STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

HEALTH AND RECOVERY SERVICES ADMINISTRATION

PO Box 45503, Olympia, WA 98504-5503

July 20, 2009

David B. Robbins, Attorney
Bennett Bigelow & Leedom, P.S.
1700 Seventh Avenue, Suite 1900
Seattle, WA 98101-1397

RE: PROVIDER NUMBER: 7922404
AUDIT NUMBER: MA 07-13

Dear Mr. Robbins:

Enclosed is the final audit report for Planned Parenthood of the Inland Northwest for services provided during the payment period of March 15, 2004, through February 26, 2007. Staff from the Office of Payment Review and Audit, Division of Systems and Monitoring, Health & Recovery Services Administration, Department of Social and Health Services, conducted the audit.

The enclosed final report specifies that an excess payment of $629,142.88 has been made to you as a medical assistance provider. Revised Code of Washington (RCW) 74.09.220 requires interest be assessed on any overpayment identified in an audit, except those resulting from an error by the department. Interest will be calculated by the Office of Financial Recovery (phone number 360-664-5455) in accordance with RCW 43.20B.695 and communicated to you under separate cover.

Please make your check payable to:
Department of Social and Health Services
Mail the check to:
Office of Financial Recovery
Post Office Box 9501
Olympia, Washington 98507-9501
Identify Audit Number MA 07-13 on the check.

If you disagree with this audit, you may elect to exercise your right under Washington Administrative Code (WAC) 388-502-0240 to an audit appeal hearing. The audit hearing will be governed by the process in RCW 43.20B.675 and will be limited to disputed items within the final audit report.

The request for a hearing must:

- Be received in writing.
- State the basis for contesting the overpayment notice and send to OFR (address below).
- Provide a detailed statement for each audit finding in dispute.
- Be received by the Office of Payment Review and Audit within 28 days of receipt of this letter.
- Be sent by certified mail (return receipt) or other manner that verifies delivery to the Office of Payment Review and Audit.

Please mail requests for an audit appeal hearing to:

Department of Social and Health Services
Office of Financial Recovery
Post Office Box 9501
Olympia, Washington 98507-9501

Include a copy of this letter with your request.

Thank you for the courtesy you extended to the audit team during the audit process. Your continued support of the Medical Assistance program is appreciated.

Sincerely,

Steve Wilson, Auditor
Office of Program Integrity
Division of Systems and Monitoring
Health & Recovery Services Administration
Post Office Box 45503
Olympia, Washington 98504-5503

Enclosure

cc: Office of Financial Recovery
cc: PPINW

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH & RECOVERY SERVICES ADMINISTRATION
DIVISION OF SYSTEMS AND MONITORING
OFFICE OF PROGRAM INTEGRITY
MEDICAL AUDIT UNIT

FINAL AUDIT REPORT OF

Planned Parenthood of the Inland Northwest
dba Planned Parenthood of Spokane – Take Charge
East 123 Indiana Avenue
Spokane, WA 99207

PROVIDER NUMBER
7922404

AUDIT NUMBER
MA 07-13

DATE CONDUCTED
May 8 – 10, 2007

DATE ISSUED
July 20, 2009

STAFF
Steve Wilson, Lead
Evonne Peryea

FINAL

TABLE OF CONTENTS

FINAL

I. INTRODUCTION

This report is issued as a result of an audit conducted by staff of the Medical Audit Unit, Office of Payment Review and Audit, within the Department of Social and Health Services (DSHS). The purpose of this audit was to determine provider compliance with applicable federal, state, and departmental regulations relative to paid claims for services provided under the Health & Recovery Services Administration (HRSA) programs.

A. BACKGROUND:

The Department of Social and Health Services (DSHS) is responsible for maintaining an ongoing program to audit providers participating in the state Health & Recovery Services Administration programs. The audits are conducted in accordance with the procedures specified in WAC 388-502-0240. Audits under this program may utilize guidelines established by the Department of Health and Human Services.

B. PROGRAM OBJECTIVES:

The HRSA provider audits have the following objectives:

- To determine if services billed and paid under the HRSA program were provided.
- To provide a systematic and uniform method of determining compliance with state and federal program regulations.
- To identify provider billing and/or payment irregularities which occur within the state's HRSA programs.
- To provide a mechanism for data gathering, which will be of use in establishing and/or modifying program policies and procedures.

C. AUDIT PROCESS:

This HRSA provider audit was conducted in the following manner:

Probability Sampling

A probability sample of procedures from the department's Medicaid Management Information System (MMIS) was randomly selected from a universe of procedures reimbursed by DSHS to the provider. This sample was selected to ensure a minimum ninety-five percent confidence level. The claims related to Algorithm Number PN001 identified by the Payment Review Program (PRP) unit with an invoice date of 1/09/06 were excluded from the universe before the sample was selected.

Findings of irregularities within the probability sample were extrapolated to the universe of procedures from which it was drawn.

FINAL

Claim-by-Claim Audit

In addition to the probability sample, the twenty-five (25) procedures with the highest reimbursement were audited on a claim-by-claim basis. These procedures were excluded from the universe of procedures used for the probability sample.

Irregularities associated with this claim-by-claim audit, if any, were not included in the projected overpayment. Rather, the actual dollar amounts were added to the projected amount.

Documentation Reviewed

Documentation to support services reimbursed by DSHS were reviewed on-site at the provider's facility. No original records were removed from the provider's premise. After the on-site review, the provider was notified of the documents necessary to complete the audit, which were not located during the on-site review.

The documents collected were analyzed to identify any billing irregularities or deviations from program rules, regulations, and the provider agreement. The results are contained in Section III of this report.

II. AUDIT PROFILE

A. PROVIDER PROFILE

Planned Parenthood of the Inland Northwest
dba Planned Parenthood of Spokane – Take Charge
East 123 Indiana Avenue
Spokane, WA 99207

Provider Number: 7922404
Provider Type: Family Planning Clinic –Take Charge
Participant in Title X of the Public Health Service Act - The National Family Planning Program

B. AUDIT SCOPE

The scope of the audit was limited to measuring compliance with regulations stated in the Revised Code of Washington (RCW), Washington Administrative Code (WAC), the provider's Core Provider Agreement with DSHS, the Schedule of Maximum Allowances, Billing Instructions, and Numbered Memoranda.

A universe of procedures paid from March 15, 2004 through February 26, 2007, was selected. Procedures paid at $0 and Medicare cross-over claims were excluded to produce the final framed universe of procedures from which the audit was conducted.

The audit consisted of a sample of 333 procedures selected from the framed universe. The framed universe of procedures from which the sample was selected contained 267,840 procedures and totaled $7,697,613.86. All procedures were itemized on the Medical Assistance Remittance and Status Reports issued weekly to the provider.

- The probability sample consisted of 308 randomly selected procedures and totaled $26,117.32. Irregularities identified in the probability sample were extrapolated to the universe containing 267,815 procedures and totaling $7,685,885.36.
- A claim-by-claim audit was done on the highest reimbursed 25 procedures. The dollar value was $11,728.50.

This report consists of findings and directives resulting from the audit of Planned Parenthood of the Inland Northwest (PPINW). The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean such practice is acceptable. Because of the limited nature of this review, no inferences as to the overall level of provider performance should be drawn solely from this report.

III. FINDINGS

For all findings listed in this report, the following record retention and documentation requirements apply:

WAC 388-502-0020 *General requirements for providers.*

(1) Enrolled providers must:
(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
(i) Patient's name and date of birth;
(ii) Dates of services;
(iii) Name and title of person performing the service, if other than the billing practitioner;
(iv) Chief complaint or reason for each visit;
(v) Pertinent medical history;
(vi) Pertinent findings on examination;
(vii) Medications, equipment, and/or supplies prescribed or provided;
(viii) Description of treatment (when applicable);
(ix) Recommendations for additional treatments, procedures, or consultations;
(x) X rays, tests, and results;
...
(xii) Plan of treatment and/or care, and outcome; and
(xiii) Specific claims and payments received for services.
(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

(c) Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services upon request, for six years from the date of service or longer if requested by federal or state law or regulation;
(d) Bill the department according to department rules and billing instructions;
...
(i) Provide all services according to federal and state laws and rules, and billing instructions issued by the department.
...

WAC 388-502-0100 *General conditions of payment.* (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:
...
(c) The service is properly authorized;
...

According to WAC 388-531-0100 *Scope of coverage for physician-related services*:
...
(6) By providing covered services to a client eligible for a medical assistance program, a provider who has signed an agreement with the department accepts the department's rules and fees as outlined in the agreement, which includes federal and state law and regulations, billing instructions, and department issuances.

Per the **Core Provider Agreement**:
...
The department reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients.
...
5. Inspection; Maintenance of Records. For six (6) years from the date of service, or longer if required specifically by law, the Provider shall:
(a) Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to the department.
(b) The provider shall make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within the department or the Secretary of the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.

6. Audit or Investigation. Audits or investigations may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and

FINAL

supportive materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required 6 year period.

Findings

1. **Prescription drugs were dispensed without an authorizing order.**

A review of the provider's documentation revealed, in seventeen (17) instances, the provider did not provide substantiating documentation for the services billed to HRSA.

Finding 1

1A. **Service billed with no current authorizing order.** In ten (10) instances, the dispenser did not have a current, valid authorizing order (prescription) to dispense and bill for the prescription drug on the date-of-service.

For example, record #75 is for oral contraceptive pills billed with a date of service of 7/23/04. Per the provider's documentation, the chart order dated 2/16/04 states: "continue Cyclessa po QD", which does not cover the date of service billed. This is an order which lacks duration or length of need.

The total amount paid for the services is asserted for recovery. See Appendix A for details.

1B. **No valid authorizing order for the service billed.** In seven (7) instances, the dispenser did not have a valid authorizing order (prescription) to dispense the prescription drug billed.

For example, record #11 is for oral contraceptive pills billed with a date of service of 9/1/06. Per a review of the provider's documentation, the office visit on 8/8/06 did not include an order for the medication billed (Ortho Tri-Cyclen Lo per the encounter form). No order for this medication was found on the exam form or in the chart notes. Also, the exam form was not signed by a licensed clinician.

Basis for Finding 1

Valid authorizing orders of medications dispensed and billed require documentation by authorized clinical staff:

In accordance with RCW 69.41.030 it is unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician... advanced registered nurse practitioner...a physician assistant...a registered nurse or advanced registered nurse practitioner under chapter 18.79 RCW when authorized by the nursing care quality assurance commission... This RCW also states that nothing

in this chapter shall prevent a family planning clinic that is under contract with the department of social and health services from selling, delivering, possessing, and dispensing commercially prepackaged oral contraceptives **prescribed by authorized, licensed health care practitioners.** [Emphasis added.]

Per WAC 388-532-110 Reproductive health services – Provider requirements.

To be paid by the department for reproductive health services provided to eligible clients, physicians, ARNPs, licensed midwives, and department-approved family planning providers must:

...

(2) Provide only those services that are within the scope of their licenses;

WAC 388-530-1050 ***Definitions:***

"**Prescription**" means an order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices in the course of the practitioner's professional practice for a legitimate medical purpose.

"**Prescription drugs**" means drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

WAC 388-502-0020 ***General requirements for providers.***

(1) Enrolled providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

...

(ii) Dates of services;

...

(vii) Medications, equipment, and/or supplies prescribed or provided;

...

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; ...

WAC 388-502-0100 *General Conditions of payment.* (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

...

(c) The service is properly authorized;

...

Per the Core Provider Agreement:

FINAL

5. Inspection; Maintenance of Records. For six (6) years from the date of service, or longer if required specifically by law, the Provider shall:

(a) Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to the department.

The Board of Pharmacy under the Department of Health (DOH) has defined the length of time a prescription for a legend drug can be written and the authorization requirement for refills. RCW 69.41.0 allowing family planning clinics to dispense prescribed medication does not preclude prescribers from following the DOH WAC 246-869-100 prescription record requirements for prescription medication usually written for a pharmacy to dispense. See the following:

WAC 246-869-100 – *Prescription record requirements.*

...

(2) The pharmacist shall be required to insure that the following information be recorded:

...

(b) Refill prescription authorization – Refills for prescription of legend drugs must be authorized by the prescriber prior to the dispensing of the refill prescription.

...

(d) Prescription refill limitations – No prescription may be refilled for a period longer than one year from the date of the original prescription. "PRN" prescriptions shall expire at the end of one year. Expired prescriptions require authorization before filling. If granted a new prescription shall be written and placed in the files.

Summary of Finding 1

For Finding 1A, there were ten (10) instances where there was no current authorizing order for the date-of-service billed. The total amount paid for the services is asserted for recovery. See Appendix A for details.

For Finding 1B, there were seven (7) instances where the authorizing order was missing for the service billed. The total amount paid for the services is asserted for recovery. See the eight claims in Appendix A and one claim in Appendix B for details.

2. **Documentation does not support the evaluation and management (E/M) service billed.**

A review of the provider's documentation revealed, in sixteen (16) instances, the documentation was missing or did not support the level of evaluation and management (E/M) procedure code billed by the provider and paid by HRSA.

Finding 2

2A. **The E/M service was coded incorrectly.** In one (1) instance, the E/M service billed and paid by HRSA was coded incorrectly. The difference between the amount paid and the amount allowed is asserted for recovery.

Record #284: Provider billed for a 99212 established patient E/M visit on 10/28/04. Provider coded 99212 for counseling and administration of an injection. Depo injection note and stamped chart entry signed by a certified medical assistant (CMA). No time noted for counseling in chart. A check of MMIS did not show the provider billed for the administration of the Depo shot for the date of service.

Review did not allow the 99212 E/M code due to lack of a clinician signed chart note reflecting a history, exam, and medical decision making was done; neither was there a time component for counseling entered and signed by a clinician. Finding is based on WAC 388-502-0020, WAC 388-502-0100, WAC 388-532-110, and lack of a face-to-face documented visit with the clinician per the 2004 CPT manual. (See Basis.)

CPT code 99211 was not allowed by reviewer as counseling time was not noted by the CMA per WAC 388-502-0020 and CPT manual. (See Basis.)

Review allowed the CPT code 90782 (See Appendix D *Physician-Related Services* Billing Instructions Page C.14 Therapeutic or Diagnostic Injections) for CMA administration of the Depo shot. CPT code 99212 paid $25.25 - $11.34 for CPT code 90782 = $13.91 overpaid.

2B. **No documentation to substantiate the 99211 E/M service billed for medication pick-up.** In fourteen (14) instances, there were no chart notes by licensed clinical staff for the date-of-service to support the 99211 E/M service billed and paid by HRSA. The total amount paid for the services is asserted for recovery.

For example, record #21 was billed as a 99211: Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. There was no chart note or any other documentation in the chart substantiating that the client had a face-to-face E/M

office visit with licensed clinical staff on the date-of-service. The total amount paid for the services is asserted for recovery. See Appendix A for details.

2C. No documentation to substantiate the 99211 E/M pregnancy test visit billed. In one (1) instance, there was no chart note or other signed documentation submitted to support the billing of an E/M visit. The total amount paid for the services is asserted for recovery.

Record #113: there was no chart note for the date of service to support the billing of a 99211 visit for a pregnancy test. The client enrolled on 2/5/07 and a pregnancy test was done on the same day, a note was entered in the chart, the pregnancy evaluation procedure form was completed, and HRSA was billed. Record #113 is for another pregnancy test on 2/14/07, but the only documentation is a patient visit flow sheet requesting a pregnancy test. No documentation of a face-to-face office visit or test outcome was noted in the chart as required by WAC 388-502-0020 and per the CPT manual. The total amount paid for the services is asserted for recovery.

Basis for Finding 2A-C

Provider documentation must include sufficient information to support the procedure code billed. See the following:

Per WAC 388-502-0020 *General requirements for providers.*
(1) Enrolled providers must:
(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
...
(ii) Dates of services:
(iii) Name and title of person performing the service, if other than the billing practitioner;
(iv) Chief complaint or reason for each visit;
(v) Pertinent medical history;
(vi) Pertinent findings on examinations;
(vii) Medications, equipment, and/or supplies prescribed or provided;
(viii) Description of treatment (when applicable);
(ix) Recommendations for additional treatments, procedures, or consultations;
(x) X rays, tests, and results;
...
(xii) Plan of treatment and/or care, and outcome; and
...
(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;
...

FINAL

WAC 388-502-0100 *General conditions of payment.* (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

...

(c) The service is properly authorized;

...

Per WAC 388-532-110 Reproductive health services – Provider requirements:

> To be reimbursed by the department for reproductive health services provided to eligible clients, physicians, ARNPs, licensed midwives, and department-approved family planning providers must:
>
> ...
>
> (2) Provide only those services that are within the scope of their license; ...

Per the HRSA ***Physician-Related Services Billing Instructions*** November 2001, Revised July 2005, and July 2006- (same page for all issues) Page A.1 – Introduction:

> **Procedure Codes**
>
> The following types of procedure codes are used within these *Physician-Related Services Billing Instructions:*
>
> - Current Procedure Terminology (CPT™); and
> - Level II Healthcare common Procedure Coding System (HCPCS).
>
> Procedures performed must match the description and guidelines from the most current CPT or HCPCS manual for all MAA-covered services. ...**To view the full CPT description, please refer to your current CPT manual.**

Per the **2004** ***Current Procedural Terminology*** (CPT®) Introduction, page xiii:

> *Current Procedural Terminology,* Fourth Edition (CPT®) is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. ...

Per Instructions for **Use of the *CPT* Book**, (same page - same issue):

> ... Any service or procedure should be adequately documented in the medical record.... Any procedure or service in any section of this book may be used to designate the services rendered by any qualified physician or other qualified health care professional.

Per the same issue - **Evaluation and Management (E/M) Services Guidelines,** Page 4:

Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family.

FINAL

Page 7:

Select the Appropriate Level of E/M Services Based on the Following

...

3. When counseling dominates (more than 50%) the face-to-face encounter, then time may be considered the key factor. The extent of counseling must be documented in the medical record.

Additional Basis for Finding 2A

Per the ***Physician-Related Service Billing Instructions*** dated July 2004, Page C.14, therapeutic or diagnostic injections, CPT code 90782 is to be used if no other service is performed on the same day.

CPT Code 99212: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components:

- A problem focused history;
- A problem focused examination ;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Physicians typically spend 10 minutes face-to-face with the patient or family.

Regarding Health Care Assistants:

Per RCW 18.135.010 Practices authorized.

> It is in this state's public interest that limited authority to: (1) Administer skin tests and subcutaneous, intradermal, intramuscular, and intravenous injections; (2) perform minor invasive procedures to withdraw blood; and (3) administer vaccines in accordance with RCW 18.135.120 be granted to health care assistants who are not so authorized under existing licensing statutes, subject to such regulations as will ensure the protection of the health and safety of the patient.

Per RCW 18.135.020 Definitions.

> ...
> (2) "Health care assistant" means an unlicensed person who assists a licensed health care practitioner in providing health care to patients pursuant to this chapter. ...

FINAL

Additional Basis for Finding 2B

There were fourteen (14) claims with the CPT code of 99211 with no clinical chart notes entered for the dates-of-service. Each face-to-face E/M service is to be performed by a qualified health care professional within the scope of their license and documented in the chart to support the level of service billed. The following is from the CPT manual.

Per **Established Patient**, page 10 (2005 CPT® manual):

> **99211 Office or other outpatient visit** for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Summary for Finding 2

For Finding 2A, there was one (1) instance where the E/M service was coded incorrectly. See Appendix A for details.

For Finding 2B, in fourteen (14) instances the E/M code 99211 billed was not supported by medical record documentation that a face-to-face office visit with a licensed clinical staff member occurred. See Appendix A for details.

For Finding 2C, in one (1) instance the E/M code billed was not supported by any documentation for the date-of-service. See Appendix A for details.

3. Item not billed per fee schedule.

A review of the documentation submitted by the provider revealed, in thirteen (13) instances, the acquisition cost (AC) of the contraceptive supply; i.e. condom, was less to the provider than the amount the provider billed to HRSA.

Basis for Finding 3

The department reimburses family planning clinics for contraceptive supplies and devices at the clinic's acquisition cost or HRSA's maximum allowable fee, whichever is specified by HRSA. According to the *Family Planning Services and Family Planning Only Program Billing Instructions*, effective July 2003, Pages 1 and E.2:

Page 1 Definitions: Acquisition cost – The cost of an item excluding shipping, handling, and any applicable taxes.

Page E.2:	Procedure Code	Maximum Allowable Fee:
	A4267 Male Condom, each	Acquisition Cost

FINAL

Summary of Finding 3

In all thirteen (13) instances HRSA was billed more than the Acquisition Cost (AC) for the contraceptive supply. See Appendix D for invoice copies. The difference between the AC on the invoices and HRSA's paid amount is asserted for recovery. See Appendix A for details.

4. **Pregnancy test billed was not medically necessary.**

A review of the provider's documentation revealed in one (1) instance the medical record documentation did not indicate a need for the pregnancy test billed and was not medically necessary.

Finding 4

In one (1) instance the documentation reviewed did not show medical necessity for the pregnancy test billed. Per provider's billing in MMIS, prior shot was given 12/15/03 (84 days prior due to leap year or equal to 12 weeks 0/7 days prior). Record #17: No note showing medical necessity for the pregnancy test on 3/08/04. Client was an inter-affiliate client from Yakima's Planned Parenthood facility, and not a new client. The second shot was given on time (at 12 weeks 0/7 days for a routine re-injection every 12 weeks).

The HOPE form (Hormones with Optional Pelvic Exam) did not indicate a need for pregnancy test. All HOPE questions were answered "no" including: "Do you think you might be pregnant now?"

There was no chart note entered by the examiner stating possible pregnancy was a concern.

The client had an affiliate's card with the date the next shot was due (3/9/04), and the affiliate phone number was available on the card.

Basis for Finding 4

WAC 388-502-0100 *General conditions of payment.* (1) The department reimburses for medical services furnished to an eligible client when all of the following apply:

...

(b) The service is medically or dentally necessary;

...

Per WAC 388-500-0005 *Medical definitions.*

"Medically necessary" is a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause

physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

Summary of Finding 4

For Finding 4, there was one (1) instance where the medical record documentation did not indicate a need for the pregnancy test billed and was not medically necessary. The record was reviewed by HRSA's Take Charge ARNP program manager. The total amount paid for the services is asserted for recovery. See Appendix A, record #17 for details.

5. **Provider billed for medication not covered by Family Planning or Take Charge programs.**

A review of the provider's documentation revealed, in one (1) instance, the provider on 10/13/04 billed separately for a medication included in a bundled service for an abortion that was covered under a different contract with this provider and a different provider number.

Finding 5

In one (1) instance, the documentation reviewed for the medication billed indicated the antibiotic Doxycycline 100 mg PO BID x 3 days was dispensed in relation to a surgical abortion performed the same day. This med should have been included in the bundled facility fee and not billed under this provider number.

Basis for Finding 5

Per the July 2003 *Family Planning Services and Family Planning Only Program* Billing Instructions Page C.2;

> What is not covered? [Refer to WAC 388-532-130]
> ...
> The following are not considered family planning services and are not covered under the Family Planning Services program:
> ...
> - Abortions;
> ...

Per the July 2003 *TAKE CHARGE Supplement* Page D.4:

> What services are not covered? [WAC 388-532-750]

FINAL

MAA does not cover certain services under TAKE CHARGE. These services include, but are not limited to, the following:

- Pregnancy services… Excluded pregnancy services include:

…

✓ Abortions…

Medication was part of the facility fee

Per the July 2004 *Physician-Related Services* Billing Instructions, Page F.14:

Abortion Center Contracts (Facility Fees)

…

- Contracted facility fee reimbursement includes all room charges, equipment, supplies, and drugs (including anti-anxiety, anesthesia, and pain medications, but excluding Rho(D) immune globulins). **Reimbursement is limited to one special agreement facility fee per client, per abortion.** …

Per contract No. 0212-11166 with Planned Parenthood (Amend date 10/01/03 thru 6/30/05):

…

3. Billing and Payment.

…

Procedure codes and facility fees for surgical abortions are **billable only under provider #7148406** while this contract is in effect.

The facility fees include:

a) All room charges;
b) Equipment and supplies;
c) Drugs, including anti-anxiety;

…

These services shall not be billed separately as they are included in the facility fees.

Summary of Finding 5

For Finding 5, there was one (1) instance where the medication billed should have been included in the bundled facility fee and not billed under this provider number. The total amount paid for the services is asserted for recovery. See Appendix A, record #58 for details.

IV. ADMINISTRATIVE FINDING (NON MONETARY)

This administrative finding identifies two related issues:

- An RN standing order protocol that does not follow the Department of Health's protocol,
- No information in the RN chart note that the oral contraceptive order is written under the standing order protocol.

In two instances (records #57 and #72), the Registered Nurse (RN) wrote an order for oral contraceptive for a new patient to PPINW without a countersignature by a clinician. The provider stated that the RN is allowed to initiate oral contraceptives under PPINW's standing orders. The standing order guidelines issued by the Department of Health Nursing Commission require a prior patient-practitioner relationship to have been established as part of the standing order protocol. Additionally, by the RN not identifying the order as following the standing orders, it is not readily apparent where the order originated. The order could have been a telephone order or an order sent by fax.

Basis

Oral contraceptives are prescription drugs and are to be dispensed only by prescription.

WAC 388-530-1050 ***Definitions:***

"**Prescription**" means an order for drugs or devices issued by a practitioner authorized by state law or rule to prescribe drugs or devices in the course of the practitioner's professional practice for a legitimate medical purpose.

"**Prescription drugs**" means drugs required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

The department only pays for services that are within the scope of the provider's license.

Per WAC 388-532-110 Reproductive health services – Provider requirements.

To be paid by the department for reproductive health services provided to eligible clients, physicians, ARNPs, licensed midwives, and department-approved family planning providers must:

...

(2) Provide only those services that are within the scope of their licenses;

Registered nursing practice is as identified below:

RCW 18.79.040 "Registered Nursing practice" defined – Exceptions.

(1) "Registered nursing practice" means the performance of acts requiring substantial specialized knowledge, judgment, and skill based on the principles of the biological, physiological, behavioral, and sociological sciences in either:

(a) The observation, assessment, diagnosis, care or counsel, and health teaching of individuals with illnesses, injuries, or disabilities, or in the maintenance of health or prevention of illness of others;

(b) The performance of such additional acts requiring education and training and that are recognized by the medical and nursing professions as proper and recognized by the commission to be performed by registered nurses licensed under this chapter and that are authorized by the commission through its rules; …

The Nursing Commission's authority to expand the RN's scope of practice.

Per RCW 69.41.030 Sale, delivery, or possession of legend drug without prescription or order prohibited — Exceptions — Penalty.

(1) It shall be unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician under chapter 18.71 RCW, an osteopathic physician and surgeon under chapter 18.57 RCW, an optometrist licensed under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a commissioned medical or dental officer in the United States armed forces or public health service in the discharge of his or her official duties, a duly licensed physician or dentist employed by the veterans administration in the discharge of his or her official duties, a registered nurse or advanced registered nurse practitioner under chapter 18.79 RCW when authorized by the nursing care quality assurance commission, …

Per the DOH Nursing Commission's Executive Director, standing orders are allowed under the *Washington State Nursing Care Quality Assurance Commission Practice Guidelines for Telehealth/Telenursing For Registered Nurses.*

…

2. Protocols are appropriate tools for implementing treatment plans. A registered nurse may use a protocol that has been written and approved by a physician to initiate a standing order for a medication or treatment. Assuming an appropriate patient-prescriber relationship exists, authorized standing orders may be implemented without consulting an authorized prescriber for a particular patient.

Administrative Finding Summary

PPINW's RN standing order protocol for new patients is not in compliance with the DOH Telehealth/Telenursing guidelines for Registered Nurses.

PPINW's standing order protocol allows an RN to write an order for OCs for a new patient, a patient that has not been seen by a PPINW clinician. This policy is out of compliance with the Nursing Commission's protocol. Additionally, by identifying the authority of the order (verbal order, fax, or standing order) there can be no doubt who the prescriber is.

V. SUMMARY

Overpayments associated with the probability sample totaled $1,743.59. When extrapolated to the universe of claims from which it was drawn, the calculated overpayment was $628,692.88. (See Appendix A for details on the overpayment.)

Overpayments associated with the claim-by-claim audit of the highest reimbursed 25 claims totaled $450.00.

Total overpayment was $629,142.88. Interest will be calculated by the Office of Financial Recovery (OFR), as described in RCW 43.20B.695.

VI. DIRECTIVES

Based upon the findings cited in this audit report, the Department of Social and Health Services directs Planned Parenthood of the Inland Northwest to:

1. Comply with all federal, state, and departmental regulations, rules, and billing instructions provided under the Medical Assistance program. Continued violations of any department's regulation, rules, and billing instructions may result in the termination or suspension of your eligibility to provide services to Medical Assistance clients per RCW 74.09.290.

2. Pursuant to RCW 74.09.220 and RCW 43.20B.695, remit your overpayment check in the amount of $629,142.88. Interest will be calculated on the total overpayment as required by RCW 43.20B.695. Payment is to be made to the Office of Financial Recovery as listed in the cover letter. (See Appendices A & B for an itemized list of findings and overpayments attached to this report.)

RCW 74.09.220 Liability for receipt of excess payments.
Any person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, that, without intent to violate this chapter, obtains benefits or

payments under this code to which such person or entity is not entitled, or in a greater amount than that to which entitled, shall be liable for (1) any excess benefits or payments received, and (2) interest calculated at the rate and in the manner provided in RCW 43.20B.695. Whenever a penalty is due under RCW 74.09.210 or interest is due under RCW 43.20B.695, such penalty or interest shall not be reimbursable by the state as an allowable cost under any of the provisions of this chapter.

RCW 43.20B.695 Vendor overpayments -- Interest -- Exceptions.
(1) Except as provided in subsection (4) of this section, vendors shall pay interest on overpayments at the rate of one percent per month or portion thereof. Where partial repayment of an overpayment is made, interest accrues on the remaining balance. Interest will not accrue when the overpayment occurred due to department error.

As a result of this audit, the Medical Audit Unit, Office of Payment Review and Audit, has notified the Office of Financial Recovery of the statistically projected and nonprojected overpayment amounts, including interest, as cited above.

Planned Parenthood of Spokane Take Charge
FINAL AUDIT REPORT
AUDIT FINDING INDEX
APPENDIX C

Finding ID	Finding Description	Finding Count
1A	No current authorizing order for the DOS	10
1B	No authorizing order for the service provided	7
2A	E/M visit coded incorrectly	1
2B	No documentation to substantiate 99211 E/M service	14
2C	No documentation to support E/M service	1
3	Item not billed per fee schedule	13
4	Lack of medical necessity for the service provided	1
5	Medication not covered by Family Planning/TC	1
Admin	RN working out of scope/Standing Orders	2