



**Before The
State Of Wisconsin
DIVISION OF HEARINGS AND APPEALS**

PROPOSED DECISION

In the Matter of MedPoint Family Care Center

Case No. ML-09-0110

Pursuant to Wis. Stat. § 227.47(1), the PARTIES IN INTEREST to these proceedings are certified to be as follows:

Petitioner:

MedPoint Family Care Center, by
Dr. Waleed Najeeb, M.D.
2501 W. Silver Spring Drive
Glendale, WI 53209

Respondent:

Department of Health Services, by
Attorney Eric Wendorff
Office of Legal Counsel
Department of Health Services
1 West Wilson St., Room 651
P.O. Box 7850
Madison, WI 53707-7850

Administrative Law Judge

William S. Coleman, Jr., Division of Hearings and Appeals

PRELIMINARY RECITALS

On April 13, 2009, the Wisconsin Department of Health Services (the Department) issued a Notice of Intent to Recover (NIR) of claimed Medicaid overpayments in the sum of \$13,264.02 from MedPoint Family Care Center (MedPoint). In the NIR the Department identified four categories of overpayments: \$228.22 for “incomplete documentation;” \$290.40 for “lack of documentation;” \$11.07 for “non-covered services;” and \$12,625.61 for “wrong procedure code.”

By letter dated April 20, 2009, and filed with the Division of Hearings and Appeals (DHA) on April 21, 2009, MedPoint requested a hearing “pertaining to the potential overpayments for wrong procedure code in the amount of \$12,625.61.” MedPoint in its letter did

not identify as subjects of its request for a hearing the other three categories of alleged overpayments.

A prehearing telephone conference was held on July 29, 2009, during which MedPoint, through its owner Dr. Waleed Najeeb, stated that MedPoint was now challenging all components of the NIR, including the sums for “incomplete documentation,” “lack of documentation,” and “non-covered services.” The Department raised no objection to the expanded scope of MedPoint’s request for a hearing, and the undersigned’s prehearing conference report dated July 29, 2009 noted the expanded scope of the hearing.

Pursuant to a scheduling order and as part of prehearing filings, the Parties entered into a Partial Stipulation of Facts and Exhibits that included matters related to all four categories of alleged overpayments, which were filed on November 3, 2009, for the hearing scheduled for January 13, 2010.

On January 8, 2010, the Department filed a Motion to Dismiss the components of MedPoint’s appeal challenging the three categories of overpayments that were not identified in its letter of April 20, 2009 requesting a hearing. In a telephone conference with the Parties on that same day, the undersigned reserved ruling on the motion until issuance of this Proposed Decision, and instructed the Parties that they should proceed with the presentation of their evidence respecting the matters that would be affected by the motion to dismiss.

The contested case hearing was conducted as scheduled in Milwaukee on January 13, 2010. Pursuant to an established briefing schedule, the Department filed its brief in chief on February 12, 2010, and MedPoint filed its responsive brief on February 24, 2010. On March 5, 2010, the Department expressed its intention not to file a brief in reply.

Prior to the hearing the Parties entered into a “Partial Stipulation of Facts and Exhibits,” the provisions of which are set forth in the Findings of Fact below.

The issue presented in this appeal is whether the Respondent, Wisconsin Department of Health Services (Department), is entitled to recover certain payments in the total amount of \$12,935.26, which the petitioner, MedPoint Family Care Center (MedPoint), received from the Wisconsin Medicaid and BadgerCare Plus Programs for physician services provided to Medicaid and BadgerCare Plus recipients, as alleged in the Preliminary Findings letter and reports (Exhibits 10-14), the Notice of Intent to Recover letter and audit report (Exhibits 15 & 16) and the final Upcoding Audit Rebuttal Summary (Exhibit 18) and final Upcoding Audit Rebuttal Detail report (Exhibit 19).¹ The disputed amount of \$12,935.26 represents a reduction in the amount DHS claimed in the Preliminary Findings and Notice of Intent to Recover, based on additional documentation and information that MedPoint provided since those reports were issued. (Stipulation, ¶1). As described below, the Department’s determinations are affirmed except as to the sum of \$29.52 for services provided to patient V.H. on 10/24/2007. The

¹ The sum of \$12,935.26 is the remainder of the original amount of \$12,980.75, less the sum of \$45.49 that had been reflected in Exhibit 27, which the Department withdrew prior to the hearing.

Department is entitled to recoup Medicaid overpayments from MedPoint in the sum of \$12,905.74.

FINDINGS OF FACT

1. The Department is the state agency responsible for administering the Wisconsin Medicaid Program (also referred to as Medical Assistance, MA, or Title 19), pursuant to Wis. Stat. ch. 49, subch. IV, §§ 49.43 to 49.499. The Wisconsin Medicaid Program is a federal-state program that pays for certain, covered, necessary physician services provided by participating, “certified,” health care providers for qualified persons whose financial resources are inadequate to provide for their health care needs. For the purpose of administering the Wisconsin Medicaid Program, the Department has promulgated the rules set out in Wis. Admin. Code Chaps. DHS 101 through DHS 108 (formerly designated as “HFS” rules). The rules establish, among other things, the criteria for recipient eligibility, the procedures for certifying health care providers as participants in the program, the specification of covered services, requirements providers must meet for reimbursement, and the rights and responsibilities of recipients and providers. (Stipulation).

2. In pursuance of its statutory duties, the Department is authorized to audit the appropriateness and accuracy of claims for reimbursement submitted by a provider of Medicaid and BadgerCare Plus services and to recover money improperly or erroneously paid, or overpayments, to a provider, after a provider has had reasonable notice and an opportunity for a contested hearing under Wis. Stat. ch. 227. See Wis. Stat. § 49.45(2)(a)10 & (g); Wis. Admin. Code § DHS 108.02(9)(a), (b) & (e). (Stipulation).

3. At all times material to this appeal, MedPoint has been a certified provider of physician services under the Wisconsin Medicaid and BadgerCare Plus Program. (Stipulation).

4. As a condition of MedPoint’s certification and participation as a provider of services under the Wisconsin Medicaid and BadgerCare Plus Program, MedPoint and the Department executed a Wisconsin Medicaid Program Provider Agreement (Exhibit 9). (Stipulation).

5. The Department conducted a desk audit of claims MedPoint submitted for Medicaid and BadgerCare Plus services during the period April 1, 2007 and March 31, 2008. As a result of the audit, the Department issued a preliminary findings letter to MedPoint, alleging that MedPoint had received overpayments totaling \$17,406.08. The Preliminary Findings letter and related audit reports the Department sent to MedPoint are set forth in Exhibits 10 through 14. (Stipulation).

6. MedPoint submitted rebuttal documentation to the Department in response to the Preliminary Findings letter. As a result of the Department’s review of the additional documentation, the Department reduced the claimed overpayment to \$13,264.02 and issued a Notice of Intent to Recover (NIR) letter for this amount. The NIR letter and the Audit Rebuttal Summary that the Department mailed to MedPoint are set forth at Exhibit 15. The Audit

Rebuttal Detail report the Department mailed to MedPoint with the NIR is set forth at Exhibit 16. (Stipulation).

7. MedPoint filed a timely request for an administrative hearing from certain audit findings, specifically challenging the findings respecting the category of “wrong procedure code.” (Exhibit 17; Stipulation).

8. In a prehearing telephone conference on July 29, 2009, the representative of MedPoint asserted that MedPoint sought to challenge the audit findings respecting the other three categories identified in the audit report – “incomplete documentation,” “lack of documentation,” and “non-covered services.” The Department did not object to expanding the scope of the contested case hearing in this respect, and the ALJ issued a report of prehearing conference the same day that noted the expanded scope of the requested hearing.

9. MedPoint submitted additional documentation and information to the Department after the Department’s issuance of the NIR, which caused the Department to further reduce the claimed overpayment to \$12,980.75. Prior to the convening of the contested case hearing, the Department withdrew its challenge to \$45.49 of this sum, by withdrawing its findings relating to Exhibit 27, thereby amending the total sum in dispute to \$12,935.26. This is the amount at issue in this appeal. The Department identifies overpayments in four different categories of audit findings as follows: \$117.69 for “incomplete documentation;” \$138.24 for “lack of documentation;” \$11.07 for “non-covered services;” and \$12,668.26 for “wrong procedure code” (the amended amount following the Department’s withdrawal of Exhibit 27 respecting the sum of \$45.49), for a total sum in dispute of \$12,935.26. (Exhibit 18).

10. Physician services are billed to the Wisconsin Medicaid Program using procedure codes, which are uniformly defined each year by the American Medical Association in a publication titled “A Comprehensive Guide to Current Procedural Terminology” and commonly referred to as the CPT Code Book. Medicaid reimbursement is based on the procedure code assigned to each physician service billed to Medicaid. In order to support the reimbursement claimed for a particular physician service, the medical records must document that the physician met the criteria for that level of service. (Stipulation).

Audit Findings as to Incomplete Documentation

Patient B.Z. on 3/5/2008 (Exs. 20 & 101)

11. MedPoint failed to generate sufficient documentation for reimbursement in the claimed sum of \$19.60 with respect to CPT code 99201 (office visit for new patient) for services that MedPoint provided for a new patient with initials B.Z. on 3/5/08. (Ex. 20).

12. The three essential elements of services provided under CPI code 99201 are: “a problem focused history; a problem focused examination; and straightforward medical decision making.” (Ex. 7, page numbered 186). The documentation that MedPoint generated was sufficient to establish that a problem focused history was taken (Ex. 20), and that a problem focused examination was conducted (Exs. 20 and 101; Najeeb testimony). However, the records

fail to demonstrate that straightforward medical decision making was done. (Ex. 101, p. 3).² “Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option.” (Ex. 7, page numbered 128). While the records indicate that the treating chiropractor ordered a spinal manipulation (CPT code 98941) as treatment (Ex. 101, p. 3), nothing in the medical records submitted reflects any treatment plan (Najeeb testimony), which is a necessary component of complete medical decision making of any level of complexity. (Paine testimony; Carr testimony; Ex. 7, page numbered 181). Since the medical record fails to reflect all three essential elements for services reimbursable under code 99201, the services provided are not reimbursable under the MA program.

Patient L.K. on 11/19/2007 (Exs. 21 and 102)

13. MedPoint did not generate sufficiently complete documentation for reimbursement for the claimed sum of \$98.09 with respect to CPT code 99244 (office consultation for new or established patient) for services that MedPoint provided for patient L.K. on 11/19/2007. (Ex. 21).

14. The three essential elements of services provided under CPT code 99244 are: “a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.” (Ex. 7, page numbered 197). The documentation that MedPoint generated was incomplete in that it failed to document either that a comprehensive physical examination had been performed or that medical decision making of moderate complexity had been conducted. (Paine testimony; Carr testimony; Ex. 21).

15. Moreover, some documentation submitted in support of this reimbursement was created in April 2009 or in November 2009, long after the services were provided. (Ex. 21; Ex. 102; Najeeb testimony). These subsequently created records are not competent to establish that MedPoint had generated and maintained sufficient documentation to support the claim at the time the claim was submitted and paid in late 2007 or early 2008. Even if these subsequently created records were deemed competent to establish a claim for reimbursement, they nevertheless fail to contain sufficient information to establish that a comprehensive physical examination had been performed or that medical decision making of moderate complexity had been conducted on 11/19/2007. (Paine testimony; Carr testimony).

16. The audit findings as to patient B.Z on 3/5/2008 and to patient L.K on 11/19/2007 are the only audit findings in dispute under the category of incomplete documentation. (Ex. 18; Stipulation ¶11). MedPoint received excess reimbursement for “incomplete documentation” in the sum of \$117.69.

² The Department’s renewed objection to the admission of the letter from Dr. Ehrmann in Exhibit 103 (Department Brief, p. 12) on the ground that it is hearsay is overruled. Wis. Stat. § 227.45.

Audit Findings as to Lack of Documentation

Patient V.H. on 10/24/2007 (Exs. 22 & 103)

17. MedPoint generated sufficient documentation for reimbursement for the claimed sum of \$29.52 with respect to CPT code 74000 for the cost of an x-ray for patient V.H. on 10/24/2007. The documentation submitted in response to the audit was misdated with the year 2008. A preponderance of the evidence establishes that the document was generated contemporaneously with the delivery of services and that the date reflected was an error, and should have reflected the year 2007 rather than 2008. (Najeeb testimony; Ex. 22; Ex. 103).

18. The finding as to patient V.H. on 10/24/2007 was the only audit finding in dispute under the category of lack of documentation. (Ex. 18; Stipulation ¶14).

19. MedPoint had previously agreed with a component of the audit finding that it had received excess reimbursement under the category of lack of documentation in the sum of \$108.72. (Ex. 18; Stipulation). This sum thus represents the complete amount of overpayment to MedPoint under the category of lack of documentation.

Audit Findings as to Non-Covered Services

Patient P.H. on 4/24/2007 (Exs. 23 & 104)

20. On 4/24/2007, a physician for MedPoint provided medical services through a telephone conversation with patient P.H., who was unable to travel to the MedPoint offices for evaluation and management. (Najeeb testimony). MedPoint claimed reimbursement for \$11.07 pursuant to CPT Code 99211 (office or outpatient visit for evaluation and management of an established patient). The Department's regulations expressly do not permit reimbursement for telephone calls pursuant to Wis. Admin. Code § 107.03(1), and the Department determined that MedPoint was not eligible for services provided to P.H. over the telephone.

21. Notwithstanding that the physician's decision to provide care to this patient through a telephone conversation was appropriate and justified under the press of circumstances that then existed (Najeeb testimony), the rules that govern the MA program prohibit reimbursement to MedPoint or any provider for such services.

22. The finding as to patient P.H. on 4/24/2007 was the only audit finding in dispute under the category of non-covered services. (Ex. 18). MedPoint received overpayment under the category of non-covered services in the amount of \$11.07.

Audit Findings as to Wrong Procedure Code

23. If a Department auditor determines upon a review of the medical records and application of the relevant CPT codes that a provider billed Medicaid for a procedure code that is not supported by the medical records, the auditor makes a finding of "wrong procedure code" and the Department seeks to recover the reimbursement the provider received over and above the

reimbursement for what the auditor has determined is the correct procedure code. Exhibits 6 and 7 reflect the CPT Code Book sections that are relevant to the findings of “wrong procedure code,” which are at issue. (Stipulation).

Patient A.D. on 9/5/2007 (Ex. 24 & 104)

24. The documentation that MedPoint generated with respect to an office consultation for patient A.D. on 9/5/2007 supported CPT code 99241 rather than procedure code 99242, which was the CPT code under which MedPoint claimed reimbursement. CPT code 99242 is reimbursed at a rate that is \$10.44 higher than code 99241. (Ex. 24).

25. Both codes 99241 and 99242 are for office consultation, with the differences being that 99241 requires “a problem focused history” and a “problem focused examination,” while code 99242 requires an “expanded problem focused history” and an “expanded problem focused examination.” (Ex. 7, pages numbered 196-197). The components of an “expanded problem focused history” are a “brief present history” and a “problem pertinent” review of systems. (Ex. 7, page numbered 138). An “expanded problem focused examination” involves “a limited examination of the affected body area or organ system and any other symptomatic or related body organ system.” (Ex. 7, page numbered 142).

26. Patient A.D. was seeking treatment for the chief complaint of “shortness of breath,” but the documentation supporting MedPoint’s claim contains no indication that the treating physician recorded any expanded history or that the physician expanded the physical examination beyond the respiratory system, to other systems that could be involved in the problem, such as the cardiovascular system. (Ex. 24; Paine testimony; Carr testimony). The documentation does not substantiate the taking of an “*expanded* problem focused examination” or an “*expanded* problem focused examination” and thus does not support a claim for reimbursement under code 99242. Rather, MedPoint’s documentation supports a claim under CPT code 99241. MedPoint received excess reimbursement of \$10.44 for the consultation with A.D. on 9/5/2007.

Patient C.G. on 5/27/2007, 5/28/2007, 7/3/2007 & 7/4/2007 (Exs. 25, 26 & 105)

27. The documentation that MedPoint generated with respect to an “inpatient consultation” of patient C.G. on 5/27/2007 was insufficient to support CPT code 99253, which was the CPT code under which MedPoint claimed reimbursement, but rather was sufficient to support CPT code 99252. (Ex 25). CPT code 99253 is reimbursed at a rate that is \$17.96 higher than code 99252. (Ex. 25).

- a. Documentation supporting a reimbursement claim under code 99253 must reflect the performance of the following essential elements: “a detailed history; a detailed examination; and medical decision making of low complexity.” (Ex. 7, page numbered 199).
 - i. The components of a “detailed history” are “chief complaint; extended history of present illness; problem pertinent system review extended to

include a review of a limited number of additional systems; pertinent past, family and/or social history directly related to the patient's problems." (Ex. 7, pages numbered 127 & 138).

- 1) A "history of present illness" is "a chronological description of the development of the patient's present illness from the first sign and/or symptom to the present [and] includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problems." (Ex. 7, page numbered 139). An "extended present history" "consists of at least four elements of the present illness or the status of at least three chronic or inactive conditions." (Ex. 7, page numbered 139).
 - 2) An "extended review of systems" "inquires about the system directly related to the problem(s) identified in the history of present illness" and the documentation should address between two and nine additional systems. (Ex. 7, page numbered 140).
 - 3) A "pertinent past, family and/or social history is a review of area(s) directly related to the problem(s) identified in the history of the present illness" and the documentation should include "at least one specific item from any of the three history areas." (Ex. 7, page numbered 141).
- ii. A "detailed examination" consists of "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." (Ex. 7, page numbered 142). Documentation of a detailed examination as to a single organ system should reflect at least twelve separate elements specified in the CPT Code Book. (Ex. 7, pages numbered 144-148.)
- b. The "pulmonary consultation report" prepared by the physician who conducted the consultation regarding patient C.G. on 5/27/2007 is the principal documentation of the services provided on 5/27/2007 relating to that claim. The additional documentation presented by MedPoint in Exhibit 105 corroborates the pulmonary consultation report, but it does not otherwise provide greater explication beyond the clearly worded narrative of the pulmonary consultation report.
- i. The pulmonary consultation report contains insufficient information to document that the physician performed an "extended review of systems," "extended present history" and "pertinent past, family and/or social history," and thus the report is insufficient documentation of the performance of a "detailed history." (Carr testimony).

- ii. The pulmonary consultation report contains sufficient information to constitute documentation that a “detailed examination” was conducted. (Ex. 25).
- iii. The pulmonary consultation report contains sufficient information to demonstrate the performance of “medical decision making of low complexity.” (Paine testimony).
- iv. Since the pulmonary consultation report contains insufficient information to substantiate the performance of one of the three essential elements for services reimbursable under CPT code 99253 (the “detailed history”), the services provided are not reimbursable under that code. The documentation, however, does support reimbursement for CPT code 99252, because it contains insufficient information demonstrating the performance of an “extended problem focused history.” (Paine testimony; Carr testimony).

28. The documentation that MedPoint generated with respect to “subsequent hospital care” of patient C.G. on 5/28/2007 supported CPT code 99231 rather than for code 99232, which was the CPT code under which MedPoint claimed and received reimbursement. (Ex 25). CPT code 99232 is reimbursed at a rate that is \$5.14 higher than code 99231. (Ex. 25).

- a. Documentation supporting a reimbursement claim under code 99232 requires the presence of at least two of the following three components: “an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity.” (Ex. 7, page numbered 193).
 - i. An “expanded problem focused history” involves a “brief present history” and a “problem pertinent” review of systems. (Ex. 7, page numbered 138).
 - 1) The documentation reflecting the performance of a “brief” history of present illness should include one to three elements of the history of the present illness. (Ex. 7, page numbered 139).
 - 2) The documentation reflecting the performance of a “problem pertinent” review of systems should include the patient’s positive and negative responses for two to nine systems. (Ex. 7, page numbered 140).
 - ii. An “expanded problem focused examination” involves “a limited examination of the affected body area or organ system and any other symptomatic or related body organ system.” (Ex. 7, page numbered 142). Documentation of an expanded problem focused examination as to a single organ system should reflect at least six separate elements specified in the CPT Code Book. (Ex. 7, pages numbered 144-148).

- iii. “Medical decision making of moderate complexity” requires the presence of (a) multiple diagnoses or management options, (b) moderate amount and/or complexity of data to be reviewed, and (c) moderate risk of complications and/or morbidity or mortality. (Ex. 7, page numbered 129).
- b. The medical record that MedPoint generated with respect to the subsequent hospital care of patient C.G. on 5/28/2007 consists of nine handwritten lines of the examining physician on the patient’s hospital chart, with each of the nine lines representing certain data or an observation. (Ex. 25). This document fails to establish any of the three components for services rendered pursuant to CPT code 99232, but does reflect documentation of the essential components for code 99231. (Carr testimony; Paine testimony). MedPoint is eligible for reimbursement for code 99231, which is \$5.14 less than what it received under code 99232.

29. The documentation that MedPoint generated with respect to an “inpatient consultation” of patient C.G. on 7/3/2007 was insufficient to support CPT code 99253, which was the CPT code under which MedPoint claimed and received reimbursement, but rather was sufficient to support CPT code 99252. (Ex 26). CPT code 99253 is reimbursed at a rate that is \$17.96 higher than code 99252. (Ex. 26).

- a. Documentation supporting a reimbursement claim under code 99253 must reflect the performance of the following essential elements: “a detailed history; a detailed examination; and medical decision making of low complexity.” (Ex. 7, page numbered 199).
- b. The documentation that MedPoint submitted to support the 99253 code reflected a “problem focused history,” rather than a “detailed history,” (Ex. 26, pp 2-5; Paine testimony; Carr testimony), and thus the documentation failed to reflect the performance of an essential component for code 99253.

30. The documentation that MedPoint generated with respect to “subsequent hospital care” of patient C.G. on 7/4/2007 supported CPT code 99231 rather than code 99232, which was the CPT under which MedPoint claimed reimbursement. (Ex 25). CPT code 99232 is reimbursed at a rate that is \$5.14 higher than code 99231. (Ex. 25).

- a. Documentation supporting a reimbursement claim under code 99232 requires the presence of at least two of the following three components: “an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity.” (Ex. 7, page numbered 193).
- b. The medical record that MedPoint generated with respect to the subsequent hospital care of patient C.G. on 7/4/2007 consists of 14 handwritten lines of the examining physician on the patient’s hospital chart, each of the lines representing certain data or observation. (Ex. 26, p. 6). This document fails to establish any of

the three principal components for services rendered pursuant to CPT code 99232, but does reflect documentation of the components for code 99231. (Carr testimony; Paine testimony). MedPoint is eligible for reimbursement for code 99231, which is \$5.14 less than what it received under code 99232.

Patient J.H. on 3/21/2008 (Ex. 19, p. 81; Ex 32)

31. MedPoint obtained reimbursement under CPT code 99243, which is a “consultation code,” with respect to patient J.H. on 3/21/2008, which MedPoint now acknowledges was in error. (Ex. 32, submitted by agreement of the Parties in conjunction with post-hearing briefing; MedPoint Brief 2/24/2010). The Department determined that the services provided to J.H. are reimbursable under Code 99214 (office visit for an *established* patient), while MedPoint claims it should be reimbursed under code 99204 (office visit for a *new* patient). “A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs in the same group practice, within the last three years.” (Ex. 7, page numbered 118). MedPoint records indicate that the physician who provided services to J.H. on 3/21/2008 (an internist) had previously been the physician who had been identified as ordering certain testing for J.H. MedPoint records also indicated that J.H. had been seen by another MedPoint physician (a urologist) on 12/13/07, 12/19/07, 01/16/08, 01/30/08, 2/19/08, and 03/06/08. (Ex. 32; Ex. 19, p. 81). The evidence is insufficient to establish that J.H. was a “new patient” as defined in the CPT Code Book as to the treating physician on 3/21/2008, and therefore the services provided to J.H. on that day are not reimbursable under code 99204. The department properly determined that the services provided to J.H. on 3/21/2008 were reimbursable under code 99214.

Patient R.T. from 8/6/2007 to 3/20/2008 (Exs. 28 & 107)

32. MedPoint was reimbursed for the office visit of patient R.T. on 8/6/07 under CPT code 99204 (new patient), and for four subsequent office visits through 3/20/2008 under CPT code 99214 (established patient).

33. Documentation supporting a reimbursement claim under code 99214 must reflect the performance of each of the following three components: “a detailed history; a detailed examination; medical decision making of moderate complexity.” (Ex. 7, page numbered 188).

34. The Department determined that patient R.T. was at all relevant times an “established patient” and that the documentation of the services provided in all of the office visits supported reimbursement under code 99213. Services are reimbursable under code 99213 if the documentation demonstrates performance of any two of the following three components: “an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity.” (Ex. 7, page numbered 188).

35. The medical record completed by the treating physician as to the services delivered on 8/6/2007 indicate that R.T. was then an established patient. (Ex. 28, p. 5). Testimonial evidence from a non-treating physician that this medical record erroneously identified R.T. as an

established patient lacked sufficient weight to overcome the reliability inherent in a contemporaneous entry in the medical record that indicated otherwise. Accordingly, the medical documentation for an office visit on 8/6/2007 does not support reimbursement for a new patient under code 99204.

36. The documentation that MedPoint submitted for the five dates in issue involves a chief complaint of tailbone pain, and indicated that the treating physician adjusted prescribed pain medications through the course of treatment over the five office visits in issue. The adjustment of the pain medications throughout the treatment is reflective of medical decision making of low complexity, notwithstanding that the medications provided are high powered drugs. (Carr testimony). The documentation for the office visits reflects medical decision making of low complexity, an expanded problem focused history, and an expanded problem focused examination. (Ex. 28; Carr testimony; Paine testimony; Ex. 107). The services provided on these five dates to R.T. were reimbursable under code 99213.

Patient J.S. 11/21/2007 (Exs. 29 & 108)

37. MedPoint was reimbursed for one office visit for patient J.S. on 11/21/2007 under CPT code 99215. Documentation supporting a reimbursement claim under code 99215 must reflect the performance of each of the following three components: “a comprehensive history; a comprehensive examination; medical decision making of high complexity.” (Ex. 7, page numbered 188).

- a. A “history of present illness” is “a chronological description of the development of the patient’s present illness from the first sign and/or symptom to the present [and] includes a description of location, quality, severity, timing, context, modifying factors and associated signs and symptoms significantly related to the presenting problems.” (Ex. 7, page numbered 139). The components of a “comprehensive history” are “chief complaint; extended history of present illness; review of systems which is directly related to the problem(s) identified in the history of present illness plus a review of all additional body systems; complete past, family and/or social history directly related to the patient’s problems.” (Ex. 7, pages numbered 127 & 138).
 - i. An “extended history of present illness consists of at least four elements of the history of present illness or the status of at least three chronic or inactive conditions.” The medical record created should describe such components of an extended history.
 - ii. A “complete review of systems” “inquires about the system(s) directly related to the problem(s) identified in the history of present illness plus all additional body systems.” (Ex. 7, page numbered 140).
 - iii. A “complete past, family and/or social history” is defined as follows: “[A] review of two or all three of the past, family and/or social history

areas, depending on the category of the evaluation and management service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.” (Ex. 7, page numbered 141). Documentation demonstrating the performance of a “complete past, family and/or social history” for an office visit of an established patient must show “[a]t least one specific item from two of the three history areas.” (*Id.*).

- b. A “comprehensive examination” consists of “a general multi-system examination or complete examination” of certain single organ systems, such as the “cardiovascular” system. Documentation of a comprehensive examination of a single organ system must reflect an examination into all elements specified for that system. (Ex. 7, page number 144). Documentation for a comprehensive examination for multiple body systems should show at least two specified elements for each of nine areas or body systems. (Ex. 7, page numbered 149).
- c. “Medical decision making of high complexity” requires the presence of (1) an extensive number of diagnoses or management options, (2) extensive amount and/or complexity of data to be reviewed, and (3) high risk of complications and/or morbidity or mortality. (Ex. 7, page numbered 129).

38. The documentation that MedPoint presented showed that the office visit on 11/21/2007 involved a follow up evaluation and management regarding existing diagnoses. The records demonstrated the performance of an expanded problem focused history (rather than a comprehensive history), and medical decision making of moderate complexity (rather than high complexity). (Paine testimony; Carr testimony). The documentation thus fails to substantiate two of the three necessary components for reimbursement under CPT code 99215, thus barring reimbursement for such services. The documentation, however, does support reimbursement for CPT code 99214, which is reimbursed at a rate \$18.96 lower. (Ex. 29).

Patient M.S. on 10/30/2007 (Exs. 30 & 109)

39. MedPoint was reimbursed for one office visit for patient M.S. on 10/30/2007 under CPT code 99215, which requires documentation that reflects the performance of each of the following three components: “a comprehensive history; a comprehensive examination; medical decision making of high complexity.” (Ex. 7, page numbered 188).

40. The documentation that MedPoint submitted to support this claim supported reimbursement under CPT code 99386, which is a “preventive medicine” code for the “initial comprehensive preventive medicine evaluation and management of a [new patient, ages 40-64 years], including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s) [and] laboratory/diagnostic procedures.” (Ex. 7, page numbered 225). (Paine testimony; Carr testimony; Ex. 30). The documentation that MedPoint submitted did not reflect the performance

of each of three essential components of services that are reimbursable under code 99215. Code 99386 is reimbursed at a rate \$8.71 lower than for CPT code 99215, and this sum represents the amount of excess reimbursement paid to MedPoint for services for M.S. on 10/30/2007.

41. MedPoint similarly received excess reimbursement under CPT code 99215 rather than under CPT code of 99386 for patient R.C. on 10/16/2007 (Ex. 19, p. 43), patient P.G. on 11/08/07 (Ex. 19, p. 76); patient T.J. on 6/28/07 (Ex. 19, p. 99), and patient R.S. on 11/5/2007 (Ex. 19, p. 153). (Paine testimony).

Patient C.W. on 12/5/2007 (Exs. 31 & 110)

42. MedPoint was reimbursed for an office visit for patient C.W. on 12/5/07 under CPT code 99214. The patient's chief complaint was "pain" in the lower back and radiating to the legs. (Ex. 30)

43. Documentation supporting a reimbursement claim under code 99214 must reflect the performance of each of the following three components: "a detailed history; a detailed examination; medical decision making of moderate complexity." (Ex. 7, page numbered 188).

44. The Department determined that MedPoint's documentation of the services provided supported reimbursement under code 99213. Services are reimbursable under code 99213 if the documentation demonstrates performance of any two of the following three components: "an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity." (Ex. 7, page numbered 188).

45. The documentation that MedPoint submitted for these services was insufficient to demonstrate the performance of either a detailed history or a detailed examination, although it did reflect medical decision making of moderate complexity. (Carr testimony). The documentation reflected the performance of expanded problem focused history and examination, and thus supported reimbursement under code 99213, which is reimbursed at a rate \$15.18 lower than code 99214.

Residual audit findings as to "wrong procedure code" at issue.

46. Exhibits 23 through 31 (exclusive of withdrawn Exhibit 27) are representative examples of the medical records MedPoint generated with respect to its claims and reimbursement pursuant to certain CPT codes, which the Department reviewed in making the findings of "wrong procedure code" that are in issue in this proceeding. (Stipulation ¶14). The findings respecting patient J.H. on 3/21/09 described above is the only audit finding of its kind in dispute under the category "wrong procedure code." The preceding findings respecting wrong procedure code control as to all other findings of wrong procedure code set forth in Exhibit 19, except as to the finding regarding patient W.H. on 7/9/2007 (Ex. 19, p. 8), which was withdrawn and which reduced the alleged excess reimbursement under the category of "wrong procedure code" by the sum of \$45.49 for a resulting net disputed sum of \$12,668.26.

47. MedPoint received excess reimbursement under the category of wrong procedure code in the amount of \$12,668.26.

DISCUSSION

Motion to Dismiss

The Department has moved to dismiss for lack of jurisdiction MedPoint's challenges to the audit findings respecting "incomplete documentation" (\$117.69), "lack of documentation" (\$29.52), and "non-covered services" (\$11.07), on the ground that MedPoint's letter requesting a hearing stated that it was requesting a hearing only as to the findings respecting "wrong procedure code." As noted at the outset in the Preliminary Recitals, during the first prehearing telephone conference in July 2009 MedPoint stated that it challenged all the audit findings, which included the three categories other than "wrong procedure code." The Department did not object and it proceeded to prepare for hearing under the assumption that all the audit findings would be in issue at the hearing. Less than a week before the hearing date, the Department filed a motion to dismiss MedPoint's challenge to any audit category other than "wrong procedure code" because MedPoint's letter requesting the appeal stated that MedPoint was challenging only the audit findings respecting "wrong procedure code," and that it did not timely file a request for hearing as to the other three categories in the audit findings. The Department contends that the failure of MedPoint to identify the remaining three categories before the expiration of its time to request a hearing deprives the Division of Hearings and Appeals of jurisdiction to consider those challenges.

The motion to dismiss is denied. The Division of Hearings and Appeals acquired jurisdiction over the matter by virtue of MedPoint's timely filing of a request for a hearing. Once the Division acquired jurisdiction over the matter, it had the authority to allow the petitioner to amend its hearing request to expand the scope of its challenge to the Department's action. The amendment of the scope of the challenge in effect relates back to the time of the filing of the request for a hearing, in much the same way that the amendment of a complaint in a civil action relates back to the time of the filing of the complaint pursuant to Wis. Stat. Rule 802.09(3). See also Wis. Stat. Rule 809.10(1)(f), which recognizes that "[a]n inconsequential error in the content of the notice of appeal is not a jurisdictional defect."

The Division of Hearings and Appeals has jurisdiction to consider MedPoint's challenges to all components of the Department audit pursuant to MedPoint's hearing request as later amended.

Applicable Legal Standards

A Medicaid provider bears the ultimate burden of establishing that it is entitled to Medicaid reimbursement. Section 49.45(3)(f), Wis. Stats., requires a provider to "maintain records as required by the department" to enable the department to verify that services were actually provided and that the claims were appropriate and accurate. The statute provides further that the Department "may deny any provider claim for reimbursement which cannot be so

verified.” Similarly, section 49.45(2)(a)10, Stats., employs mandatory language, providing that the Department "shall" "recover money improperly or erroneously paid, or overpayments."

A determination by the Department that it has found MA overpayments to have occurred will not be disturbed in a contested case hearing before the Division of Hearings and Appeals unless a preponderance of the evidence demonstrates that the Department erred in its determination. *See Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982). If the Department presents sufficient evidence to establish a *prima facie* case that the provider was overpaid, the burden of producing evidence to counter the Department’s evidence shifts to the petitioner.

Wisconsin Admin. Code Chapter HFS 106,³ “Provider Rights and Responsibilities,” provides in section HFS 106.02(4) as follows: “A provider shall be reimbursed only if the provider complies with applicable state and federal procedural requirements relating to the delivery of the services.” The provisions of Wis. Admin. Code section HFS 106.02(9) describing the required content of the medical records of MA providers, are such a procedural requirement, and provide in part as follows:

(9) MEDICAL AND FINANCIAL RECORDKEEPING AND DOCUMENTATION.

(a) *Preparation and maintenance.* A provider shall prepare and maintain truthful, accurate, complete, legible and concise documentation and medical and financial records specified under this subsection, s. HFS 105.02(6), the relevant provisions of s. HFS 105.02(7), other relevant sections in chs. HFS 105 and 106 and the relevant sections of ch. HFS 107 that relate to documentation and medical and financial recordkeeping for specific services rendered to a recipient by a certified provider....

* * * *

(e) *Provider responsibility.* 1. Each provider is solely responsible for the truthfulness, accuracy, timeliness and completeness of claims ... and any other supplementary information relating to the provider’s MA certification or reimbursement for services submitted to MA.... This includes but is not limited to the truthfulness, accuracy, timeliness and completeness of the documentation necessary to support each claim.... The use ... of a service, system or process for the preparation and submission of claims ..., whether in electronic form or on paper, does not in any way relieve a provider from sole responsibility the truthfulness, accuracy, timeliness and completeness of ... claims for reimbursement for services submitted to MA....

(f) *Condition for reimbursement.* Services covered under ch. HFS 107 are non-reimbursable under the MA program unless the documentation and medical recordkeeping requirements under this section are met.

³ All references to Wisconsin Administrative Code relating to Medical Assistance are to the provisions that were in effect at the time MedPoint submitted the reimbursement claims. Since that time, the pertinent code chapters have been re-designated as “DHS” rules, whereas at the time that MedPoint submitted the claims they had been designated as “HFS” rules.

(g) *Supporting documentation.* The department may refuse to pay claims and may recover previous payments made on claims where the provider fails or refuses to prepare and maintain records ... required under s. HFS 105.02 (6) or (7) and the relevant sections of chs. HFS 106 and 107 for purposes of disclosing, substantiating or otherwise auditing the provision, nature, scope, quality, appropriateness and necessity of services which are the subject of claims or for purposes of determining provider compliance with MA requirements.

Wisconsin Admin. Code § HFS 106.02(2) provides: “A provider shall be reimbursed only for covered services specified in ch. HFS 107.” Thus, if MedPoint failed to comply with Medicaid’s stringent documentation requirements, it is not entitled to Medicaid reimbursement and the money improperly paid is subject to recoupment.

Audit Findings

Physician services are billed to the Wisconsin Medicaid Program using procedure codes defined by the American Medical Association’s CPT Code Book. Medicaid reimbursement is based on the procedure code assigned to a physician service. In order to support the reimbursement claimed for a particular physician service, the medical records must document that the physician met the criteria for that level of service. (Stipulation ¶13).

The physician services at issue with respect to the findings of wrong procedure code are almost all “management and evaluation” services. The three key components for determining the correct procedure code for an evaluation and management service are the patient history elicited by the physician, the physician’s examination of the patient, and the physician’s medical decision making. (Exhibit 7, p. 120) The determination of the correct procedure code is based upon the extent of the history obtained, the extent of the examination performed, and the complexity of the medical decision making. (Exhibit 7, pp. 7-8) The CPT Code Book defines different levels of service in each of the three key components and provides guidelines for determining what levels have been met. (Exhibit 7, pp. 121-124, 125-130, 137-149, 180-184)

The CPT Code Book sets a stringent standard for documenting that the elements of a procedure code have been met:

Documentation in the patient’s medical report must clearly support the procedures, services, and supplies coded on the health insurance claim form. Most medical chart reviewers take the position that if something is not documented in the medical record, then the service or procedure was not performed and therefore is not subject to reimbursement.

* * * *

If the provider reported a service or procedure on the health insurance claim form but did not document it, or document it completely, in the patient’s records, from the point of view of Medicare or private health insurance company auditors, the service was not performed, can’t be reported, and therefore will not be paid.

(Exhibit 7, pages numbered 7 & 134). The Wisconsin Medicaid Program applies the same stringent standard. (Paine Testimony).

The Department presented reliable and probative evidence to support all of the audit findings at issue except as to the “lack of documentation category.” In that category, MedPoint carried its burden to establish that the medical record that it generated regarding the x-ray done for patient V.H. on 10/24/2007 merely had a typographical error as to the year, and was created contemporaneously with the services provided. (Najeeb testimony). The documentation for this service met the standards required for Medicaid reimbursement in the sum of \$29.52.

MedPoint did not dispute the other finding in the audit respecting “lack of documentation” relating to overpayment in the sum of \$108.72 under that category. (Ex. 18; Stipulation).

The Department presented a prima facie case as to the remainder of the audit findings, and MedPoint failed to present sufficient evidence to overcome the Department’s prima facie case. In a number of instances, the sole witness for MedPoint noted that many of the documentation problems identified through the audit were a result of problems that MedPoint was experiencing with its new electronic medical records system, and also by the practices of certain of MedPoint’s physicians and the level of their computer skills. The sole MedPoint witness indicated that most such problems have since been cured and that MedPoint creates far better medical records today than those reflected over the audit period. While this certainly explains the state of certain of MedPoint’s records, it does not excuse compliance with controlling rules, which make clear that the provider alone bears the risk of failures or flaws in medical record creation and maintenance. Wis. Admin. Code § HFS 106.02(9)(e).

The Department has neither suggested nor sought to establish that MedPoint possessed any fraudulent or evil motive with respect to the submission of any of the claims in dispute, but rather has simply alleged and established as to most of the audit findings that the medical documentation that MedPoint generated was inadequate to support the reimbursement claimed.

MedPoint, while arguing that its records were generally sufficient to support its claims for reimbursement, also argues that the documentation requirements demanded by the MA program are unduly burdensome and interfere with the delivery of effective medical services. While this may indeed be a fair criticism of the controlling regulations, it is of no relevance to this proceeding. The documentation requirements for the MA program are prescribed by statutes and administrative rules, which embody the policy choices made respecting documentation requirements. The undersigned has no authority to pass on the wisdom or efficacy of those documentation requirements – such policy decisions are the prerogative of the legislature through passage of statutes and promulgation of agency rules pursuant to Chapter 227, Stats. Rather, the role of the undersigned in this contested case hearing is to determine only whether MedPoint complied with the documentation requirements specified by those statutes and administrative rules.

By all indications, MedPoint is staffed by caring and conscientious professionals who work in a challenging environment to provide their largely needy patient base with necessary medical services. It is unfortunate that MedPoint's problems with its system of electronic medical records has prevented it from receiving all the reimbursement to which it believes it is due for the services actually delivered. The Department has the duty, however, to require all providers to adhere strictly to the documentation requirements of the applicable statutes and administrative rules. The Department has done so with respect to almost all of its audit findings, as described above.

CONCLUSIONS OF LAW

1. The Department is empowered to audit an MA provider. Wis. Stat. § 49.45(2)(b)4.
2. MedPoint timely requested a hearing challenging the Department's Notice of Intent to Recover (NIR) letter. The Division of Hearings and Appeals has jurisdiction over MedPoint's challenges, as allowed to be amended, to the findings in the NIR letter.
3. For all disputed claims for reimbursement set forth in Exhibit 18, the Department provided sufficient evidence to establish that MedPoint did not create or maintain sufficient records to demonstrate its entitlement to reimbursement in the sums that it received, except as to the sum of \$29.52 for alleged "lack of documentation" as to patient V.H. on 10/24/07 and the sum of \$45.49 for "wrong procedure code" as to patient W.H. on 7/9/2007. The remainder of the Department's audit findings are sustained, so that the Department is entitled to recoup from MedPoint the sum of \$117.69 for "incomplete documentation," the sum of \$108.72 for "lack of documentation," the sum of \$11.07 for "non-covered services," and the sum of \$12,668.26 for "wrong procedure code," for a total recoupment of \$12,905.74.

NOW, THEREFORE, it is ORDERED

If, and only if, this Proposed Decision is adopted by the Secretary of the Department of Health Services as the Department's Final Decision, then the Department of Health Services' final audit that MedPoint is liable for an overpayment of Medical Assistance Payments totaling \$12,980.75 is VACATED with respect to the payment of \$45.49, REVERSED with respect to payment of \$29.52, and AFFIRMED in all other respects for the sum of \$12,905.74.

NOTICE TO RECIPIENTS OF THIS DECISION:

This is a Proposed Decision of the Division of Hearings and Appeals. IT IS NOT A FINAL DECISION AND SHOULD NOT BE IMPLEMENTED AS SUCH.

If you wish to comment or object to this Proposed Decision, you may do so in writing. It is requested that you briefly state the reasons and authorities for each objection together with any argument you would like to make. Send your comments and objections to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy to the other parties named at the outset as "PARTIES IN INTEREST."

All comments and objections must be received no later than 15 days after the date of this decision. Following completion of the 15-day comment period, the entire hearing record together with the Proposed Decision and the parties' objections and argument will be referred to the Secretary of the Department of Health and Family Services for final decision-making. The process relating to Proposed Decision is described in Wis. Stat. § 227.46(2).

Dated at Madison, Wisconsin on April ____, 2010.

By _____
William S. Coleman, Jr.
Administrative Law Judge