A Unique Approach to Auditing the Primary Care Exception

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Agenda

UMDNJ background
The Primary Care Exception (PCE)
Identifying data
The analysis
Validation of results and gaps addressed
Reporting the results
Background information on the University of Medicine and Dentistry of New Jersey (UMDNJ)

- The nation's largest ($1.8B) free-standing public health sciences university in the country with more than 6,000 students and 15,000 employees, including nearly 3,000 faculty members, located on five different campuses. It is a statewide network of eight schools, two hospitals and three faculty practice plans with more than 1,300 employed physicians on five campuses.

NJ Medical and Health Sciences Restructuring Act eliminated UMDNJ effective July 1, 2013
- University Hospital became a stand alone state entity
- The School of Osteopathic Medicine joined Rowan University
- All other units joined Rutgers, The State University of New Jersey

Background information

UMDNJ School of Osteopathic Medicine (SOM)

<table>
<thead>
<tr>
<th>Organization Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 223 paid faculty at UMDNJ-SOM</td>
</tr>
<tr>
<td>- 18 full time paid faculty in the Department of Family Medicine</td>
</tr>
<tr>
<td>- 26 total family medicine residents for the 2011/2012 academic year</td>
</tr>
</tbody>
</table>

Today, the SOM is a component of Rowan University.
**Background information**

**Chronology of events**

- **11/11/96**: UMDNJ-SOM notified Xact Medicare Services that UMDNJ-SOM met requirements for Primary Care Exception (PCE)
- **09/21/04**: UMDNJ-SOM restated their belief that PCE requirements were being met, adding additional locations
- **02/08/12**: UMDNJ-SOM notified they may not be following necessary requirements to submit claims to Medicare under PCE
- **06/05/12**: UMDNJ-SOM notified the Office of the Inspector General (OIG) of the identified issue and stated that outside assistance would be sought to further evaluate the matter
- **06/20/12**: UMDNJ-SOM initiated the waiver of Request for Proposal process
- **08/06/12**: Deloitte & Touche LLP selected to perform this assessment

**Current Environment**

- **UMDNJ was operating** under a Corporate Integrity Agreement (CIA) with the Office of Inspector General of the Department of Health and Human Services (OIG), which began on September 25, 2009 and is effective through September 24, 2014.
- Office of Ethics, Compliance & Corporate Integrity (“OECCI”) was responsible for University wide Compliance Program.
- Under the terms of the CIA, UMDNJ was required to report certain “reportable events” to the OIG.
- This issue was reported preliminarily by telephone to the OIG and then formally in writing on June 5, 2012. This notification stated that UMDNJ had identified certain overpayments related to compliance with the PCE and that UMDNJ would be seeking outside assistance in further evaluating this matter.
Medicare’s Primary Care Exception

CMS Pub 100-4 Chapter 12: Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

<table>
<thead>
<tr>
<th>Primary Care Exception</th>
<th>New Patient</th>
<th>Established Patient</th>
<th>Preventative Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>99201</td>
<td>99211</td>
<td>G0402</td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>99212</td>
<td>G0438</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>99213</td>
<td>G0439</td>
</tr>
</tbody>
</table>

For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.
Primary Care Exception

CMS Pub 100-4 Chapter 12: Exception for E/M Services Furnished in Certain Primary Care Centers

- Outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments.
- Does not include physician’s office or home visits.
- Residents must have completed at least six months of a GME approved residency program.
- Teaching physicians may not supervise more than four residents at any given time.
- Must direct the care from such proximity as to constitute immediate availability.
- The teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than six months in a GME approved residency program.

Primary Care Exception (continued)

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident
- Have the primary medical responsibility for patients cared for by the residents
- Ensure that the care provided was reasonable and necessary
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient’s medical history, the resident’s findings on physical examination, the patient’s diagnosis, and treatment plan (i.e., record of tests and therapies)
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.
Primary Care Exception (continued)

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

• Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
• Coordination of care furnished by other physicians and providers; and
• Comprehensive care not limited by organ system or diagnosis

Services performed by residents under the primary care exception should be billed with the GE modifier - Service has been performed by a resident without the presence of a teaching physician under the primary care exception

New Jersey Medicaid requirements
Primary Care Exception – New Jersey Medicaid

New Jersey Administrative Code N.J.A.C. 10:54-2.2 Direction of Physician Services allows for an exception to the participating physician's physical presence requirement for resident services, but it applies to "Services are furnished at the outpatient department of a hospital or another licensed ambulatory care facility, and not at a physician's office or a patient's residence."

The SOM services are provided in the physician office setting and based on information provided in interviews and the data analysis the teaching physician was not present for the services being analyzed. As such, all the New Jersey Medicaid services were categorized as errors.

Identifying the data and electronic analysis
Data and work plan

A work plan was developed to analyze the claims in question

1. Initial review of two years of claims with the GE modifier by UMDNJ
   - Confirmed that GE not used consistently
   - Confirmed that teaching physicians were not present for all services provided by residents through a manual review of schedules and claims data

2. Deloitte & Touche LLP was hired as an outside consultant to assist with further evaluation and calculation of repayment obligation, if any.

3. Work plan was discussed at meeting attended by UMDNJ OECCI, Deloitte Partner and OIG Monitor.

4. Interviews with practice management and physicians at multiple locations were conducted to clarify and confirm the issue:
   - Resident scheduling
   - Assignment of Teaching Physicians and oversight of Family Medicine Residents
   - Practice management and physician knowledge of the PCE requirements
   - An investigative team conducted additional interviews to assess intent
   - Assessed the availability of data (scheduling and billing) in regards to the PCE

5. Based on the initial records reviewed and interviews, the issue was confirmed to be that teaching physicians were seeing their own patients while supervising residents at most — but not all — locations.

6. Options discussed were a sampling approach or electronic analysis:
   - Determine the availability of data in regards to the PCE exemption.
   - GE Modifier not applied so could not be used to identify PCE claims.
   - The IDX scheduling module was implemented in May 2000.
   - The scheduling system has fields for recording the billing doctor, the scheduling doctor and the time the patient is scheduled.
   - Patient was scheduled to the resident, but billed by teaching physician
Data and work plan

A work plan was developed to analyze the claims in question

7. Residents and teaching physicians are scheduled together in half day blocks of time.

8. Data analysis plan was developed to calculate the amount of overpayment:
   - Scheduled times for teaching physicians were analyzed for times scheduled within two hours of the times patients were scheduled for each resident service.
   - Two hours established as it was determined that residents are scheduled in half day time blocks and a four hour window should be a conservative window for the evaluation.
   - This methodology was tested for one month of claims (December 2009), along with a review of 27 medical records to further assess the results of the data analyzed.

The draft work plan was then presented to UMDNJ's monitor from the OIG.

Data request

A data analysis plan was developed to calculate the amount of overpayment.
The analysis - source documentation and population of data

IDX paid claims data that contained scheduling information was used for the analysis with dates of service from May 30, 2000 through September 28, 2012.

Claims data analyzed was limited to the CPT codes that are included in the primary care exception:

- 99201 – 99203
- 99211 – 99213
- G0402, G0438, G0439
- For Medicaid – the preventive medicine codes were included (99381 – 99387 and 99391 – 99397)

The analysis - source documentation and population of data (cont.)

Several steps were taken to confirm the results of the automated analysis:

1. IDX data sets
   IDX data sets, supporting tables and data availability were confirmed by extracting and validating various samples of data sets.

2. Finance reports
   Finance Reports were created to confirm the completeness of data and accuracy of data for each of the years. This data showed a less than <1% variance.

3. Medical record review
   Samples of office medical records were reviewed to confirm the results of the analysis.
The analysis - source documentation and population of data (cont.)

Key Data Used for the Analysis

1. Date of Service
2. Manual resident schedules
3. IDX and manual schedule data for scheduled and billed physician and resident
4. Resident names and periods of service
5. List of teaching physicians and preceptors
6. Preceptor schedules
7. Office locations and final list of locations where the PCE was in effect

Example of Results (1)

Medicare - 2 yr Comparison analysis

<table>
<thead>
<tr>
<th>R INV</th>
<th>Billing Doctor</th>
<th>Scheduled Doctor</th>
<th>PROC</th>
<th>R SVC DT</th>
<th>R TM</th>
<th>Billing Doctor</th>
<th>Scheduled Doctor</th>
<th>T VIS</th>
<th>T SVC DT</th>
<th>T TM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Teaching Physician</td>
<td>Resident A</td>
<td>99213</td>
<td>21-Aug-00</td>
<td>03:45PM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>1</td>
<td>21-Aug-00</td>
<td>03:00PM</td>
</tr>
<tr>
<td>1</td>
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<td>Resident A</td>
<td>99213</td>
<td>21-Aug-00</td>
<td>03:45PM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>2</td>
<td>21-Aug-00</td>
<td>02:30PM</td>
</tr>
<tr>
<td>2</td>
<td>Teaching Physician</td>
<td>Resident B</td>
<td>99203</td>
<td>24-Aug-00</td>
<td>10:30AM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>3</td>
<td>24-Aug-00</td>
<td>11:00AM</td>
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<tr>
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<td>Teaching Physician</td>
<td>Resident B</td>
<td>99203</td>
<td>24-Aug-00</td>
<td>10:30AM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>4</td>
<td>24-Aug-00</td>
<td>08:45AM</td>
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<tr>
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<td>Resident B</td>
<td>99203</td>
<td>24-Aug-00</td>
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<td>Teaching Physician</td>
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<td>Resident B</td>
<td>99203</td>
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<td>Teaching Physician</td>
<td>6</td>
<td>24-Aug-00</td>
<td>09:00AM</td>
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<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>7</td>
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<td>10:45AM</td>
</tr>
<tr>
<td>2</td>
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<td>Teaching Physician</td>
<td>8</td>
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<td>08:45AM</td>
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<tr>
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<td>Resident B</td>
<td>99203</td>
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<td>10:30AM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>9</td>
<td>24-Aug-00</td>
<td>10:45AM</td>
</tr>
<tr>
<td>2</td>
<td>Teaching Physician</td>
<td>Resident B</td>
<td>99203</td>
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<td>10:30AM</td>
<td>Teaching Physician</td>
<td>Teaching Physician</td>
<td>10</td>
<td>24-Aug-00</td>
<td>10:45AM</td>
</tr>
</tbody>
</table>

(1) These do not reflect actual patient data or results.
Some discrepancies were identified in the data:

- Some of the IDX data did not have the scheduling physician or time recorded.
- Practices reported in interviews did not always match what the data showed, e.g., one office indicated that the attending only saw one patient at the start of a shift when there were three or four residents in the office and then did not see any other patients during the four-hour shift.
- When assessing physician and resident names, there were discrepancies in spelling and format that required clean up.
- Some residents eventually became attending physicians so dates of residency status were used to confirm whether the physician who saw the patient was a resident.

Validation of The Analysis

• ACL was the statistical sampling software used in selecting the samples
• Random claims selections were generated from ACL to identify the samples for further testing
• The sample selected was a validation sample to confirm the results of the data analysis rather than a statistically valid sample to be used for extrapolation of errors
• Confirm Billing doctor and scheduled doctor within the IDX system align with the documented notes within the record for the resident and the teaching physician/preceptor
• Confirm office location and time
• Confirm teaching physician/preceptor documented as required for the PCE

Review the care provided by the resident during or immediately after each visit. This must include a review of the patient’s medical history, the resident’s findings on physical examination, the patient’s diagnosis, and treatment plan (i.e., record of tests and therapies)

Document the extent of his/her own participation in the review and direction of the services furnished to each patient
Some discrepancies were identified in the validation record review for claims identified as not in error:

- There were instances where the billing doctor name in IDX was not the physician who was scheduled and signed the record. When these cases were rechecked using the correct physician name, it was found that the physician who was supervising was seeing their own patients at the same time that the resident was seeing patients.
- The physician at times did not document his/her review of the resident service as required by the PCE.
- The physician at times signed the record at a later date.
- For some records, the physician handwriting in the paper record was not legible.

The number of instances of the missed variance was identified and added to the confirmed errors for repayment.

**Validation of the analysis**

<table>
<thead>
<tr>
<th>Sample ID</th>
<th>Service Date</th>
<th>Scheduled Time</th>
<th>Signature Detail</th>
<th>Comment</th>
<th>TP-sign on DOS</th>
<th>TP Attests</th>
<th>TP signing matches DR</th>
<th>Redact on claims data</th>
<th>Allow</th>
<th>New Doctor name to query</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5/25/2021</td>
<td>09:00AM</td>
<td>Resident signs on 5/23 and 5/29; TP signs on 5/29</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>11/10/2020</td>
<td>02:00PM</td>
<td>Resident signs on 11/10; TP signs on 11/12</td>
<td>Signed by different physician than billing physician</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>2/15/2021</td>
<td>12:00PM</td>
<td>TP signs that he performed the service with the resident</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>5/22/2021</td>
<td>09:00AM</td>
<td>Resident signs on 5/22; TP signs on 5/29</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>6/8/2021</td>
<td>15:30PM</td>
<td>Resident signs on 6/8; TP signs on 6/11</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>No</td>
</tr>
</tbody>
</table>

These do not reflect actual patient data or results.
Closing comments

Data analysis

<table>
<thead>
<tr>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Requires ability to use tools such as SAS and Access</td>
</tr>
<tr>
<td>• Requires availability of required data points for the time period under review</td>
</tr>
<tr>
<td>• Careful review and confirmation of data is needed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Evaluate complete population if available</td>
</tr>
<tr>
<td>• Works for a very large population of claims</td>
</tr>
<tr>
<td>• Accuracy</td>
</tr>
<tr>
<td>• Efficient process – less labor intensive compare to record review</td>
</tr>
<tr>
<td>• Recognized cost savings</td>
</tr>
</tbody>
</table>
Closing comments
Other investigations where data analysis may be used

Discussion and questions
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