with most of those findings and requested a hearing. The findings objected to can be divided into three classes: 1) insufficient documentation of the amount of service provided; 2) insufficient documentation of the services rendered; and 3) the evaluation and management billing codes used for billing office visits.[1] A hearing was held on March 2, 3, and 4, 2011. The record was left open at the conclusion of the hearing to allow for written closing arguments. Those arguments have been received and considered.

Based on the evidence in the record and the arguments of the parties, the findings of the audit are upheld with respect to those overpayments based on insufficient documentation of the services rendered, but not upheld as to all other alleged overpayments.

II. WITNESSES

Allan Hansen was the Division's only witness. Mr. Hansen is a manger for Meyers and Stauffer, which is the firm that conducted the audit of Family Medical Clinic's billing records. He is trained in mathematics and actuarial science, and has extensive experience in conducting Medicaid billing audits. He was qualified as an expert witness in Medicaid Auditing.[2] When conducting an audit, Mr. Hansen oversees staff members who work on the audit and he reviews their work before the final report is created. In this case, the staff members working on the audit were a supervisor, an accountant, and a nurse.

---

[1] Some claims fell into more than one of these three categories.

[2] Judgment was reserved as to the scope of the area for which he is an expert. After hearing all the evidence, it is clear that he is a qualified expert on conducting audits but that he does not have any special expertise in interpreting medical records or determining the proper billing code to apply to patient examinations.

Dr. Lavern Davidhizer testified on behalf of Family Medical Clinic. He is a Doctor of Osteopathy and he operates Family Medical Clinic. He explained the electronic medical record system in place during the period of time audited. He also testified about the patient records for many of the disputed claims.

One patient also testified. She testified about the level of care provided by Dr. Davidhizer, and his thoroughness in conducting exams.

Janice Walgenbach was called as an expert witness on behalf of Family Medical Clinic. She has worked for the clinic for 3 years, and has a total of 6 years experience with medical coding. She is a member of and is certified by the American Academy of Professional Coders. Although no formal training is required to become a coder, she has had training in addition to her professional experience. She testified about published guidelines for coding, articles in professional journals, and the manner in which the claims at issue in this case were coded. She reviewed each of the claims here, and concluded that they were properly coded and billed.

III. DISCUSSION

A. Applicable Regulations

The parties agreed that 7 AAC 43.030 as it existed at the time services were provided was applicable here.[3] That regulation read:

> (a) A provider shall maintain accurate financial, clinical, and other records necessary to support the care and services for which payment is requested. The provider is responsible to assure that the provider's designated billing service, or other entity responsible for the maintenance of financial, clinical, and other records, meets the requirements of this section.
>
> (b) A provider's record must indentify patient information including
>
> (1) recipient receiving treatment;
>
> (2) specific services provided;
>
> (3) extent of each service provided;
>
> (4) date on which each service is provided; and
>
> (5) individual who provided each service.
>
> (c) A provider's record must identify financial information including
>
> (1) the date of service and charge for each service provided;
>
> (2) each payment source pursued;

[3] The regulation has since been repealed.

> (3) the date and amount of all debit and credit billing actions for each date of service provided; and
>
> (4) the amounts billed and paid.
>
> (d) A provider shall maintain a clinical record, including a record of therapeutic services, according to professional standards applicable to the provider, applicable state and federal law, the applicable *Alaska Medicaid Provider Billing Manual* as of May 9, 1997, and any pertinent contracts. The clinical record maintained by the provider must have clinical information to
>
> (1) identify the recipient's diagnosis;
>
> (2) identify the medical need for each service;
>
> (3) identify each service, prescription, supply, or plan of care prescribed by the provider, if applicable; and
>
> (4) include annotated case notes, signed, dated, or initialed by the individual who provided the service, for each service delivered.

The parties also agreed that the Division had the burden of proving the overpayments to Family Medical Clinic that it seeks to recover from the clinic.[4]

B. Pre-Printed Time Increments

Two reimbursement claims were questioned because of the use of pre-printed time increments on the Lumbar Treatment Log.[5] As an auditor, Mr. Hansen has some "professional skepticism" as to the amount of time a treatment was applied when the time is on a preprinted form. Absent additional information, that skepticism is appropriate. It is certainly possible that a particular treatment billed in 15 minute increments might be prescribed for 15 minutes, 30 minutes, 45 minutes, or more, depending on the needs of a particular patient. In this case, however, additional information was provided to the auditors. Family Medical Clinic provided an explanation for why the time was pre-printed.

> The DRS lumbar treatment log shows that 45 minutes of decompression was provided in a pre-printed format. This format was always performed at 45 minutes. There was never any variation in the amount of time of a treatment. The DRS, as stated at the top of the log, is the actual service provided. Therefore it does identify the specific procedure provided. All of the decompression services were always provided by my medical [assistants] under my direct supervision. This treatment is provided by applying intermittent traction at different angles and

[4] Record at 37; Family Medical Clinic's Pre-Hearing Brief at 3.

[5] Claims D703001 and D703005. Exhibits 1 and 3. Claims are summarized in Appendix A to the Audit Report, Record pages 48 – 64. The claims were referred to at the hearing by the last one or two digits, and that practice will be used in the remainder of this decision.

> different lengths of time to decompress the spinal canal and nerve roots that cause pain due to disc herniation.[6]

In reviewing this response, the auditors focused on the last sentence and stated "[t]his statement suggests that the length of time spent providing treatment can vary."[7] A fair reading of this entire explanation from Family Medical Clinic is that the treatment lasts for 45 minutes and that within that 45 minutes, traction is applied at different angles for different lengths of time. To the extent there is any ambiguity in this, the issue was clarified during Dr. Davidhizer's testimony during the hearing. At Family Medical Clinic, DRS treatment is always prescribed in 45 minute intervals. For this reason, the log comes pre-printed with 45 minutes inserted. If for some reason treatment terminates early, the log is manually adjusted to account for that change. The testimony from Dr. Davidhizer outweighs the auditor's professional skepticism. The Division has not met its burden of proof that there was any overpayment based on the auditor's findings that the treatment time was not properly documented.

C. Incomplete Record Keeping

The audit found 15 instances of insufficient documentation that service was performed or who provided the service, or both.[8] A typical example[9] of one of these claims is claim number 25 involving patient J.H.[10] The patient's medical records include a page labeled "recommendations."[11] On that page, the recommended therapy was osteopathic manipulation and physical therapy evaluation. The recommended follow up was an office visit in one month, and the general recommendation was to continue with current medications.[12] The next page is a print of a screen shot from the clinic's electronic medical record.[13] This screen shot shows that the osteopathic manipulation was recommended, along with the appropriate billing code. Under the category "status" is an indication that this was performed.

The audit challenged the billing for the osteopathic manipulation. According to the audit, there is no documentation that this recommended osteopathic manipulation was actually

---

[6] Record at 2.
[7] Record at 19.
[8] Claims 6, 9, 12, 17, 22, 23, 25, 29, 31, 34, 45, 46, 47, 50, and 61.
[9] During the hearing, the various witnesses were asked their views on several examples of each type of claim or disputed audit item. The parties agreed that the claims and concerns within each category were similar, and that the testimony as to each would be similar. Accordingly, not every disputed claim was specifically addressed at the hearing.
[10] Family Medical Clinic Exhibit 11; Record at 57, 444 – 449, and 688 – 696.
[11] Exhibit 11, page 3.
[12] *Id.*
[13] Exhibit 11, page 4.

performed. The audit also challenged whether the documentation indicates the body region involved, the techniques used, or the individual who provided the service.[14]

Dr. Davidhizer testified that all of this information is in the documentation. First, he explained that the screen shot specifically indicated that the recommended treatment had been performed. He testified that the screen shot will only show "performed" under the status if someone specifically enters that status into the program, which is only done if the treatment has been performed.[15] Dr. Davidhizer's testimony is persuasive. The auditors focused on the term "recommended" and ignored that the status of the recommended treatment was marked "performed". If Family Medical Clinic had been using paper medical records, Dr. Davidhizer could have written "done," "completed," or "performed" after each recommended treatment. Presumably that would have been considered acceptable documentation. Because the clinic uses an electronic record, the method to indicate completion is to change the status box to indicate "performed." That is proper documentation that the recommended treatment had been provided.

Dr. Davidhizer also testified that the documentation shows who provided the service, the technique used, and the body region treated. Osteopathic manipulation is the technique used, and that is clearly identified. He testified that by looking at the physical examination notes[16] one can see the body region or regions identified as needing treatment. For this example, the cervical spine and thoracic spine are noted as having problems. Finally, since he is identified as the attending physician,[17] and since he is the only person in the office who provides osteopathic manipulation, there should be no question that he is the one who performed the service.

While Dr. Davidhizer's position makes some sense in the context of his practice, the documentation is not sufficient for an outside auditor to determine the required information. An auditor cannot assume from these records that there is no other osteopath in the clinic who might perform the service.[18] Nor can an auditor assume that the body regions listed as having problems were in fact the same regions actually treated. They should be, but unfortunately sometimes they won't be. In addition, with this particular example, the physical examination

---

[14] Record at 57.

[15] The only question in this case is whether the Medicaid billings were properly documented. There is no dispute as to whether the service was provided. However, the clinic can only be paid if the service is *both* provided and documented.

[16] Exhibit 11, page 2.

[17] Exhibit 11, page 1.

[18] Auditors cannot even assume, in a worst-case scenario, that the manipulation was performed by a qualified professional. That is one reason for asking who performed the service.

indicated a problem with both hands.[19] It is possible that some form of osteopathic manipulation was performed on the patient's hands. An auditor cannot determine which body regions were manipulated.

For several other patients, the recommended therapy was an injection.[20] The auditors found that there was a lack of documentation that the injection was administered, what the actual medication was, the injection site, number of injections, and who provided the service.[21] As with the osteopathic manipulations, the records do show that the injections were actually given.[22] They also show the actual medication used.[23] What they do not show is who provided the injections.

Family Medical Clinic argues that it only needs to document who *ordered* the injections, and that this information can be found in the patient records. In this example, the documents show that the injections were ordered by the physician assistant working at the clinic at that time.[24]

The regulation specifically states there must be documentation of the "individual who provided each service."[25] Using a dictionary definition of "provide," Family Medical Clinic argues that it is the person ordering the service who "provides" or makes this service available. The clinic also notes that the term "provider" is used throughout the Medicaid regulations and is defined as "an individual, firm, corporation, association, or institution that provides or has been approved to provide, medical assistance to recipient under Medicaid."[26] According to Family Medical Clinic, this definition uses "provide" to refer to the entity that is billing for the services, and not necessarily the individual who actually administers the service.[27] Family Medical Clinic argues that the term "provide" in 7 AAC 43.030 should be given the same interpretation.

The regulation at issue, however, does not say there must be documentation of the provider. It requires documentation of the <u>individual</u> who provided the service. By using the word "individual," the regulation specifies that it is not asking for documentation of the firm, corporation, association, or institution that is the Medicaid provider. Instead, the regulation

---

19 Exhibit 11, page 2.
20 *E.g.* patient D.C., claim 9. Exhibit 5, Record at 53, 401 – 415, and 620 – 631.
21 Record at 53.
22 Exhibit 5, pages 8 and 9.
23 Exhibit 5, page 9.
24 Exhibit 5, page 7.
25 7 AAC 43.030(b)(5).
26 Family Medical Clinic's Closing Statement at 6, quoting former 7 AAC 43.1990.
27 Corporations, firms, institutions, and associations can only act through individuals.

requires identification of the specific individual who administered the service as opposed to the person or organization that made it available by ordering or prescribing the service.

The Division has met its burden of proving this category of overpayments because the records do not document the individual providing the services and, for the osteopathic manipulation, does not identify the body region treated.

D. Evaluation and Management Services Codes

When a medical practitioner sees a patient, he or she may conduct a variety of different types of examinations. For Medicaid billing purposes, different Evaluation and Management Services Codes (E/M Codes) are assigned to distinguish between different levels of service. Depending on the time and professional judgment needed to evaluate and manage the patient's condition, these codes run from a simple E/M Code of 99211 to a complex E/M Code of 99215. The auditors found 22 claims billed with a 99215 or 99214 code that they believe should have been billed with the 99213 code.[28]

According to both Mr. Hansen and Ms. Walgenbach, the proper E/M code is based on several elements. The first of these is the patient history, which is made up of the history of present illness (HPI), a review of systems (ROS), and the patient, family, social history (PFSH). The second element is the level of examination, ranging from problem focused limited examinations to comprehensive examinations. The third element is the medical decision making (MDM) level. MDM level is determined by looking at the potential number of diagnoses or management options, the complexity or amount of data to be reviewed, and the risk of complications, morbidity, or mortality.

Family Medical Clinic provided compelling evidence that it properly coded these office visits. Dr. Davidhizer discussed the patient records, the patient's medical conditions, the scope of the office visit, and the reasons for an extensive patient history and physical examination.[29]

Ms. Walgenbach testified as an expert witness as to how office visits should be coded.[30] Ms. Walgenbach created worksheets to use in determining the proper code to bill for each office visit. She testified that these worksheets were developed based on American Academy of Professional Coders guidelines and on the Centers for Medicare and Medicaid Services (CMS)

---

[28] These codes are for established patients. A different set of codes would be used for new patients.

[29] As noted above, the parties agreed that witnesses could be asked about several example patients and that the testimony would be similar for the remaining patients.

[30] The Division did not object to her qualifications as an expert.

Evaluation and Management Services Guide.[31] She testified that use of worksheets of this type is common in her profession.

The audit suggested that merely counting items of patient history, body systems reviewed, and elements of a physical examination was not a valid method to determine the complexity of an office visit and, therefore the proper E/M code.[32] The audit stated:

> [T]he design and use of the worksheets appear to be based on a flawed premise that merely counting various attributes of the patient history, body systems or components of an examination will result in a meaningful classification of the office visit to the appropriate E/M intensity level.[33]

Family Medical Clinic, however, presented convincing evidence that counting of various attributes is a proper method of determining the E/M code. Not only did Family Medical Clinic's expert witness testify to this, but the admitted exhibits all suggest some form of counting is the way to determine the proper E/M code.

Exhibit 30 contains published guidelines used by the State of Alaska in its training programs.[34] The difference between a brief and an extended HPI depends on whether there are fewer than four HPI elements documented in the medical record.[35] There are three levels for Review of Systems depending on whether the examination reviewed one system, two to nine systems, or more than nine systems.[36] Patient, Family, Social History (PFSH) is divided into Pertinent or Complete based on the number of elements reviewed.[37] The level of physical examination is also determined by the number of organ systems or body areas examined.[38]

Exhibit 32 contains additional guidelines for determining the proper coding for E/M services. This document instructs that the proper code level is based on counting of various elements of patient history, review of systems, examination, and medical decisionmaking.[39]

Ms. Walgenbach also tested her worksheet against another published worksheet, Exhibit 35, which is published by CMS for Medicare part B auditors. Like Ms. Walgenbach's worksheet, the CMS worksheet requires counting of items in the medical record and basing the

---

[31] Exhibit 30.
[32] Record at 14.
[33] *Id.*
[34] Testimony of Ms. Walgenbach.
[35] Exhibit 30, page 10.
[36] Exhibit 30, page 11.
[37] Exhibit 30, page s 11 – 12.
[38] Exhibit 30, page 16.
[39] Exhibit 32, pages 9 – 11; 13 – 14; 20; 22; 26.

complexity of the exam on the total numbers found in different categories. She found the results under this worksheet to be comparable to the results from using her worksheet.[40]

The proper E/M code is also partly based on the required elements of medical decision making.[41] Ms. Walgenbach's worksheets are designed to help evaluate this aspect of an office visit properly. The number of diagnoses is counted, with newer or worsening conditions given more points than established or minor conditions.[42] The amount or complexity of the data reviewed is also based on a point system.[43] The risk level is more subjective, but is established by comparing the medical records to the CMS Table of Risk Chart.[44] Ms. Walgenbach's worksheet is similar in approach to the CMS worksheet.[45]

The only evidence against Family Medical Clinic's coding came from Mr. Hansen. He does not have any medical training, and instead relied on advice he received from the nurse on his audit team to conclude that merely counting up the different elements of the exam was not a proper basis for determining the proper billing level. The nurse did not testify, and none of her notes or worksheets are in the record. As an expert witness, it is reasonable for Mr. Hansen to rely on information he received from the audit team nurse.[46] But without more information about the nurse's reasoning in reaching her conclusions, Mr. Hansen's testimony on this issue loses some of its persuasive value.

The auditors may have been inclined to discount Family Medical Clinic's method of calculating the E/M code based on a misunderstanding of the clinic's electronic records. The audit indicated a belief that the records were pre-populated with negative findings about body systems and patient history.[47] Mr. Hansen's testimony also suggested his belief that these records would automatically list elements of an examination even if those elements were not actually examined during a particular office visit. Dr. Davidhizer's uncontradicted testimony, however, was that those elements did not show up automatically. They only appeared if they were in fact part of the examination being billed. As he conducted his examination, the computer screen would give him options about patient history and physical examinations. If he

---

40 Exhibit 36.
41 Exhibit 30, page 19.
42 *E.g.* Exhibit 26, page 9.
43 Exhibit 26, pages 9 – 10.
44 Exhibit 26, pages 10 – 11; Exhibit 30, page 22.
45 Exhibit 36.
46 Alaska Rule of Evidence 703.
47 Record at 14.

asked questions about patient history or body systems, or if he examined body systems, he would check the appropriate box on the screen. The medical system would then automatically fill in negative findings for those questions or examinations and gave the clinician the opportunity to add additional findings. Any additions would display or print in bold to indicate those additions.

That the computerized program inserted generic responses does not indicate that Dr. Davidhizer did not ask questions or conduct the examination. Instead, it indicates that he did ask questions or conduct the examination and that there were no findings to remark upon. The lack of any findings for a particular examination can be just as important medically as specific positive findings.

The Division's closing argument also questions why most of Family Medical Clinic's office visits are billed at higher E/M codes, and why there are so many more 99215 codes than 99214. There is no evidence in the record, however, that billing codes are or should be randomly distributed, or distributed in a bell curve centered on the 99213 code.[48] Dr. Davidhizer saw many patients with long and complex medical histories. Based on the level of examinations he actually conducted and billed for, most of his billing codes were either 99213 or 99215. There is no reason to believe that the billing codes submitted do not accurately reflect the level of service provided.

The Division has the burden of proving that Family Medical Clinic received overpayments by using the wrong billing code for office visits. As discussed above, there is convincing evidence that Family Medical Clinic's coding methods are based on the standards in the profession as well as on training provided by the State of Alaska. The Division has not met its burden of proving that there were overpayments based on the E/M billing codes.

//

//

//

//

//

//

//

---

[48] A random distribution would result in an equal number of visits at each of the 5 billing codes. A bell curve would show most visits at the middle level with fewer visits at either extreme.

IV. CONCLUSION

For the reasons discussed above, overpayments have been established for those audited claims where the audit found insufficient documentation of who provided the service or the body region treated through osteopathic manipulation. The Division is entitled to recoup those overpayments. The division did not meet its burden of proof for the other alleged overpayments and is not entitled to recoup those amounts. The Division will need to recalculate the total amount due from Family Medical Clinic based on the findings of this decision.

DATED this 1st day of April, 2011.

By: *Signed*
Jeffrey A. Friedman
Administrative Law Judge

Adoption

The undersigned adopts this decision as final under the authority of AS 44.64.060(e)(1). Judicial review of this decision may be obtained by filing an appeal in the Alaska Superior Court in accordance with AS 44.62.560 and Alaska R. App. P. 602(a)(2) within 30 days after the date of this decision.

DATED this 3rd day of May, 2011.

By: *Signed*
Signature
William J. Streur
Name
Commissioner
Title

[This document has been modified to conform to the technical standards for publication.]