

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>P. Giese</i>	DATE <i>4-19-11</i>
-----------------------	------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>1011476</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____		
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Ketch</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-29-11</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action		
<i>Releg to a different area, see attached e-mail.</i>			

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1. <i>Cleared 5/5/11, letter attached.</i>			
2.			
3.			
4.			



RECEIVED

Remarkable People. Remarkable Medicine.

APR 19 2011

April 1, 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Anthony E. Keck, Director
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

RE: Provider # GP4549
Case # P4902

Dear Mr. Keck;

Our office recently had a chart review and subsequent request for refund from Nancy Pittman, RN which has been submitted to SC DHHS. However, we are not in agreement with one of the two issues cited as it contradicts guidance of The American College of Obstetricians and Gynecologists (ACOG). Specifically, it is the accusation of billing more than one New patient EM code during a pregnancy.

The scenario is unique to patients who are new to our office which included all patients in the SC DHHS review and refund request. These patients presented to our office with signs and/or symptoms of pregnancy and were seeking confirmation. The visits were billed as New patient EM visits as the patients were indeed New to our office. However, the initial OB records were not initiated at this visit. Per ACOG guidelines, if the initial OB record was not started at the confirmation visit, the visit is not included in the OB global package.

Ms. Pittman mentioned the chart reviews showed many patients received prescriptions for antenatal vitamins at the confirmation visit triggering to SC DHHS reviewers the visit was the initial OB visit. ACOG addresses this specifically (see enclosure) and again states the visit is outside of the global if the OB record is not started.

Should these patients return (for what was their second visit to our office), the OB record is then started and this visit is billed using a New patient EM code to signify the start of a NEW pregnancy per SC Medicaid billing guidelines.

In summary, our office has followed ACOG guidelines in the absence of clear directions from the SC DHHS Provider Manual for this specific scenario of confirmatory visits wherein the initial OB record is not started. The requested refund was remitted in order to avoid offsets of future payments however we feel the review findings are not justified and refund request thereby inappropriate. We respectfully submit our appeal and look forward to hearing from your office. Thank you in advance for your attention to this matter.

Sincerely,

James Hubbard, MD

Glenn Raymond, MD



Coding for the “Initial OB Visit”

ICD-9-CM code V72.42 (Pregnancy examination or test, positive result) should be reported for the initial obstetric visit when the pregnancy is confirmed but the antepartum record is not initiated.

When coding for the “initial ob visit”, there are a few things that have to be taken into consideration. *First you have to determine if the patient is there for a confirmation of pregnancy or if the pregnancy has already been confirmed. The second thing that needs to be determined is if the OB record has been initiated. Once this has been established you can determine how the visit should be reported.*

Here are two examples to further your understanding:

- If a patient presents with signs or symptoms of pregnancy and the patient is there to confirm pregnancy, this visit may be reported with the appropriate level of E/M services code. However, if the ob record is initiated at this visit, then the visit becomes part of the global ob package and is not billed separately.
- If the physician is confirming a pregnancy which has been diagnosed by some other source (including a home pregnancy test), then the physician may report the appropriate level of E/M services code. However, if the ob record is initiated at this visit, the visit becomes part of the global ob package and is not billed separately.

Keep in mind that the physician may draw blood and prescribe prenatal vitamins during this initial visit and still report it as a separate service as long as the ob record is not started.

Diagnostic Reporting Options:

- V72.40 Pregnancy examination or test, pregnancy unconfirmed
- V72.41 Pregnancy examination or test, negative result
- V72.42 Pregnancy examination or test, positive result

The physician should use V72.40 if the encounter is to test for a suspected pregnancy and the patient leaves without knowing the results. If the test is negative, report V72.41. Report code V72.42 if the results are positive. The physician can report these codes without performing a pelvic examination.

A point to keep in mind is that every initial Ob visits will not be reportable outside of the global package. Deciding when to initiate the antepartum depends on the clinical circumstances and the physicians’ medical judgment.

Feb. 3. 2011 10:59AM

No. 4816 P. 3/10



Anthony E. Keel, Director
Nikki R. Haley, Governor

January 31, 2011

CERTIFIED MAIL

Carolina OB-GYN of York County
Novant Medical Group Inc.
360 S. Hartong Ave.
Rock Hill, S.C. 29732-1160

PROVIDER #: GP4549
CASE #: P4902

Dear Drs. Hubbard, Little & Raymond,

The Department of Health and Human Services is mandated by the federal government to provide surveillance and utilization review of the services rendered to Medicaid beneficiaries to safeguard against unnecessary or inappropriate use of Medicaid services. The Division of Program Integrity performs reviews to identify and recover excessive or inaccurate payments to providers, and insure compliance with the applicable Medicaid laws, regulations and policies. Program Integrity policies and operating procedures as well as citations to appropriate State and Federal Regulations can be found in Section 1 of each provider manual.

In a review of your paid claims data during the review period of 01/01/2008 through 12/31/2010 we have identified the following billing errors. According to South Carolina Medicaid Policy vaginal and caesarean section deliveries are considered surgical packages. All routine post operative follow-up care is included in the payment for the delivery with the exception of one post partum visit which may be billed with procedure code 59430. A review of your claims data supports that your office frequently bills an examination and management code in addition to procedure code 59430 for the same date of service. This practice is in violation of South Carolina Medicaid Policy and these claims were billed in error. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 01/01/11 update, Section 2, page 92).

We have also identified billing errors where claims were billed for more than one new patient visit during a pregnancy. Medicaid policy states "*only one initial OB exam (procedure code 99202 or 99203) may be billed per pregnancy*". (Refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Manual updated 01/01/2011, section 2, pages 86 – 88).

Medicaid Surveillance and Utilization Review (SURS) reports identified claims that were billed for two new patient visits or a post partum code and an examination and management code where overpayments were made. Enclosed are Detailed Claims Reports that provide you with the names of clients and the dates of service that were included in the review. There is a separate spreadsheet for each year for each type of error. Because Medicaid policy states that only one OB visit can be billed with a new patient code we have allowed the first visit as it was billed. The second visit to your office has been allowed at the level of procedure code 99213.

Carolina OB GYN of York County
January 31, 2011
Page 2 of 2

When Program Integrity identifies that improper payments have been made, Medicaid requires a refund of the overpayments. The dollar amount found in the column titled "Disallowed Amount" is the amount of money that needs to be refunded to Medicaid. (Refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Manual updated 01/01/11, section 1, pages 27 and 28.)

The total overpayment for the claims identified on all 6 reports is \$43,158.31

If we do not hear from you within 10 working days of the receipt of this letter, we will presume that you agree with our findings. If you disagree with our analysis of your claims detail, you must submit documentation to support your claim(s) within 10 days of the date of this letter. The documentation should be sent to ATTN: Cyndi Wellborn, RN, SCDHHS, Division of Program Integrity, P.O. Box 100210, Columbia, South Carolina 29202-3210. We will review your documentation, make adjustments in the overpayment amount if warranted, and let you know of our determination. At the time you contact us, we may set up an informal conference to discuss the findings.

If you have any questions regarding the findings, please contact Cyndi Wellborn at (803) 898-2602.

Sincerely,



Nancy Pittman, R.N., Supervisor
Department of Medical Service Review

Enclosures

Note: The Federal and State authority for this review and recovery of the improper payments can be found at Reg. 126.401 et seq. Code of Laws of South Carolina 1076 as amended. - Administrative Sanctions against Medicaid Providers; 42 CFR 433.300 et seq. - Refunding of Federal Share of Medicaid Overpayments to Providers; See also 42 CFR Part 431.107 - Required Provider Agreement; 455 - Program Integrity, and 456 - Utilization Control.

Log #476 ✓

From: Annmarie McCanne
To: Janelle Smith
CC: Brenda James; Melanie Giese
Date: 05/03/2011 4:23 PM
Subject: Re: Log Letter 476

No, I am cc'ing Brenda so she can update her files.

Thanks,
Annie

>>> Janelle Smith 5/3/2011 4:06 PM >>>
Annie,

This log letter was given to PI by Maureen, do I need to get it back from them to get it re-logged. Janelle

>>> Annmarie McCanne 5/2/2011 12:40 PM >>>

Ok. Just send the Blue sheet back up and I can have Brenda re-log.

>>> Valeria Williams 5/2/2011 11:53 AM >>>

Annie, the above log letter needs to be reassigned to PI for response. I met with the Division Director BJ this morning to discuss the agencies response and we decided that it is best that PI response because the letter is the result of a PI audit. Thanks Val

May 5, 2011

CERTIFIED MAIL

Carolina OB-GYN of York County
Novant Medical Group, Inc.
360 S. Herlong Ave.
Rock Hill, South Carolina 29732-1160

PROVIDER #: GP4549
CASE #: P4902

Dear Dr. Hubbard and Dr. Raymond:

This letter is in response to your correspondence dated April 1, 2011, addressed to Mr. Anthony Keck, Director, South Carolina Department of Health and Human Services (SCDHHS). I understand you are not in agreement with one of the issues cited as not in compliance with South Carolina Medicaid policy. We understand your concerns and hope to alleviate them with this explanation.

We would like to first address the guidelines from the American College of Obstetrics and Gynecologists in your enclosure headed "Coding for the Initial OB Visit". Those guidelines refer to what can and what cannot be billed *outside of a global OB package*. However, South Carolina Medicaid does not reimburse antepartum care with a global fee. South Carolina Medicaid provides pregnant women with unlimited ambulatory care visits and recognizes evaluation and management procedure codes as antepartum visits when billed in conjunction with a pregnancy diagnosis code. You are paid for each service that you render to the patient with the exception of inpatient hospital services, which are considered part of the delivery reimbursement. Our policy specifically states, "Obstetrical care provided under the Healthy Mothers/Healthy Futures program (HM/HF) must be billed as separate charges (fragmented), not as global OB care". Also, the ACOG guidelines do not address billing more than one "new patient" visit code.

In addition, as stated in our policy which accompanied the letter to you dated January 31, 2011, we adhere to the guidelines as presented by the American Medical Association in Current Procedural Terminology (CPT). Those guidelines, under the Evaluation and Management Services heading in any CPT edition, state that a new patient is "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years". CPT goes on to define "professional" services as "those face-to-face services that are performed by a physician and reported by a specific CPT code". By billing the first visit with procedure code 99203 or 99204 you indicated that the patient had been seen face-to-face by the physician or nurse practitioner. According to CPT, once you have billed for any face-to-face service, from that point the patient becomes an established patient.

The documentation that we reviewed and office visits that you billed using 99203 or 99204 fulfilled the requirements for the initial OB exam as defined by Medicaid policy. Medicaid policy clearly allows one initial OB exam, as designated by new patient procedure code 99202 or 99203, to be billed per pregnancy. The new patient visit codes require that all three of the

Carolina OB-GYN of York County

May 5, 2011

Page 2

following key components be met: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision making of low to moderate complexity. Your documentation supported the new patient office visit with a positive pregnancy test determination and the initiation of the OB plan of care including instructions to the patient and orders for labs, ultrasounds and medications. The second visit you billed was allowed as an established visit because, as explained above, an OB global package does not apply to Medicaid antepartum policy.

In the letter to you dated January 31, 2011, we requested that you submit documentation to support your claims or call the Division of Program Integrity to schedule an informal conference if you disagreed with our findings. We instructed you to submit your supporting documentation to us or contact us within 10 calendar days of the receipt of the letter. We were contacted on February 7, 2011, via phone, by members of your billing staff who stated that they agreed with the findings in the original letter. On March 13, 2011, we received a letter from Michele Grier, Senior Vice President and Chief Operating Officer of Novant Medical Group, dated March 4, 2011. Ms. Grier's letter also indicated that you did not dispute our findings and in fact stated that our review enabled Novant to identify errors in their billing practices. Upon receipt of that letter the case was closed.

I hope this further clarifies South Carolina Medicaid policy regarding new patient office visits. If you have any further questions, please contact Cyndi Wellborn, RN, at (803) 898-2602.

Sincerely,



Kathleen C. Snider, Bureau Chief
Compliance and Performance Review

KCS/wm

cc: Betty Jane Church, Director, Division of Program Integrity
Valeria Williams, Director, Division of Physician, Pharmacy and DME Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

Yal

ACTION REFERRAL

TO <i>Grise</i>	DATE <i>4-19-11</i>
--------------------	------------------------

DIRECTOR'S USE ONLY		ACTION REQUESTED	
1. LOG NUMBER <i>101476</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____ <input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>4-29-11</i> <input type="checkbox"/> FOIA DATE DUE _____ <input type="checkbox"/> Necessary Action		
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Fect</i>			

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

April 1, 2011

APR 19 2011

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Anthony E. Keck, Director
South Carolina Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

RE: Provider # GP4549
Case # P4902

Dear Mr. Keck;

Our office recently had a chart review and subsequent request for refund from Nancy Pittman, RN which has been submitted to SC DHHS. However, we are not in agreement with one of the two issues cited as it contradicts guidance of The American College of Obstetricians and Gynecologists (ACOG). Specifically, it is the accusation of billing more than one New patient EM code during a pregnancy.

The scenario is unique to patients who are new to our office which included all patients in the SC DHHS review and refund request. These patients presented to our office with signs and/or symptoms of pregnancy and were seeking confirmation. The visits were billed as New patient EM visits as the patients were indeed New to our office. However, the initial OB records were not initiated at this visit. Per ACOG guidelines, if the initial OB record was not started at the confirmation visit, the visit is not included in the OB global package.

Ms. Pittman mentioned the chart reviews showed many patients received prescriptions for antenatal vitamins at the confirmation visit triggering to SC DHHS reviewers the visit was the initial OB visit. ACOG addresses this specifically (see enclosure) and again states the visit is outside of the global if the OB record is not started.

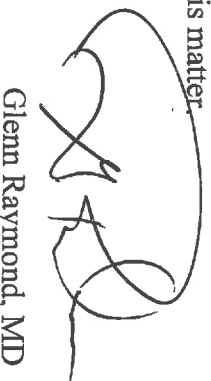
Should these patients return (for what was their second visit to our office), the OB record is then started and this visit is billed using a New patient EM code to signify the start of a NEW pregnancy per SC Medicaid billing guidelines.

In summary, our office has followed ACOG guidelines in the absence of clear directions from the SC DHHS Provider Manual for this specific scenario of confirmatory visits wherein the initial OB record is not started. The requested refund was remitted in order to avoid offsets of future payments however we feel the review findings are not justified and refund request thereby inappropriate. We respectfully submit our appeal and look forward to hearing from your office. Thank you in advance for your attention to this matter.

Sincerely,



James Hubbard, MD



Glenn Raymond, MD



Coding for the “Initial OB Visit”

ICD-9-CM code V72.42 (Pregnancy examination or test, positive result) should be reported for the initial obstetric visit when the pregnancy is confirmed but the antepartum record is not initiated.

When coding for the “initial ob visit”, there are a few things that have to be taken into consideration. *First you have to determine if the patient is there for a confirmation of pregnancy or if the pregnancy has already been confirmed. The second thing that needs to be determined is if the OB record has been initiated.* Once this has been established you can determine how the visit should be reported.

Here are two examples to further your understanding:

- If a patient presents with signs or symptoms of pregnancy and the patient is there to confirm pregnancy, this visit may be reported with the appropriate level of E/M services code. However, if the ob record is initiated at this visit, then the visit becomes part of the global ob package and is not billed separately.
- If the physician is confirming a pregnancy which has been diagnosed by some other source (including a home pregnancy test), then the physician may report the appropriate level of E/M services code. However, if the ob record is initiated at this visit, the visit becomes part of the global ob package and is not billed separately.

Keep in mind that the physician may draw blood and prescribe prenatal vitamins during this initial visit and still report it as a separate service as long as the ob record is not started.

Diagnostic Reporting Options:

- V72.40 Pregnancy examination or test, pregnancy unconfirmed
- V72.41 Pregnancy examination or test, negative result
- V72.42 Pregnancy examination or test, positive result

The physician should use V72.40 if the encounter is to test for a suspected pregnancy and the patient leaves without knowing the results. If the test is negative, report V72.41. Report code V72.42 if the results are positive. The physician can report these codes without performing a pelvic examination.

A point to keep in mind is that every initial Ob visits will not be reportable outside of the global package. Deciding when to initiate the antepartum depends on the clinical circumstances and the physicians’ medical judgment.



Anthony E. Keel, Director
Nikki R. Haley, Governor

January 31, 2011

CERTIFIED MAIL

Carolina OB-GYN of York County
Novant Medical Group Inc.
360 S. Herlong Ave.
Rock Hill, S.C. 29732-1160

PROVIDER #: GP4549
CASE #: P4902

Dear Drs. Hubbard, Little & Raymond,

The Department of Health and Human Services is mandated by the federal government to provide surveillance and utilization review of the services rendered to Medicaid beneficiaries to safeguard against unnecessary or inappropriate use of Medicaid services. The Division of Program Integrity performs reviews to identify and recover excessive or inaccurate payments to providers, and insure compliance with the applicable Medicaid laws, regulations and policies. Program Integrity policies and operating procedures as well as citations to appropriate State and Federal Regulations can be found in Section 1 of each provider manual.

In a review of your paid claims data during the review period of 01/01/2008 through 12/31/2010 we have identified the following billing errors. According to South Carolina Medicaid Policy vaginal and caesarean section deliveries are considered surgical packages. All routine post operative follow-up care is included in the payment for the delivery with the exception of one post partum visit which may be billed with procedure code 59430. A review of your claims data supports that your office frequently bills an examination and management code in addition to procedure code 59430 for the same date of service. This practice is in violation of South Carolina Medicaid Policy and these claims were billed in error. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 01/01/11 update, Section 2, page 92).

We have also identified billing errors where claims were billed for more than one new patient visit during a pregnancy. Medicaid policy states "*only one initial OB exam (procedure code 99202 or 99203) may be billed per pregnancy*". (Refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Manual updated 01/01/2011, section 2, pages 86 - 88).

Medicaid Surveillance and Utilization Review (SURS) reports identified claims that were billed for two new patient visits or a post partum code and an examination and management code where overpayments were made. Enclosed are Detailed Claims Reports that provide you with the names of clients and the dates of service that were included in the review. There is a separate spreadsheet for each year for each type of error. Because Medicaid policy states that only one OB visit can be billed with a new patient code we have allowed the first visit as it was billed. The second visit to your office has been allowed at the level of procedure code 99213.

Carolina OB GYN of York County
January 31, 2011
Page 2 of 2

When Program Integrity identifies that improper payments have been made, Medicaid requires a refund of the overpayments. The dollar amount found in the column titled "Disallowed Amount" is the amount of money that needs to be refunded to Medicaid. (Refer to the Medicaid Physicians, Laboratories, and Other Medical Professionals Manual updated 01/01/11, section 1, pages 27 and 28.)

The total overpayment for the claims identified on all 6 reports is \$43,158.31

If we do not hear from you within 10 working days of the receipt of this letter, we will presume that you agree with our findings. If you disagree with our analysis of your claims detail, you must submit documentation to support your claim(s) within 10 days of the date of this letter. The documentation should be sent to ATTN: Cyndi Wellborn, RN, SCDHHS, Division of Program Integrity, P.O. Box 100210, Columbia, South Carolina 29202-3210. We will review your documentation, make adjustments in the overpayment amount if warranted, and let you know of our determination. At the time you contact us, we may set up an informal conference to discuss the findings.

If you have any questions regarding the findings, please contact Cyndi Wellborn at (803) 898-2602.

Sincerely,



Nancy Pittman, R.N., Supervisor
Department of Medical Service Review

Enclosures

Note: The Federal and State authority for this review and recovery of the improper payments can be found at Reg. 126.401 et seq., Code of Laws of South Carolina 1076 as amended. – Administrative Sanctions against Medicaid Providers; 42 CFR 433.300 et seq. – Refunding of Federal Share of Medicaid Overpayments to Providers; See also 42 CFR Part 431.107 – Required Provider Agreement; 455 – Program Integrity, and 456 – Utilization Control.