

11. AUDIT OF CLAIMS

11.1 OVERVIEW

This section has been included to provide a brief overview of MCP Medical Audit practices, policies, and procedures.

There are two main audit programs in the Audit Services Division: 1) the Provider Medical Audit Program which is comprised of the Preliminary/Comprehensive Audit and the Claims Monitoring System; and 2) the Beneficiary Utilization Audit. One investigates and corrects potential physician misbillings while the other investigates chronic beneficiary abuse and/or physician over-servicing.

Physicians are entitled to payment for services which are rendered and appropriately recorded. The purpose of auditing a physician's billing is to verify that services were paid in accordance with the rates and regulations specified in the MCP Payment Schedule.

Medical Audit is based primarily on the documentation contained in the physician's record of service. In cases where specific elements of record/documentation requirements are specified in the Payment Schedule Preamble but do not appear in the patient's record of service, that element of service is deemed not to have been rendered and the fee component represented by that element is not payable.

In addition to the record of service, the Audit Services Division will also consider several other audit factors which include, but are not limited to, such items as medical necessity, patterns of servicing, and information supplied by beneficiaries as well as other individuals.

The following description of the Medical Audit Program covers general medical audit procedures. There may be slight deviations to these procedures at times to allow for specific peculiarities of individual audits.

11.2 PHYSICIAN MEDICAL AUDIT PROGRAM

11.2.1 Audit Initiation Indicators

Audits can be initiated based on the following indicators:

11.2.1.1 Beneficiary Verification Audits

This involves the random selection of claims on a regular basis and the sending of confirmation letters/questionnaires to beneficiaries for verification of recent

services. Audit verification is performed using a methodology which ensures that a sample of services billed by all physicians will be verified on a continual basis.

Whenever a discrepancy exists between the service billed and the information supplied by the beneficiary, the Audit Services Division may request the record of service from the physician. Based upon the findings of a verification audit, an audit may proceed to the Physician Medical Audit Program.

11.2.1.2 Complaints or Voluntary Information

Occasionally, the Audit Services Division receives complaints regarding the billings or pattern of practice of a particular physician from a number of sources (eg. beneficiaries, other physicians, etc). These complaints are reviewed in conjunction with all available information. Records of service or other information may be requested from the physician. After the review of this information, it may be decided to proceed to the Physician Medical Audit Program.

11.2.1.3 Physician Practice Profiles

Reports are regularly compiled to present a comparative picture of service patterns of physicians. Whenever service volume significantly exceeds area or provincial averages or when practice patterns are otherwise deviant, such cases will be investigated and may result in the commencement of a physician audit. Depending on the situation, it may begin in either the Preliminary or Comprehensive Stage.

11.2.1.4 Audits of Targeted Fee Codes/Premium Codes

Such audits are initiated when certain services appear to be subject to widespread misinterpretation or incorrect billing. These audits are an important means by which Payment Schedule rules and definitions may be clarified, reviewed, and improved.

11.2.1.5 Beneficiary Utilization Audits

During the investigation of a beneficiary who is flagged due to high levels of utilization, issues may develop regarding the billing or documentation practices of the physician(s). These issues are analysed and may result in the commencement of a physician audit. Depending on the situation, it may begin in either the Preliminary or Comprehensive Stage.

11.2.1.6 Claims Monitoring System (CMS)

CMS is an automated claims selection program designed to constantly monitor the integrity of claims billed under MCP through examination of service documentation and comparison to the MCP Payment Schedule and Preamble requirements. All fee-for-service physicians will be affected by this program. Non-compliant physicians will be referred to a preliminary/comprehensive audit.

This new system was designed to ensure that physicians are continuously aware of the elements required to substantiate Medical Care Plan (MCP) billings, resulting in fewer comprehensive audits.

CMS consists of two separate programs—the Verification Program and the Compliance Program. All fee-for-service physicians initially enter the program in the first stage of the Verification Program (VP1).

Verification Program

Within the Verification Program, there exists two separate and distinct stages. The first stage, VP1, consists of a random electronic selection of one service for each physician per month (two pay periods).

A physician who has acceptable records for three consecutive months will move to the second stage of the Verification Program, VP2, and will only be required to submit records of service for one claim every third month (every six pay periods).

The physician is requested to submit the record of service to Audit Services within 14 days. The patient is simultaneously requested to verify the service billed.

The patient response and the physician record is reviewed by the audit staff for compliance with the MCP Payment Schedule and Preamble.

A record which complies with the Preamble criteria is accepted and the claim is released for payment. Should a record not comply with the criteria, the claim is appropriately adjusted or cancelled and the physician is notified and instructed in proper documentation requirements.

A physician who has an unacceptable record in the Verification Program (either VP1 or VP2) will progress to the second program—the Compliance Program (CP), for the unacceptable fee code. The physician will also continue in the VP1 program for different fee codes.

Compliance Program

The Compliance Program consists of four separate and distinct stages. The first stage, CP1, will require a physician to submit four (4) records of the identified fee code—all of which must meet established criteria to exit from the Compliance Program.

The second stage of the Compliance Program, CP2, occurs when there are deficiencies in any of the requested records from CP1. This stage will require the physician to submit six (6) records of the identified fee code for review.

The third stage of the Compliance Program, CP3, occurs when there are deficiencies in any of the requested records from CP2. This stage will require the submission of ten (10) records of the identified fee code for review.

If deficiencies still occur at the CP3 stage, the provider may proceed to the fourth stage, CP4. During the fourth stage, CP4, audit management will have the option to request all records claimed by a physician for the identified fee code.

If there are significant unsubstantiated claims after all these steps, a Comprehensive Audit may be carried out.

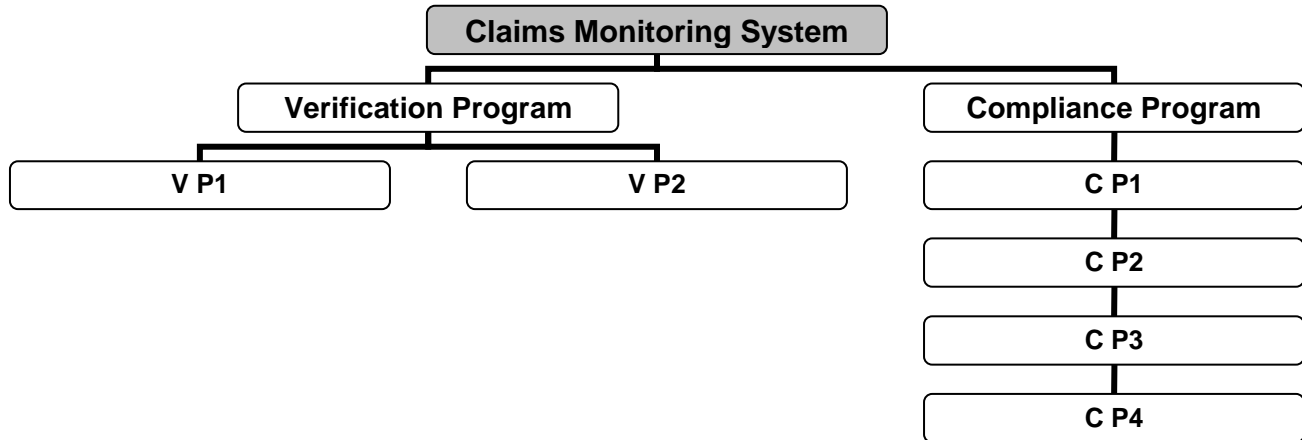
At any stage in the Compliance Program, a physician with records that meet billing and document requirements will be removed from the Compliance Program.

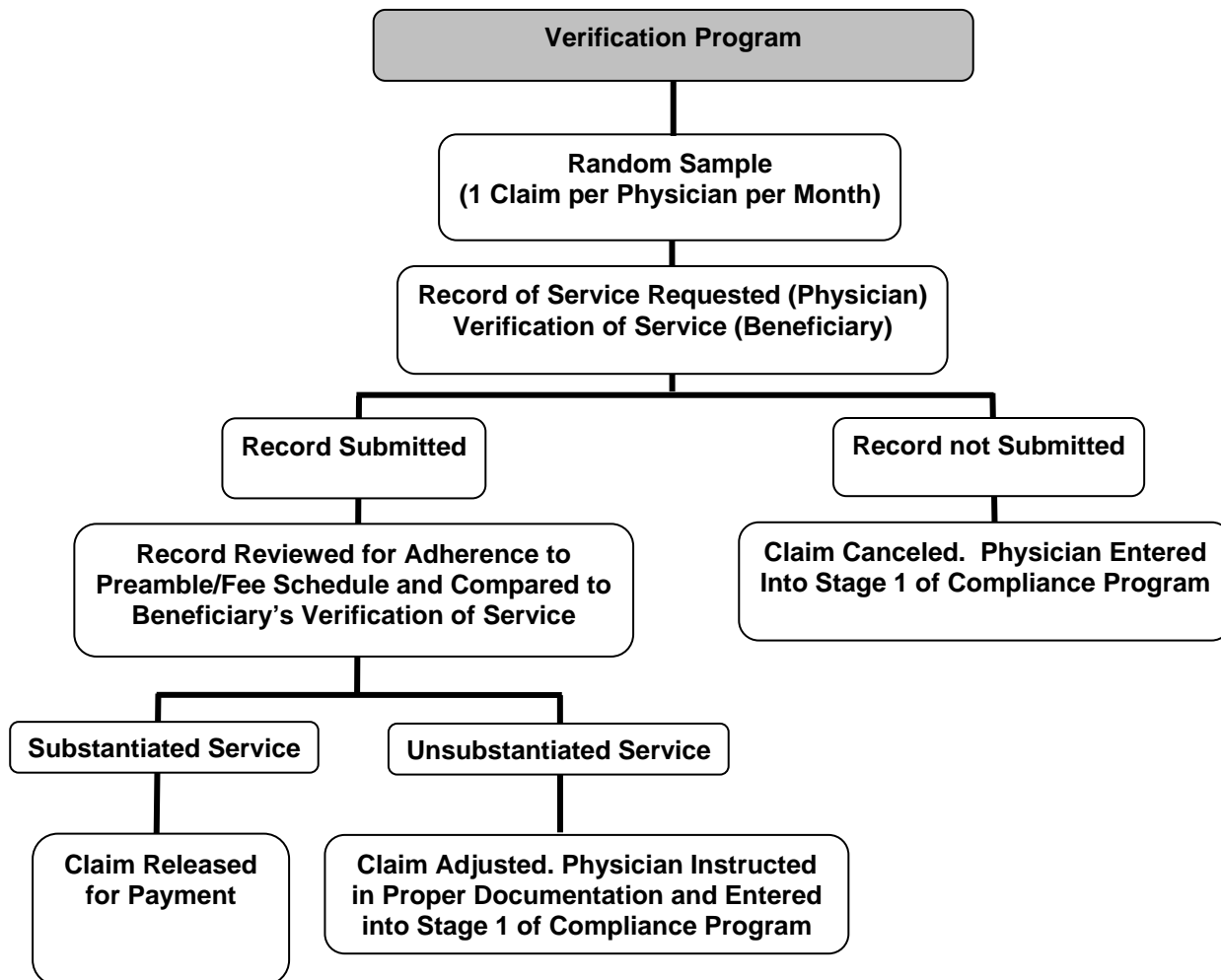
The Audit Services Division will provide the physician with electronic notification (TAD) of a request for a record. Paper claim submitters will receive a request through the mail.

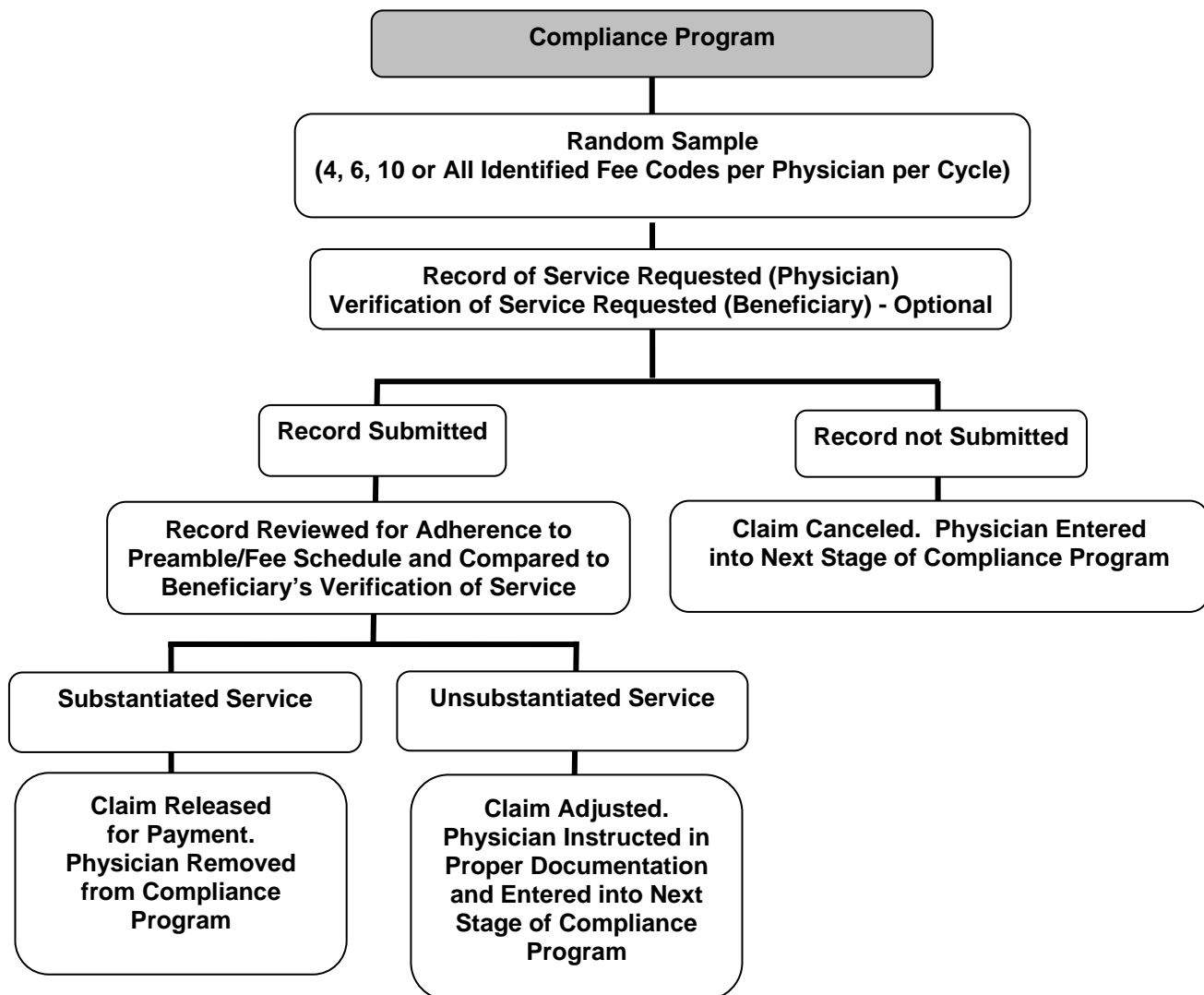
If a record is acceptable, the claim will be released for payment. If the record is not acceptable, the physician will also receive electronic notification with reference to relevant Preamble information (mailed for paper claim filers).

Should the physician be unable to provide documentation within the required time frame due to unforeseen circumstances, claims inquiry staff should be contacted at (709) 758-1566. Failure to provide requested documents without providing a valid reason will result in claim cancellation and progression to the next stage of the program.

COMPLIANCE MONITORING SYSTEM



VERIFICATION PROGRAM

COMPLIANCE PROGRAM

11.2.2 Preliminary Audit

As a result of any one or more of the preceding audit initiation indicators, a preliminary audit may be commenced. A small sample of claims for the service item in question is randomly selected for review. Physicians will be asked to provide copies of their records of service to substantiate their claims.

After the review of these records is completed, if no or insignificant amounts of misbilling is found, the audit is closed and the physician is notified of the findings of the audit. Where minor billing errors have occurred, payment adjustments may be made.

11.2.3 Comprehensive Audit

As a result of any one or more of the preceding audit initiation indicators or a preliminary audit, a comprehensive audit may be commenced. The size of the sample is determined by a statistical formula. The period of audit for the comprehensive stage is normally two years. Physicians will be asked to provide copies of their records of service to substantiate their claims.

Depending on the situation, records can be obtained by two means. The physician may be required to provide photocopies of the sampled records of service. These copies can be mailed or hand delivered to the Audit Services Division within the time limit specified on the request.

Where necessary, the Audit Services Division may deem it necessary to retrieve the sampled records of service on-site by a team of medical audit staff. During the course of an On-Site Audit, the medical audit team retrieves and copies sampled records of service from the patient charts and depending on the situation, may interview selected beneficiaries, interview the physician's staff, and perform other actions as deemed appropriate.

The records of service obtained by either method are reviewed by the Audit Services Division in conjunction with the Medical Consultant to Audit.

If the records combined with any other supporting evidence substantiate the physician billings, the audit is closed and the physician is notified of the findings. In cases where a small percentage of misbilling is found, a direct recovery (claims adjustment) is made and the physician is given instructions on proper billing procedures either by letter or in person.

If there is significant misbilling, the findings are extrapolated over the population of claims under audit and the physician is notified of the audit findings.

At the discretion of the Audit Director, some cases may be presented to the Medical Consultants' Committee (MCC) for their recommendations. The MCC may recommend that a physician be entered into the Physician Claims Intervention Program.

11.3 PHYSICIAN CLAIMS INTERVENTION PROGRAM (PCIP)

If potential problems with a particular physician's billings have been identified, that physician may be entered into the PCIP.

PCIP is designed to prevent the incorrect payment of claims and to ensure that physicians are continuously aware of the elements required to substantiate billings. Physicians with questionable billing patterns or practices are identified and their claims for selected services are rejected by the MCP payment system. In order to be paid for the rejected service, the physician must submit copies of patient records and other supporting information as deemed appropriate in order to support their billings. Following review of this information by the Audit Services Division, MCP is directed to pay the physician the correct amount for each service rendered.

The provider will remain in the program until it is determined that their billings are in order.

11.4 PHYSICIAN INTERVIEW

Before the information obtained in the comprehensive stage of the audit is finalized or presented to the MCC, physicians under audit may be contacted and requested to attend a Physician Interview. At this interview, the Medical Audit Manager and the Medical Consultant to Audit discuss the issues which were found during the course of the audit. Physicians are offered the opportunity to respond to these issues by providing explanations and further information.

If the case is to go to the MCC, the Audit Services Division will inform the physician of his/her right to make a written submission to be presented to the MCC for their consideration.

11.5 MEDICAL CONSULTANT'S COMMITTEE (MCC)

Where significant service pattern deviations occur and substantial numbers of claims cannot be supported by record notations, or where significant discrepancies are detected, such cases may be referred for professional review by the MCC.

This Committee is comprised of seven members including three physicians nominated by the NLMA, the Medical Consultant to Audit, Medical Director and Dental Director, and a private industry chartered accountant. Its mandate is to assess and make recommendations with regard to

cases of physician and beneficiary over-utilization, inappropriate billing and/or abuse.

11.6 NOTIFICATION OF RECOVERIES

The recommendations of the Audit Services Division are presented to the Minister of Health and Community Services. Where the Minister finds that an inappropriate pattern of practice exists or that certain services have been improperly billed or cannot otherwise be substantiated, the Audit Services Division may be issued a Ministerial Order instructing them to notify the physician of the Department's intention to undertake a recovery of funds.

Recovery periods are normally two years but may vary depending upon any or all of the following factors:

- effective date of Payment Schedule conditions, legislative provisions or other agreements
- effective date of commencement of practice
- effective date of commencement of billing for service(s) in question; and legal time limitations

The actual amount to be recovered will be based upon the percentage of unsubstantiated claims within a statistically valid sample of all claims for one or more fee codes during the audit period and extrapolated to the population.

Should the audit findings indicate fraudulent activity, the Audit Services Division consults with the Justice Department who may in turn request a police investigation.

Should the audit findings indicate practices unbecoming a physician or practices which endanger the public, Audit Services Division reports its findings to the College of Physicians and Surgeons of Newfoundland and Labrador.

It should be noted that other penalties may also be applied in accordance with the *Medical Care Insurance Act*. These are as follows:

- imposing a ten percent financial penalty
- deeming the physician to be non-participating
- reducing the amount payable for insured services

Depending on the situation, the Audit Services Division may enter the physician's current claims into the PCIP. Under this program, payments for all claims submitted by a flagged physician will be stayed pending further assessing action. This may include the review of the record of service for the purposes of determining medical necessity, the review of the physician's pattern of practice, and any

other applicable information.

11.7 ALTERNATE DISPUTE RESOLUTION (ADR) PROCESS

Alternate Dispute Resolution is an alternative for resolving issues between the Audit Services Division and the physician.

It is the intent of the Audit Services Division to:

- encourage a cooperative climate
- achieve fair and appropriate settlements, and
- avoid the excessive financial, psychological, and procedural costs associated with formal court proceedings.

As outlined in the notification letter, ADR must be requested by the physician within thirty (30) days from the date of the notification letter.

The ADR Process has a maximum ninety (90) day time limit from the date of the first ADR meeting.

In the event that an agreement is reached, any adjustments to the recovery amount will be made accordingly. The audit will then proceed to the recovery stage as part of the ADR agreement. The physician will waive the right to appeal the audit findings to the Audit Review Board.

If a mutually acceptable agreement is not reached within the ninety (90) day time limit, the conclusions and recovery amount stand and the audit will proceed to either recovery or a hearing before the Audit Review Board.

11.8 HEARING BY AUDIT REVIEW BOARD

In accordance with the *Medical Care Insurance Act*, upon notification of intent to proceed with a recovery, the physician in question may make written representation of his/her position and request a hearing before a Review Board. Representation may also be made in writing by the NLMA.

The Review Board shall consist of three (3) members. From a review panel consisting of up to fifteen (15) members, one (1) member is appointed by the Minister, one (1) member is appointed by the physician under audit, and the remaining third member is jointly appointed by the Minister and the physician. Where the Minister and the physician cannot agree on the joint member, the last person rejected by either of them shall be considered to be their nominee.

The members of the Board are selected from a Review Panel of up to fifteen (15) members who are appointed by the Lieutenant-Governor in Council. Five (5) of these members are physicians and two

(2) of these members are dentists. They are selected from lists of nominees provided by the NLMA and the NLDA respectively.

At the Hearing, the physician, witnesses (if any), the NLMA/NLDA, and the Audit Services Division present oral and documentary evidence. The Committee considers all of this information and presents a written report with recommendations to the Minister.

11.9 MINISTERIAL ORDER

After considering the representations made by the NLMA or NLDA, the report of the Review Board (if a hearing was held), the recommendations made by the MCC or the DMC (if any) and the recommendations of the Audit Services Division, the Minister may:

- withhold from the provider all or part of the money which has been claimed
- estimate and impose on the provider a penalty of an amount not exceeding the amount of a loss sustained by the Crown together with 10% of the amount of the loss
- consider the provider to be non-participating for the purposes of the Act either permanently or for the period specified in the order
- reduce the amount payable to a participating provider for insured services by a percentage for a period specified in the order.

11.10 APPEAL TO SUPREME COURT TRIAL DIVISION

A physician aggrieved with the Ministerial Order may file notice of appeal within sixty (60) days from the date on the Ministerial Order to a judge of the Supreme Court (Trial Division). Within fourteen (14) days after servicing this notice of appeal, the physician shall apply to the judge for the appointment of a day for the hearing of the appeal.

The Minister shall produce all papers and documents in his/her possession relating to the audit to the judge. The judge will hear the appeal and the evidence brought forward by the physician, Crown and the Minister. After considering all factors, the judge may:

- uphold the Ministerial Order
- amend the Ministerial Order
- revoke the Ministerial Order, or
- make another decision as deemed appropriate

Further appeal may be made to the Court of Appeal and the Supreme Court of Canada.

11.11 PHYSICIAN CLAIMS AUDIT PROCESS—FLOW CHART

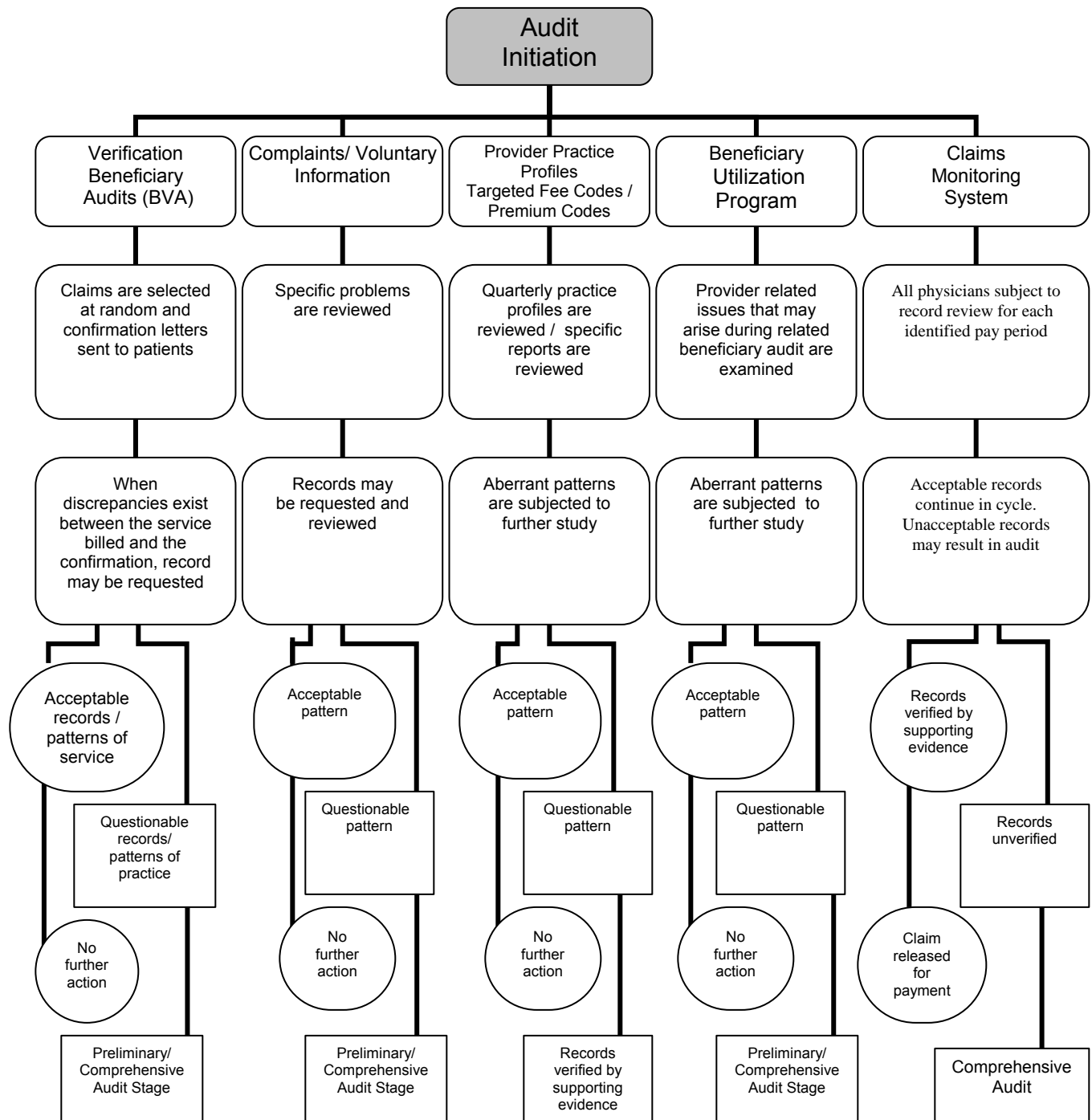
The following flow chart has been prepared in an attempt to present pictorially in logical sequence, the various steps and actions which are normally followed in relation to audits of physician claims.

Where exceptional circumstances apply, the procedures or investigative methods outlined in these charts may be modified to some extent.

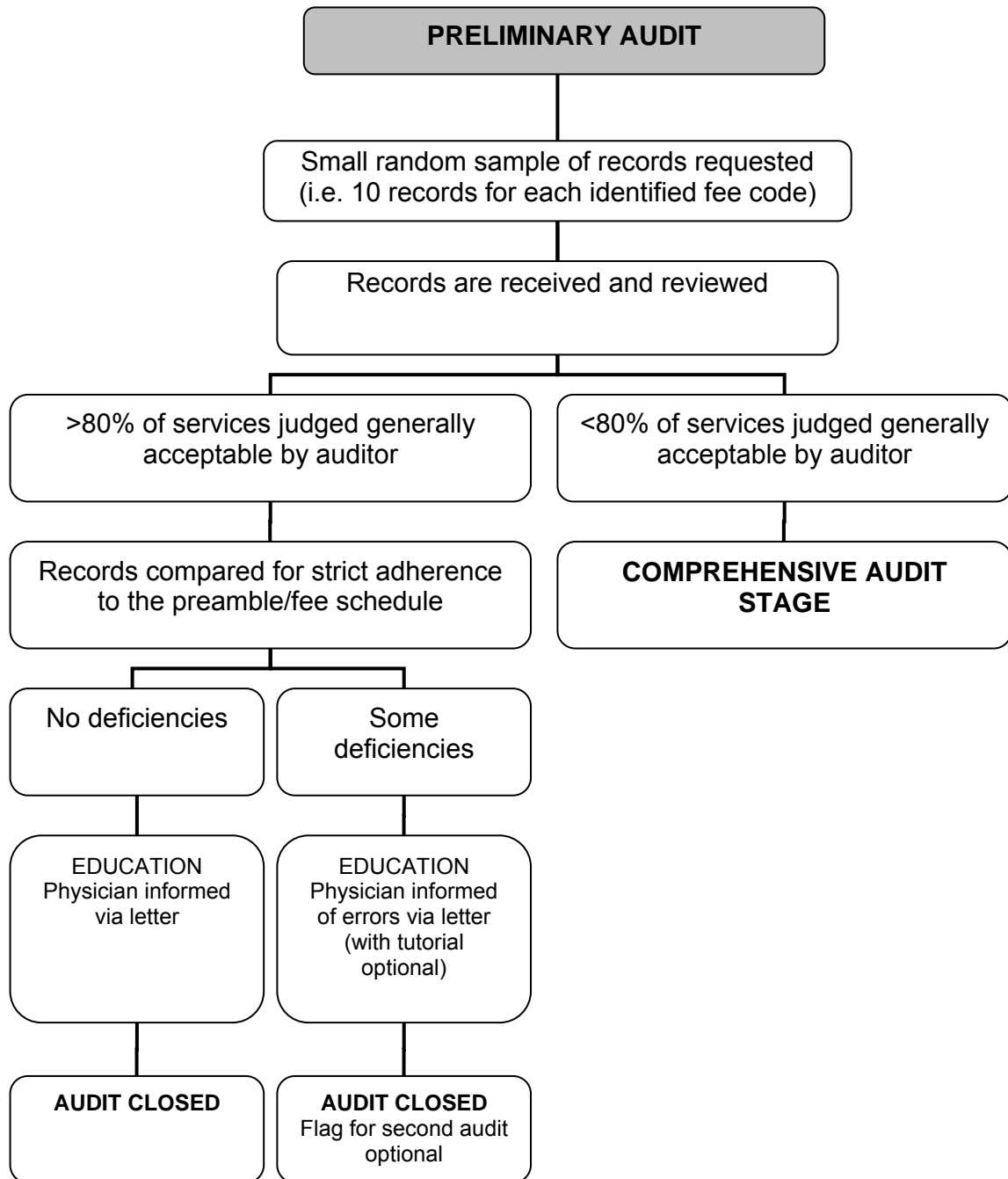
Provider Medical Audit Program

1. AUDIT INITIATION
2. PRELIMINARY AUDIT STATE
3. COMPREHENSIVE AUDIT STAGE
4. PHYSICIAN CLAIMS INTERVENTION PROGRAM (PCIP)
5. PROVIDER INTERVIEW
6. MEDICAL CONSULTANTS' COMMITTEE (MCC)/
DENTAL MONITORING COMMITTEE (DMC)
(OPTIONAL)
7. NOTIFICATION
8. ALTERNATE DISPUTE RESOLUTION (ADR)
9. HEARING BY AUDIT REVIEW BOARD
10. MINISTERIAL ORDER
11. APPEAL TO SUPREME COURT

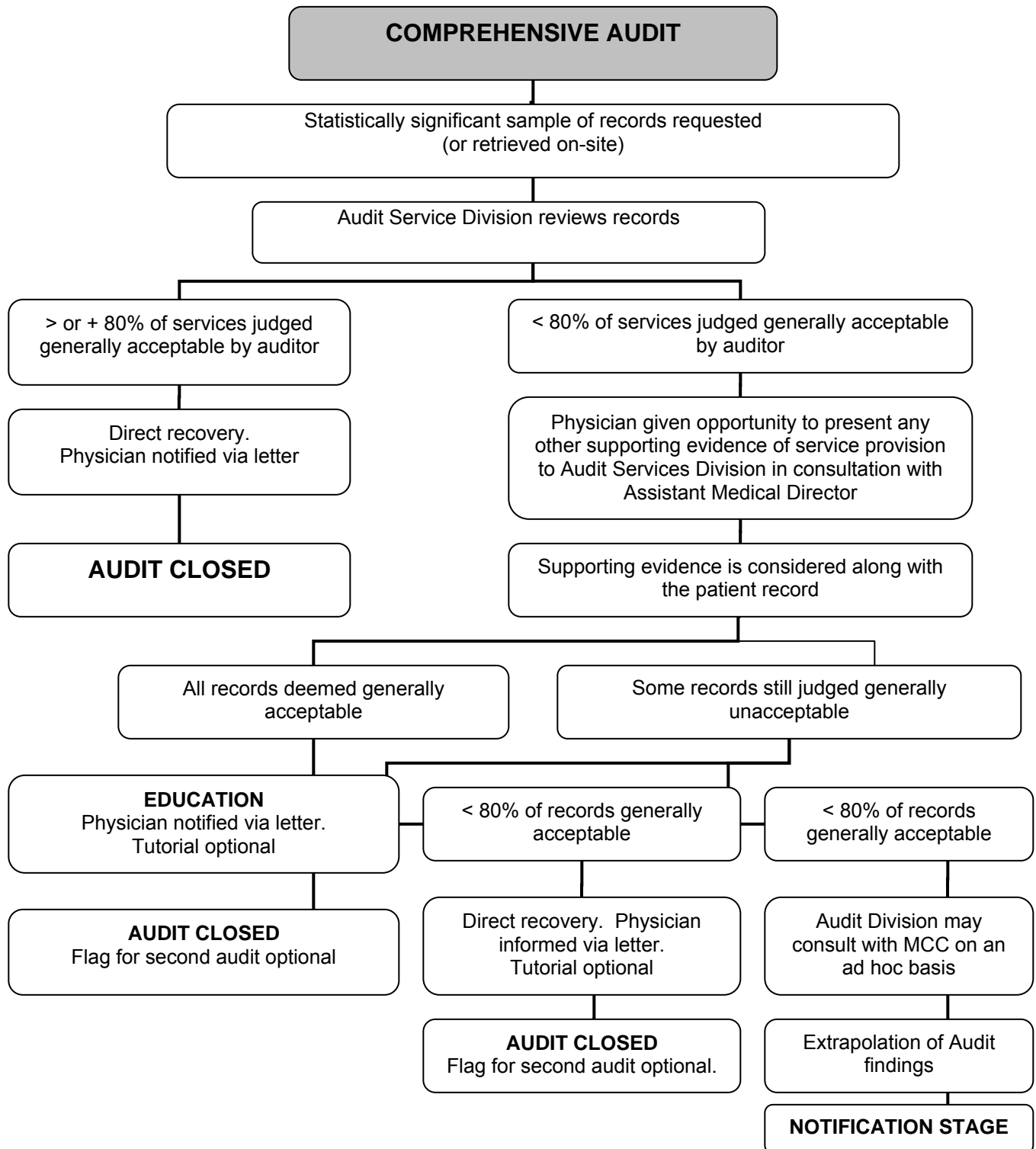
11.11.1 Audit Initiation

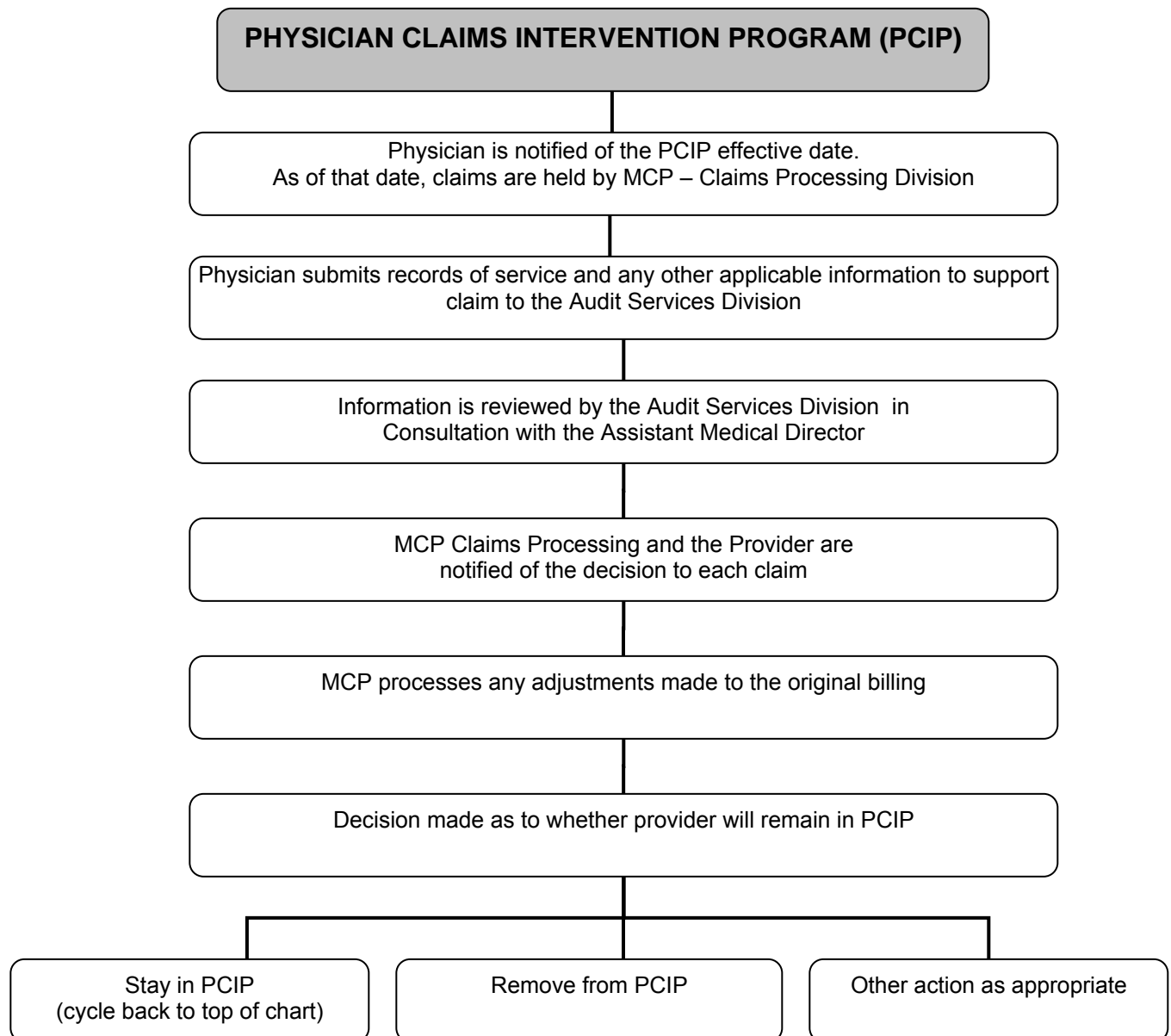


11.11.2 Preliminary Audit Stage

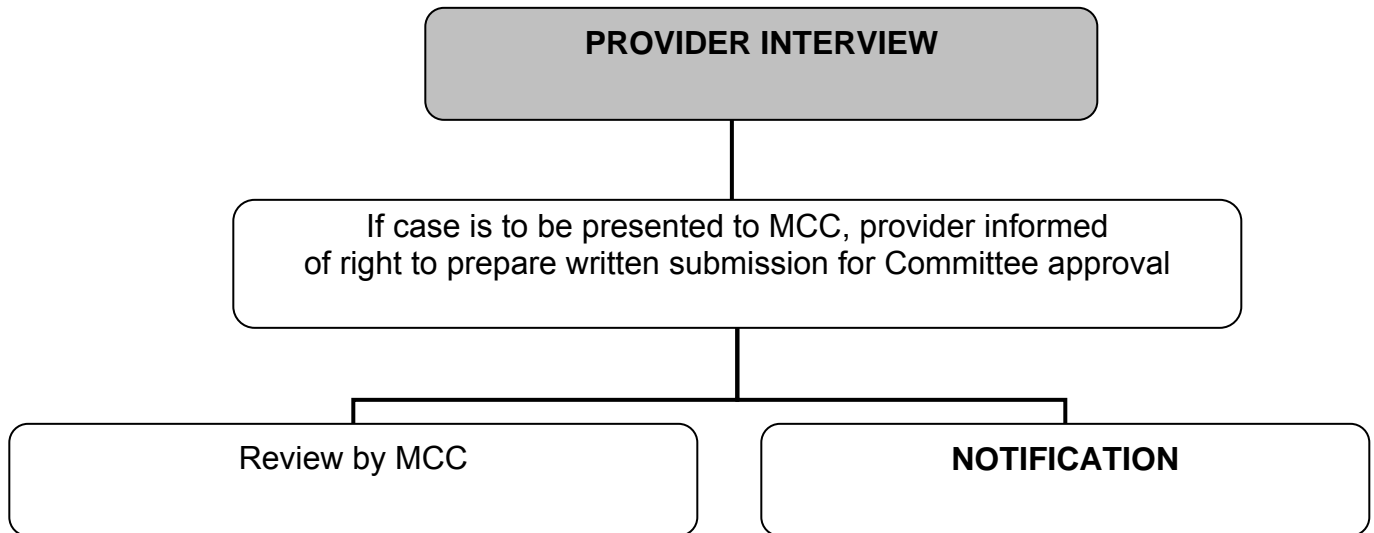


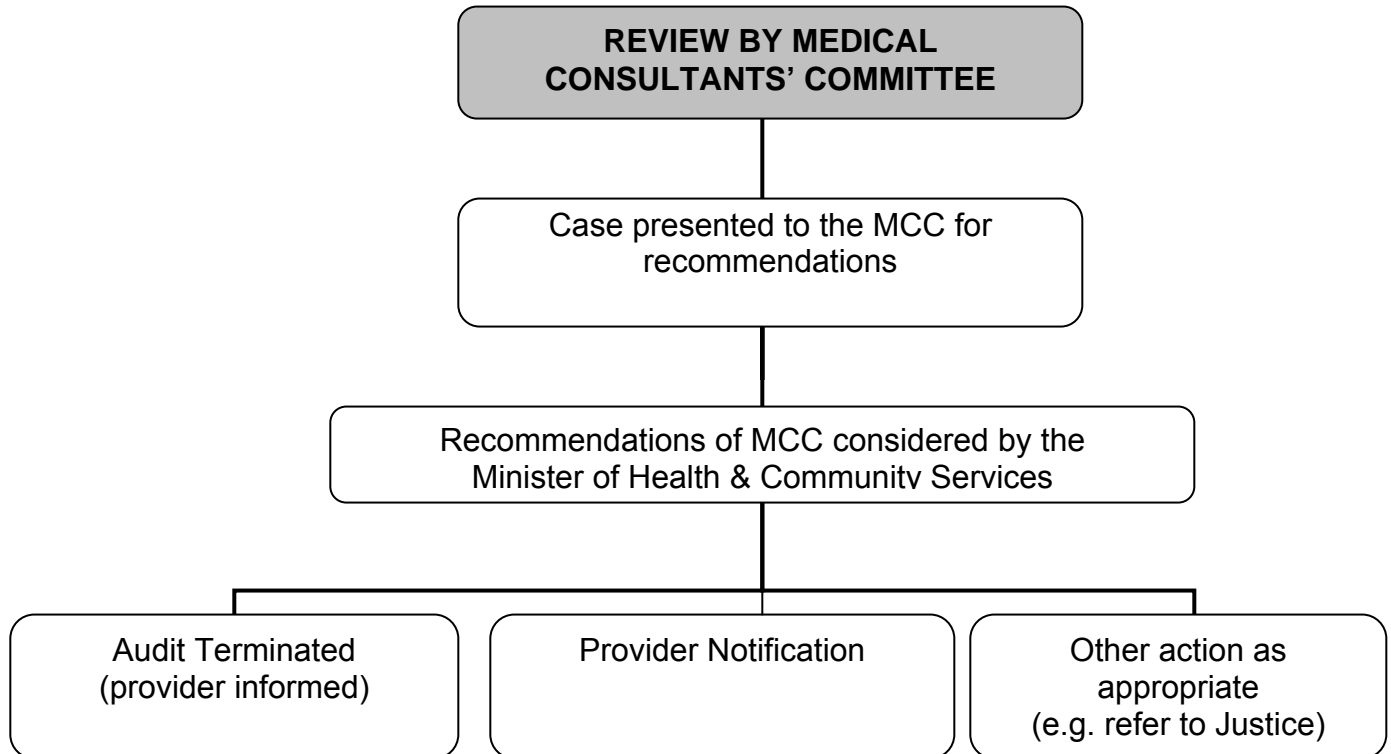
11.11.3 Comprehensive Stage

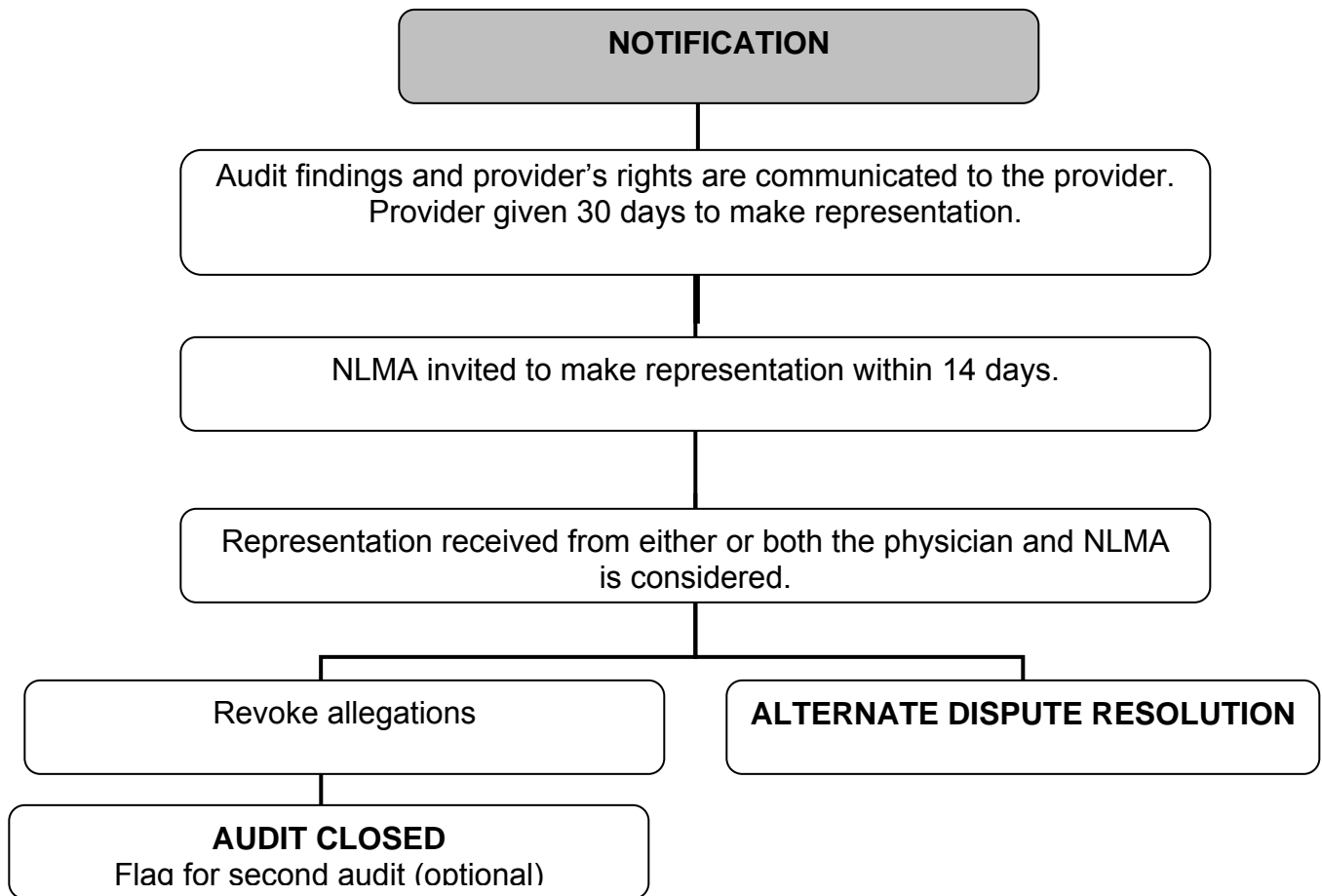


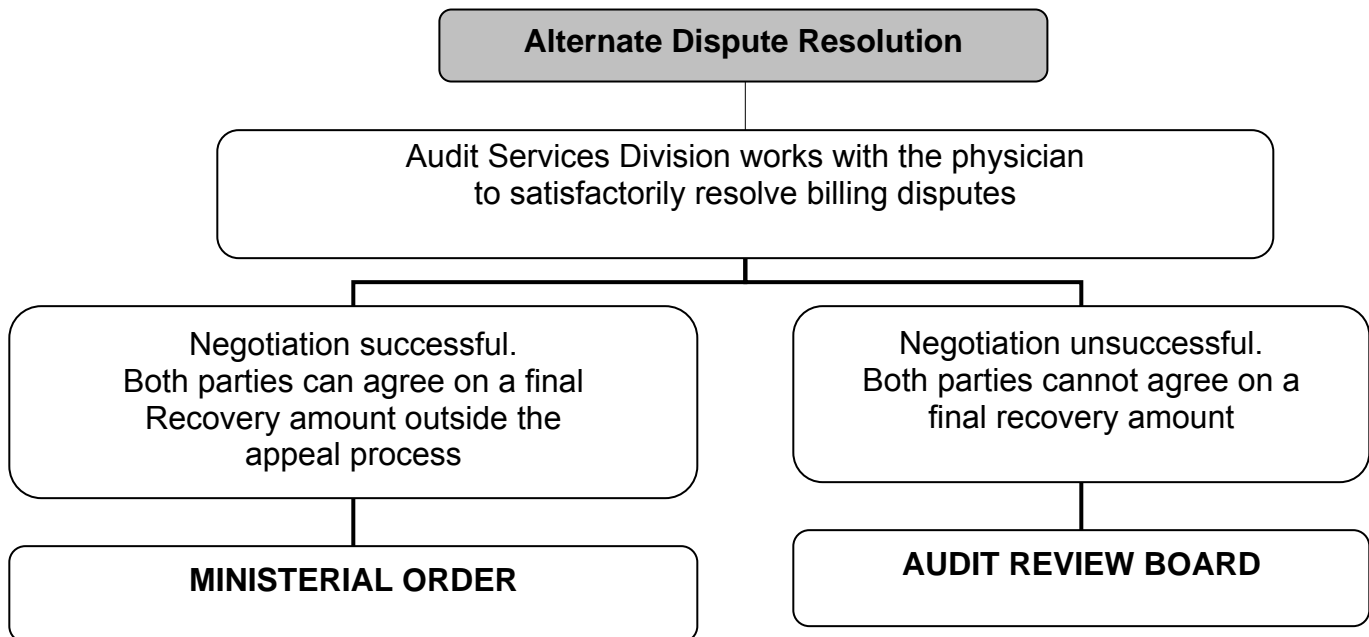
11.11.4 Physician Claims Intervention Program (PCIP)

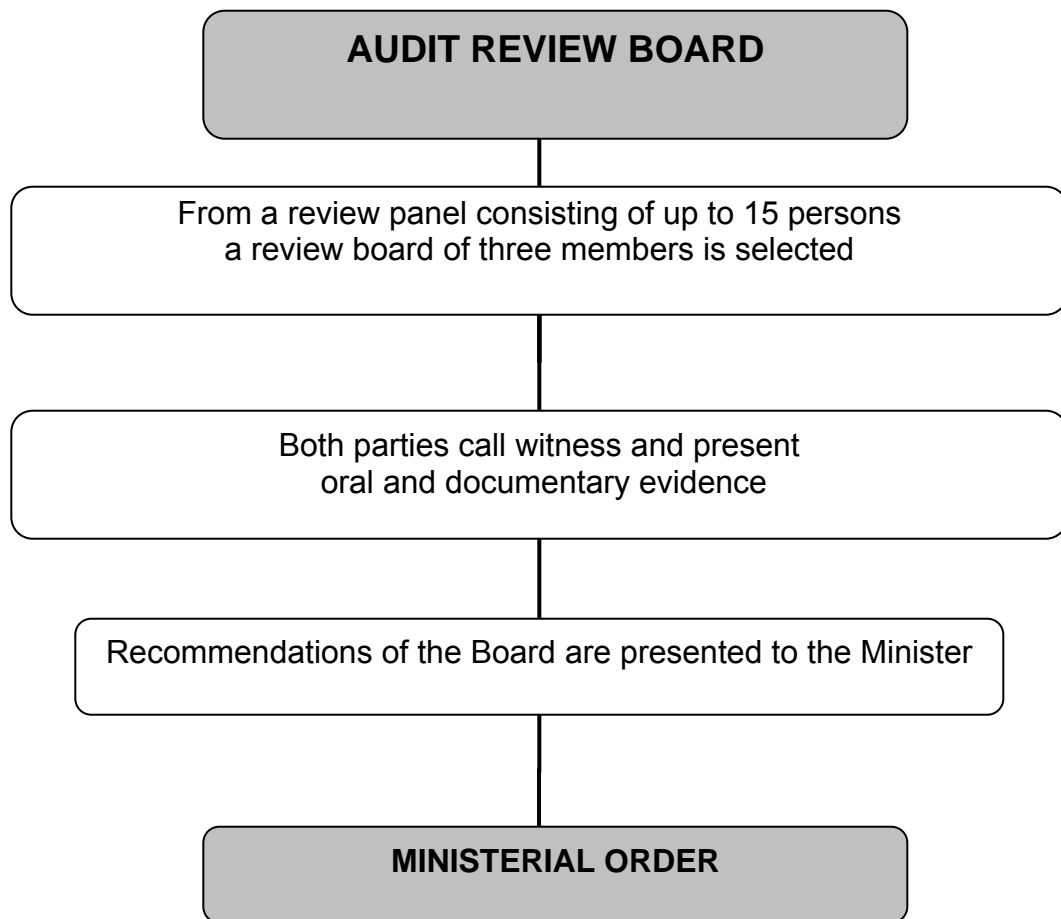
11.11.5 Provider Interview



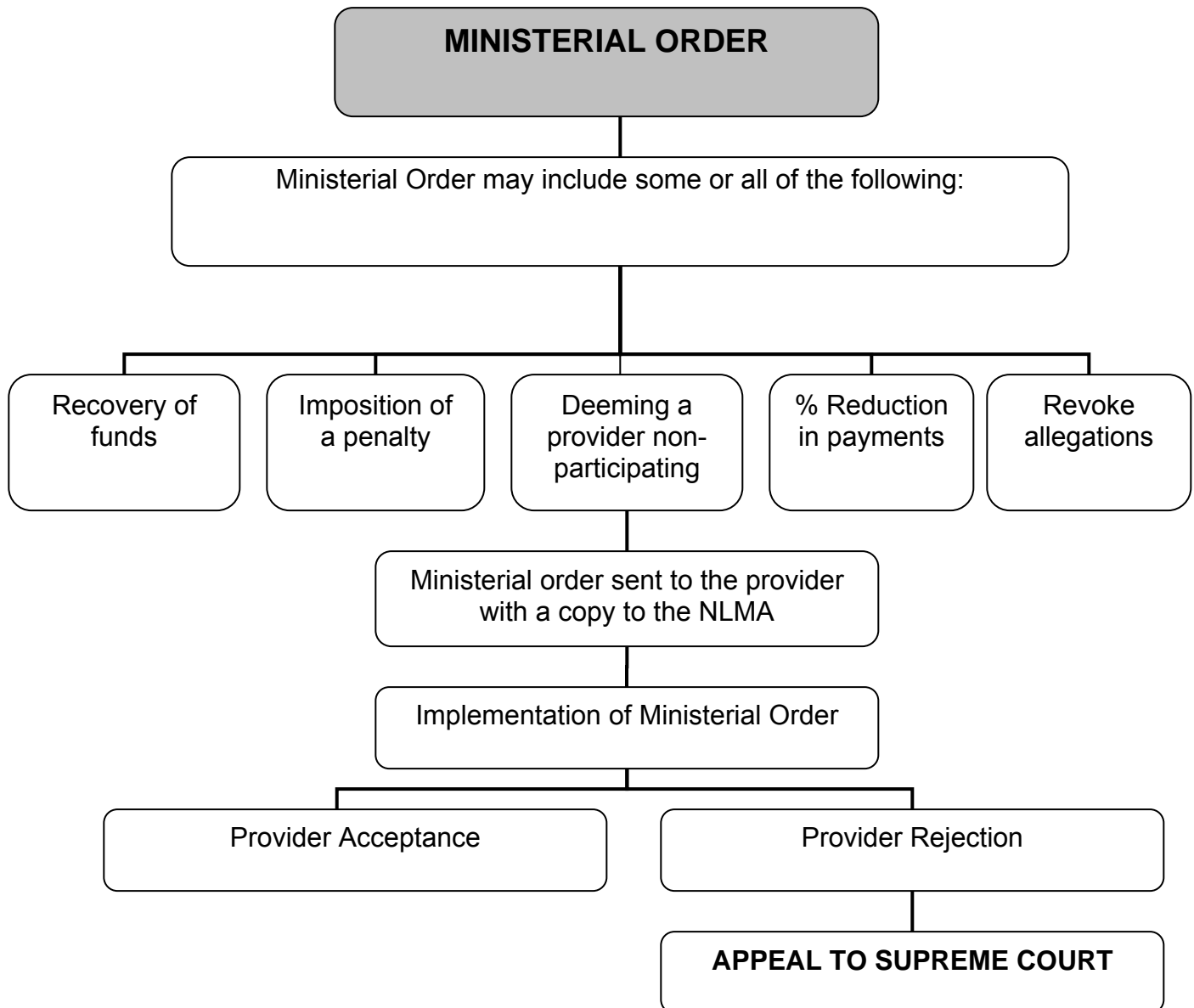
11.11.6 Review by Medical Consultant's Committee (MCC)/Dental Monitoring Committee (DMC) (optional)

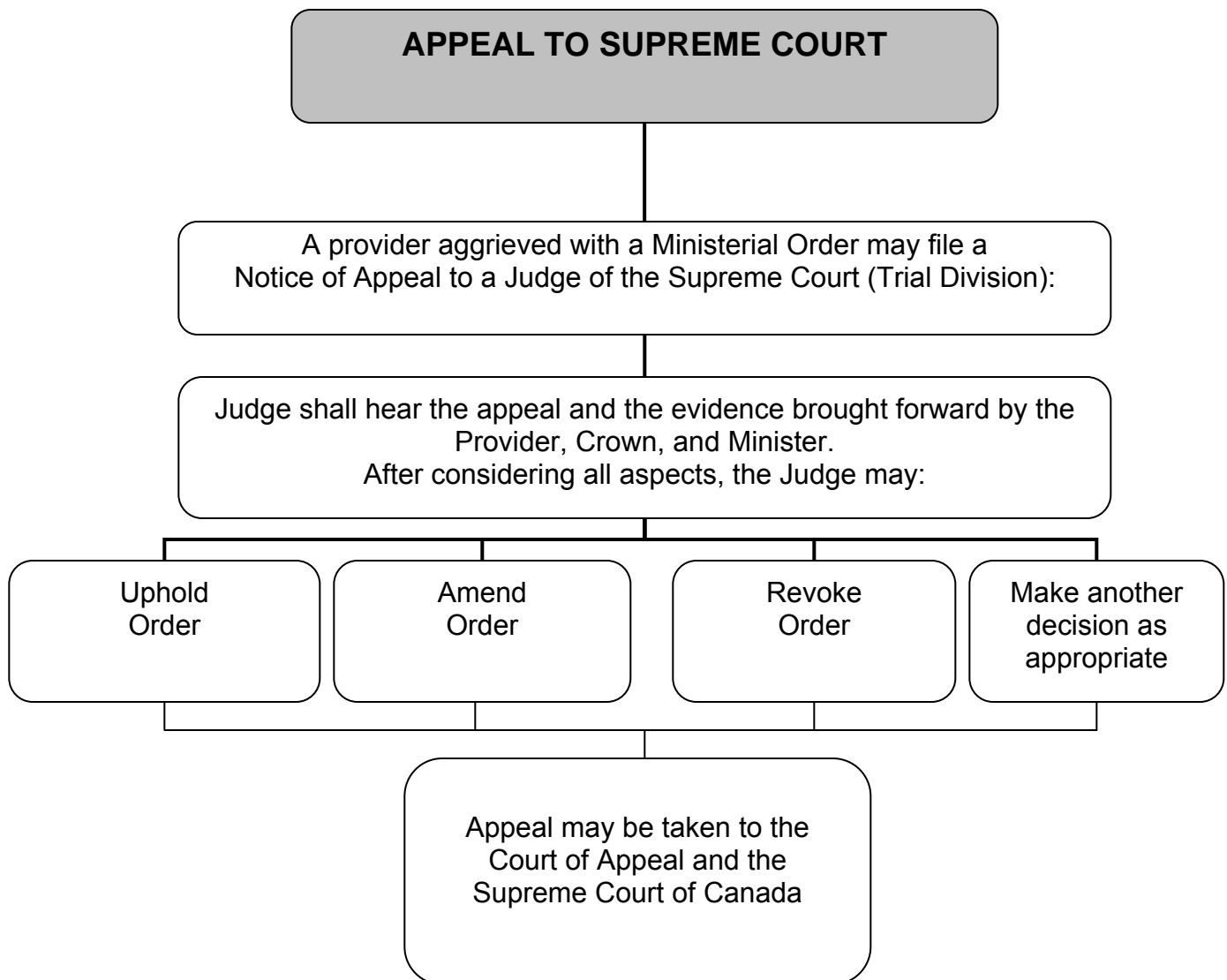
11.11.7 Notification

11.11.8 Alternate Dispute Resolution (ADR)

11.11.9 Hearing by Audit Review Board

11.11.10 Ministerial Order



11.11.11 Appeal to the Supreme Court Trial Division

11.12 BENEFICIARY AUDIT PROGRAM FOR MCP AND NEWFOUNDLAND AND LABRADOR PRESCRIPTION DRUG PROGRAM (NLPDP) BENEFICIARIES

Beneficiary Utilization Audits are those which are conducted in order to determine whether high utilization by beneficiaries may be categorized as 'legitimate illness' or program abuse. In these instances, where it is determined that a significant number of services are of questionable medical necessity, physicians may be asked to provide all claim-related information on beneficiaries for a specific period of time. Physicians may also be asked to provide comments upon the beneficiary's use of the program. This intervention process may also include meetings with the physician and beneficiary in order to review the utilization pattern and explore alternative means of medical care.

Preliminary determination of 'illness' or 'abuse' will be made by the Medical Consultant to Audit or in some instances by the MCC based upon the information and comments received from physicians.

Where there is strong evidence of abuse by beneficiaries supported by information to this effect from physicians, the beneficiaries are written, informed of the problem and told of the intent to monitor future utilization. They may also be required to repay any amounts paid by MCP on their behalf for unnecessary medical services.

Where there is strong evidence of over-servicing by a physician, the physician claims for services may be subjected to a Physician Medical Audit. Beneficiaries who are suspected of fraudulent use of the program are reported to police authorities for investigation.

In cases where the beneficiary does not reduce utilization levels after intervention by MCP, the individual may be entered into the Beneficiary Claims Intervention Program (BCIP). Under BCIP, payments for all claims on behalf of the beneficiary are stayed pending a review of the physician's record of the service, the utilization levels of the patient, and any other applicable information. Claims are reviewed by the Medical Consultant to Audit, and the MCC in some cases. Only those claims for medically necessary services are paid.

In cases where the beneficiary is strongly suspected of repeatedly visiting numerous general practitioners for the purposes of illegally obtaining prescriptions for narcotics (pain medications) and benzodiazepines (sedatives) under the NLPDP, one or more of the following actions may be taken:

1. Restriction of NLPDP drug card to one pharmacy of the beneficiary's choosing.
2. Letters to Physicians which can include one or more of the following:
 - Include information on utilization levels (MCP and NLPDP)
 - A request to reduce servicing and prescribing levels to an appropriate level
 - A request for a written explanation to servicing patterns
 - Notification of the beneficiary's entrance into BCIP
 - A request for an interview

- A request for a copy of the beneficiary's chart to aid in further analysis
 - A copy of the beneficiary's medication history for approximately a one year period for the physician's information
 - Notification of other appropriate action
3. Letters to Pharmacies which may include one or more of the following:
- Correspondence to the Pharmacist in Charge (PIC) of each pharmacy where the beneficiary received a controlled substance indicating DOHCS' intent to restrict the drug card – no medication history is sent
 - A request for an interview
 - A request for a written explanation to dispensing patterns
 - A request for copies of prescriptions to aid in a further analysis
 - Notification of other appropriate action
4. Letters to Beneficiaries which may include one or more of the following:
- A request for a written explanation of utilization levels
 - Notification of the inappropriateness of utilization levels
 - Explanation of the card restriction process
 - A request to limit visits to only one General Practitioner who will be better able to properly manage their care
 - An advisory that under Section 7 of the *Medical Care Insurance Beneficiaries and Inquiries Regulations* under the *Medical Care Insurance Act, 1999*, MCP has the authority to recover from patients all payments for medical services which are subsequently found not to have been medically necessary
 - Notification that all physicians that have been seen by the beneficiary have been notified of the utilization problem
 - Notification of future monitoring
 - Notification of entrance into BCIP
 - A request for an interview.
 - Notification of other appropriate action
5. Interview with either the beneficiary, pharmacy(ies) and/or the physician(s).
6. Physician and/or Pharmacy Audit.
7. Recover MCP payments from the beneficiary.
8. Referral to the Beneficiary Utilization Review Committee (BURC).

After interventions are made, Audit Services Division will prepare a monthly report summarizing the utilization levels of beneficiaries for both the MCP and the NLPDP plans. In cases where the

beneficiary reduces utilization levels, there will be no further action at that time. Monitoring will continue on a monthly bases. In cases where the beneficiary does not reduce utilization levels, he/she is once again identified for review and further interventions.

11.13 BENEFICIARY UTILIZATION REVIEW COMMITTEE (BURC)

In cases where it is believed that the beneficiary may be in violation of Section 4(2) of the *Controlled Drugs and Substances Act*, the pharmacist of the Pharmaceutical Services Division prepares a summary file outlining past interventions and summarizing current concerns and forwards a copy to the Audit Services Division for investigation. Where analysis by the Audit Services Division shows that the *ACT* may have been violated by a beneficiary, the report summarizing the investigation is forwarded to the BURC.

This committee is comprised of the Executive Director of the Audit and Claims Integrity Division (ex-officio), the Assistant Director of Physician Services/Medical Consultant to Audit, and the Director Pharmaceutical Services Division.

BURC considers these reports as well as the MCP and NLPDP utilization levels of beneficiaries and recommends cases to the Minister which should be released to the Police for investigation.

11.14 INFORMATION REGARDING RECORDS OF SERVICE

11.14.1 Record Requests

Record requests are an integral part of the audit process and in most medical audits, records form the basis for recovery through record review and the extrapolation of findings.

Record requests may be made in the following instances:

- as a result of discrepancies in information provided by beneficiaries compared with that which has been claimed
- when a physician service profile indicates that the physician billing deviates significantly from that of his/her peers when beneficiary utilization indicates possible program abuse
- when the physicians records, upon review, do not support the service billed necessitating a request for further records
- or other cases as deemed appropriate

With regard to sensitive patient care information, the following points should be considered:

- Photocopies of records pertaining to specific services may be requested but only that information which documents and substantiates the billing is required to be submitted. However, where beneficiary utilization is being audited, physicians may also be asked to provide voluntary comment or additional information with respect to the legitimacy of the beneficiary's medical service needs.
- All services are subject to audit. Certain services are more likely to contain sensitive information than others. Notations of sensitive information are not normally required unless they form an integral part of the documentation which substantiates the service claimed. Where such notes are not essential for service verification, they may be withheld or sent directly to the Medical Consultant for his review.

In certain instances, entire patient charts will be requested in order to investigate a mode of treatment or pattern of servicing / utilization.

Where physicians fail to comply with requests for records within clearly prescribed time limits without reasonable explanation, claims from the sample selected will be deemed to be unsubstantiated.

The purpose of a request for record information is to substantiate a statistical sample of a broader base of claims which appear to have been misbilled. There are significant consequences for not providing the required information. The sample size in the Comprehensive Stage is determined from the entire base of claims by an established and proven extrapolation methodology. Therefore, any claims not submitted will have a significant impact upon the overall percentage of unsubstantiated claims, since records that have not been submitted are considered to be unsubstantiated claims.

In the case of chronic patient abuse, the legitimacy of a patient's many requests for service, usually to a large number of physicians, must be verified. While there may be no initial indication of misbilling and therefore no intent by the Audit Services Division to recover monies from the physician(s), a refusal to provide required claim information will lead to cancellation and recovery.

11.14.2 Record Copy Protection/Disposal

Record information requested for audit purposes is considered by MCP to be highly confidential and is subject to strict control. It is held under secure conditions until the completion of an audit. It is not otherwise distributed, unless presented through a report to Medical Audit Management, the Medical Consultant to Audit, or the MCC.

11.14.3 Record Retention for Audit Purposes

Audits are normally limited to claims submitted within the previous two years. However, in

exceptional circumstances, audits may cover a longer period. Because of this it is required that physicians maintain records supporting services billed to MCP for a period of six years.