APPENDIX FOR WRIT OF CERTIORARI

To South Carolina Supreme Court

From South Carolina Court Of Appeals

Case No. 2015-002088

Laurens Pediatric Clinic,

Petitioner

v.

South Carolina Department Of Health And Human Services,

Respondent

RECEIVED
FEB 25 2016
SC Court of Appeals

APPENDIX

PETITIONER
Laurens Pediatric Clinic
P.O. Box 1367
Laurens, S.C. 29360

RESPONDENT
SCDHHS
Mr. Evan Gessner
Office Of Counsel
1801 Main St. Suite 1100
Columbia, S.C. 29202-8206

February 18, 2016

Writ Of Certiorari – Appendix

Ref: Laurens Pediatric Clinic – Appellant
v.
South Carolina Department Of Health And Human Services-Respondent
SC Court Of Appeals Case No. 2015-002088

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-Ruling SC Court Of Appeals (dismissing the case on technicality)- November 5, 2016. . . p 5
-Appellant's Notice Of Entry (in reply letter from the SC Court Of Appeals dated October 27, 2015) – November 3, 2015 . . . . . p 6
-Letter SC Court Of Appeals to Appellant (accepting they received proof of service to SC Administrative Law Court, but demanding written notice of entry of the order or judgment or case will be dismissed) - October 27, 2015 . . . . . p 7
-Proof Of Service to SC Administrative Law Court – October 22, 2015 . . . . . p 8
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-Ruling SC Administrative Law Court- September 2, 2015 . . . . . p 10-15
-Petitioner rebuttal to Respondent's Brief – July 19, 2015 . . . . . p 16-19
-Letter Of SCDHHS Counsel to Judge Durden where he tells that Respondent's Brief was left at the mail room for delivery to Petitioner with attached copy of Respondent's Brief-July 8, 2015. . . . . p 20-27
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-Letter of SCDHHS Counsel to Judge Durden where he admits he failed to mail on time Certificate Of Mailing with Respondent's Brief – June 18, 2015 . . . . . p 29-30
-Appellant's Brief to SC Administrative Law Court, with pertinent information on Addendum 1,2,3,4 - May 18, 2015 (date filed) . . . . . p 31-153
-Letter to SC Administrative Law Court requesting to appeal the ruling of Chief Officer Mr. Robert French – February 22, 2015 . . . . . p 154-158

NOTE: 17 volumes of bounded record (pp.R0001-R3287)from Division Of Appeals & Hearings was forward to SC Administrative Law Court by Officer French. These are not included in the Appendix. In them you can find ruling of Officer Mr. French dated January 25, 2015 (copied for this Appendix), and transcript of Hearing held October 31, 2012 (parts of transcript copied for this Appendix), and evidence(in part mentioned and copied in Appendix 3, 4 of the Appellant's Brief to SC Administrative Law Court).

Ref: Division Of Appeals And Hearings

-Parts of transcript of Hearing held October 31, 2012 . . . . . p 159-176
-Ruling of Chief Officer Mr. Robert French – January 25,2015 . . . . . p 177-250
-Letter of Appellant to Mr. Robert French, where internal review is mentioned and discrepancies add to no more than $1,601.19, and requesting an appeal– June 14, 2012 . p 251
-Letter Of SCDHHS after informal hearing to Appellant, note the only option offered was to appeal, settlement or request for hardship were not offered, despite disallowing $11,149.99 (27% of that paid) – May 16, 2012 . . . . . p 252-255
-Letter after site audit from SCDHHS to Appellant – February 22, 2012 . . . . . p 256-261

The South Carolina Court of Appeals

Laurens Pediatric Clinic, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2015-002088

ORDER

Appellant has filed a petition to rehear the dismissal of its appeal. After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing.[1] Accordingly, the petition is denied.

Thomas E. Huff J.

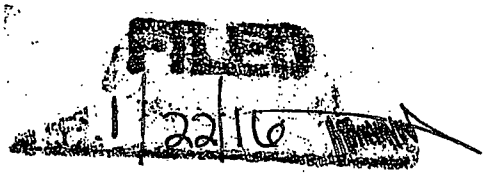
J.

[1] *See* Rule 203(b)(6), SCACR (stating an appellant must serve the notice of appeal from a decision of the ALC on all parties and the ALC within thirty days of receipt of the decision); Rule 263(b), SCACR ("The time prescribed by these Rules for performing any act *except the time for serving the notice of appeal* under Rules 203 and 227 may be extended . . . ." (emphasis added)); *Mears v. Mears*, 287 S.C. 168, 169, 337 S.E.2d 206, 207 (1985) (explaining service of the notice of appeal is a jurisdictional requirement, and the appellate courts have no authority to extend the time in which the notice must be served).

Stephanie P. McDonald J.

Columbia, South Carolina

cc: Laurens Pediatric Clinic (Nilsa I. Nazario)
Evan Markus Gessner, Esquire
Jana E. Shealy



November 10, 2015

SC Court Of Appeals
Clerk Of Court
P.O. Box 11629
Columbia, S.C. 29211

Laurens Pediatric Clinic -Appellant
v.
SCDHHS -Respondent

Trial Court Case No. 2015ALJ080109AP

Petition for Rehearing

To the Clerk Of Court:

I hereby request to reinstate appeal of this case. I received on November 9, 2015 the Court Order of dismissal filed 11/05/2015 (see enclosed copy).

I had served all parties Notice Of Appeal but inadvertently missed the mail on time for SC Administrative Law Court. This is the reason for dismissal, however, I request reconsideration from the court as this will eliminate my chances to appeal the ruling of Honorable Judge Deborah Brooks Durden issued September 2, 2015.

I apologize for any inconvenience to the court, I work as a solo practitioner in rural South Carolina, and I will do my best to comply with the court rules.

Sincerely,

Nilsa I. Nazario, M.D., F.A.A.P.
P.O. Box 1367
Laurens, S.C. 29360-1367

PROOF OF SERVICE

THE STATE OF SOUTH CAROLINA
In The Court Of Appeals

APPEAL FROM SOUTH CAROLINA
Administrative Law Court

Trial Court Case No. 2015ALJ080109AP

Laurens Pediatric Clinic

Appellant

v.

South Carolina Department Of Health And Human Services

Respondent

This is to certify that I sent copy of the Petition For Rehearing, along with copy of Court Dismissal Of Case Order, and copy of this proof of service to the Respondent and S.C. Administrative Law Court, by US postal service priority mail, signature confirmation on November 10, 2015.

November 10, 2015

Nilsa I. Nazario, M.D., F.A.A.P.
P.O. Box 1367
Laurens, S.C. 29360-1367

cc. Mr. Evan Gessner
Counsel SCDHHS
1801 Main St. Suite 1100
Columbia, S.C. 29201-8206

SC Administrative Law Court
Clerk Of Court
Edgar A. Brown Building
1205 Pendleton St.,Suite 224
Columbia, S.C. 29201

The South Carolina Court of Appeals

Laurens Pediatric Clinic, Appellant,

v.

South Carolina Department of Health and Human Services, Respondent.

Appellate Case No. 2015-002088

The Honorable Deborah Brooks Durden
Trial Court Case No. 2015ALJ080109AP

ORDER

Appellant has failed to timely serve the notice of appeal on the Administrative Law Court, as required by Rule 203 of the South Carolina Appellate Court Rules. Accordingly, this matter is dismissed. The remittitur will be sent as provided by Rule 221(b), SCACR.

FOR THE COURT

BY V. Claire Allen, Deputy
CLERK

Columbia, South Carolina

FILED
11-05-2015

cc:
Nilsa I. Nazario
Evan Markus Gessner, Esquire
Jana E. Shealy

November 3, 2015

SC Court Of Appeals: Clerk Of Court
PO Box 11629
Columbia, SC 29211

Re: Laurens Pediatric Clinic v. SCDHHS
Appellate Case No. 2015-002088

Attention: Chelsea at Clerk Of Court

I am enclosing copy of the envelope received with judgment from the SC Administrative Law Court. It was sent by regular US postal service on September 2, 2015, and was received on September 4. 2015. This satisfies requirement for notice of entry.

Sincerely,

Nilsa I. Nazario, M.D., F.A.A.P.
P.O. Box 1367
Laurens, SC 29360-1367

cc. Mr. Evan Gessner- Counsel SCDHHS

The South Carolina Court of Appeals

JENNY ABBOTT KITCHINGS
CLERK

V. CLAIRE ALLEN
DEPUTY CLERK

POST OFFICE BOX 11629
COLUMBIA, SOUTH CAROLINA 29211
1220 SENATE STREET
COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE: (803) 734-1890
FAX: (803) 734-1839
www.sccourts.org

October 27, 2015

Laurens Pediatric Clinic
Nilsa I. Nazario
PO Box 1367
Laurens SC 29360-1367

Re: Laurens Pediatric Clinic v. SCDHHS
Appellate Case No. 2015-002088

Dear Dr. Nazario:

The Court received your proof of service stating that the Administrative Law Court was served. You must provide this Court with the date you received written notice of entry of the order or judgment within ten days of the date of this letter or your appeal will be dismissed.

Very truly yours,

J. a. Kitchings

CLERK

cc: Evan Markus Gessner, Esquire

PROOF OF SERVICE OF A NOTICE OF APPEAL

THE STATE OF SOUTH CAROLINA

In The Court Of Appeals

From South Carolina Administrative Law Court

Honorable Judge Deborah Brooks Durden

Docket No. : ALJ-08-0109-AP

Laurens Pediatric Clinic,

Appellant

v.

South Carolina Department Of Health and Human Services,

Respondent

PROOF OF SERVICE

SC Administrative Law Court has been mailed copy of the Notice Of Appeal by US Postal service. October 21, 2015. The parties SC ALC and SCDHHS knew of my intent to appeal since September 3, 2015 when I confirmed receiving Honorable Judge Durden ruling by e-mail. I have also requested by phone on October 20, 2015, an extra copy at my cost of the record pertaining SC ALC. The latter will suffice rule 267 as I was told by Ms. Shealy. I apologize for the oversight to include this proof of service.

October 22, 2015

Nilsa I. Nazario, MD, FAAP
PO Box 1367
Laurens, SC 29360-1367

cc. Mr. Evan Gessner
Counsel SCDHHS-Respondent

The South Carolina Court of Appeals

JENNY ABBOTT KITCHINGS
CLERK

V. CLAIRE ALLEN
DEPUTY CLERK

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COLUMBIA, SOUTH CAROLINA 29201
TELEPHONE: (803) 734-1890
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www.sccourts.org

October 15, 2015

Nilsa I. Nazario
PO Box 1367
Laurens SC 29360-1367

Re: Laurens Pediatric Clinic v. SCDHHS
Appellate Case No. 2015-002088

Dear Dr. Nazario:

Upon reviewing your notice of appeal, the following deficiency has been noted under the South Carolina Appellate Court Rules (SCACR), and any deficiency must be corrected within ten (10) days of the date of this letter or your appeal will be dismissed:

- A proof of service showing that a copy has been timely served on the agency and/or the Administrative Law Court has not been provided as required by Rule 203(b)(6), SCACR.

Very truly yours,

V. Claire Allen, Deputy

CLERK

cc: Evan Markus Gessner, Esquire
Jana E. Shealy

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Laurens Pediatric Clinic, Appellant, vs. South Carolina Department of Health and Human Services, Respondent.	Docket No. 15-ALJ-08-0109-AP **ORDER**

This matter comes before the Administrative Law Court (Court or ALC) pursuant to the appeal of Laurens Pediatric Clinic (Appellant) from a decision of the South Carolina Department of Health and Human Services (DHHS or Department) to recoup overpayments for Medicaid services identified in an audit performed by the Department's Division of Program Integrity.

BACKGROUND

The Department's Division of Program Integrity performed an audit of Medicaid services provided by Appellant during the period from September 1, 2009 to August 31, 2011. The Department performed a comprehensive review of twenty-nine (29) Medicaid recipients' records and found a number of errors, such as coding errors and insufficient documentation. After an informal conference with Appellant, the Department determined that Appellant had been overpaid $11,199.49 for Medicaid services during the audited time period. On June 14, 2012, Appellant's sole owner, Dr. Nilsa I. Nazario, appealed the Department's proposed recoupment. A hearing was held on October 31, 2012, before the Department's Hearing Officer, Robert French. In a detailed written Final Administrative Decision, French found that the Department was entitled to recoup the entire amount of $11,199.49 from Appellant.

ISSUES

1. Was the Hearing Officer's January 25, 2015 decision supported by substantial evidence in the record?
2. Was the Hearing Officer biased in his January 25, 2015 decision?

FILED
September 2, 2015
SC ADMIN. LAW COURT

STANDARD OF REVIEW

The ALC hears appeals from decisions of DHHS pursuant to the Administrative Procedures Act (APA). S.C. Code Ann. § 44-6-190 (2002 & Supp. 2014); Estate of Nicholson ex rel. Nicholson v. S.C. Dept. of Health and Human Servs., 377 S.C. 590, 660 S.E.2d 303 (Ct. App. 2008). Accordingly, the APA's standard of review as set forth in § 1-23-380 governs these appeals. See S.C. Code Ann. § 1-23-600(D) (Supp. 2014). That section states:

> The court may not substitute its judgment for the judgment of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:
> (a) in violation of constitutional or statutory provisions;
> (b) in excess of the statutory authority of the agency;
> (c) made upon unlawful procedure;
> (d) affected by other error of law;
> (e) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or
> (f) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

S.C. Code Ann. § 1-23-380(5) (Supp. 2014).

A decision is supported by substantial evidence when the record as a whole allows reasonable minds to reach the same conclusion as the agency. Friends of the Earth v. Pub. Serv. Comm'n of S.C., 387 S.C. 360, 366, 692 S.E.2d 910, 913 (2010). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's findings from being supported by substantial evidence. Waters v. S.C. Land Res. Conservation Comm'n, 321 S.C. 219, 226, 467 S.E.2d 913, 917 (1996). In applying the substantial evidence rule, "a reviewing court will not overturn a finding of fact by an administrative agency 'unless there is no reasonable probability that the facts could be as related by a witness upon whose testimony the finding was based." Sea Pines Ass'n for Prot. of Wildlife, Inc. v. S.C. Dept. of Natural Res., 345 S.C. 594, 603-04, 550 S.E.2d 287, 292 (2001) (quoting Lark v. Bi-Lo, Inc., 276 S.C. 130, 136, 276 S.E.2d 304, 307 (1981)). However, the ALC may reverse or remand a decision which is affected by an error of law. Gilliam v. Woodside Mills, et al., 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993). An error of law occurs when the lower court is vested with discretion but the order reveals the lower court did not exercise that discretion. Fontaine v. Peitz, 291 S.C. 536, 354 S.E.2d 565 (1987).

DISCUSSION

The Department administers the South Carolina Medicaid Program. The Department's Division of Program Integrity is entrusted to "safeguard against unnecessary, harmful, wasteful, and uncoordinated utilization of services by Medicaid eligible recipients and health care providers." S.C. Code Reg. § 126-435. Appellant's medical practice, Laurens Pediatric Clinic, is a health care provider enrolled in the state's Medicaid program. The Division of Program Integrity performed an audit of Medicaid services rendered by Appellant between September 1, 2009 and August 31, 2011. After auditing twenty-nine (29) Medicaid recipients' records, the Department's auditor discovered a number of issues, including coding errors and insufficient documentation. After an informal conference with Appellant, the Department determined that Appellant had been overpaid $11,199.49 in Medicaid payments during the review period. On January 25, 2015, the Hearing Officer determined that the Department was entitled to recoup the overpayments from Appellant.

In her brief, Appellant repeats the same arguments she presented at the hearing concerning the proper billing codes to apply to services she rendered. She does not show a lack of substantial evidence supporting the Hearing Officer's January 25, 2015 decision or that there is an error of law in the Department's decision. Instead, she invites this Court to reweigh the evidence and overturn the Hearing Officer's findings of fact. It is evident from the record that the hearing officer painstakingly reviewed all of the contested Medicaid beneficiary files, analyzed the Department's findings on each contested charge, and considered the testimony and evidence presented by Appellant and Respondent. Hearing Officer Robert French's 73-page Final Decision exhaustively details the evidence, or lack thereof, relied upon to reach a finding on each and every one of over 300 contested charges. Appellant fails to demonstrate a lack of evidence to support any one of these findings, instead restating her own view and interpretation of the medical records. The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's findings from being supported by substantial evidence. Waters, 321 S.C. at 226. Based on a thorough review of the whole record, this Court finds that the Hearing Officer's findings are supported by the evidence in the record.

Appellant argued at the hearing and again alleges in her brief, that she was prejudiced by inconsistencies in documents produced by the Department in relation to the audit. As part of the audit, the Department utilizes a checklist, which is referred to as an HCPro form. This checklist

was a tool utilized by the auditor to determine whether or not a medical record meets criteria in the Medicaid guidelines to receive a certain billing code. Appellant argues that the checklists the Department presented at the informal hearing are substantially different than those at the October 31, 2012 hearing. She claimed that the names of Medicaid recipients as well as dates of service were missing from certain checklists. The Hearing Officer clearly stated in his decision that he did not use the Department's checklists in his review of the audit. They were simply a tool used by the auditors in doing their work. The Hearing Officer's decision ignored those worksheets and measured the evidence before him against the standards contained in the controlling publications: American Medical Association, Current Procedural Terminology, (4th ed.); U.S. National Center for Health Statistics, International Classification of Diseases, (9th ed.); and the Physicians' Provider Manual (2010) published by the Department. I find no error in the Hearing Officer's decision related to the HCPro forms.

Appellant next argues that she did not receive due process because the Hearing Officer was biased toward her. She points to two circumstances in support of this argument – the Hearing Officer's reference to a previous audit in which the Department recouped money from Appellant, and the timing of the issuance of the Department's Final Decision.

Appellant argues that the Hearing Officer mentioned her previous audit in his opinion with a "negative tone." At the hearing, Appellant testified that she had been audited by the Department when she was cross-examined by the Department's attorney. There is only one mention of this previous audit in the Hearing Officer's decision, it states, "The [Appellant] did testify that she had been audited in the past and SCDHHS had recouped money." Under the South Carolina Code of Regulations § 126-402C, the Department's prior imposition of sanctions against a particular party is one of the grounds that must be considered when determining whether or not the Department should issue a particular sanction. There is nothing in the hearing transcript or decision to support Appellant's assertion of bias. Rather, with respect to the language Appellant asserts demonstrates bias, the Hearing Officer was required by South Carolina law to consider the prior audit as part of his determination as to whether the Department's sanctions were appropriate.

Appellant also argues in her brief that the Hearing Officer's decision was timed to arrive days before Appellant was to receive a payment from the Department for services rendered under the Affordable Care Act (ACA payment) in early 2014. Due to an administrative delay, Appellant's ACA payment was scheduled to be paid on January 30, 2015. Appellant asserts that

the Hearing Officer "rushed to issue a decision" so that the Department could send her a bill for the recouped payments just before she received the APA payment. Appellant has not given any explanation as to how the coincidence of timing benefited the Department, nor presented any evidence tending to show that the Hearing Officer was even aware of the unrelated payment. Moreover, the decision issued by Hearing Officer French could hardly be characterized as "rushed." It is obvious from the most casual reading of the order that French spent untold hours meticulously reviewing the evidence. Moreover, the case was pending for two years between the hearing and decision. Appellant's argument concerning the timing of the decision demonstrates only that the timing of the ruling and resulting bill from the Department were inconvenient to her. I find no indication of bias against Appellant in the timing of the order and the ACA payment.

I will not substitute my judgment for that of the agency because there is adequate evidence to support the decision which is clearly not arbitrary, capricious or affected by any personal bias or prejudice. The Hearing Officer's decision dated January 25, 2015, is supported by substantial evidence and does not exhibit any errors of law or abuse of discretion.

IT IS HEREBY ORDERED that the decision finding the Department was entitled to recoup Medicaid payments from Appellant is **AFFIRMED.**

AND IT IS SO ORDERED.

Deborah Brooks Durden

Deborah Brooks Durden
Administrative Law Judge

September 2, 2015
Columbia, South Carolina

CERTIFICATE OF SERVICE

I, Robin E. Coleman, hereby certify that I have this date served this Order upon all parties to this cause by depositing a copy hereof, in the United States mail, postage paid, in the Interagency Mail Service, or by electronic mail to the address provided by the party(ies) and/or their attorney(s).

Robin E. Coleman
Judicial Aide to Deborah Brooks Durden

September 2, 2015
Columbia, South Carolina

FILED

September 2, 2015

SC ADMIN. LAW COURT

Laurens Pediatric Clinic c/o Nilsa I. Nazario, M.D., F.A.A.P.
P.O. Box 1367, Laurens, S.C. 29360
Tel. 864-984-4263// Fax 864-984-4158

July 19, 2015

Honorable Judge Deborah Brooks Durden
SC Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, S.C. 29201

Docket No. 15-ALJ-08-0109-AP

Laurens Pediatric Clinic vs SCDHHS

Petitioner's Rebuttal to Respondent's Brief

Presented to Judge Durden:

The Respondent's Brief was received by certified mail after 4pm on Friday July 10, 2015.

A- The following important points of the Petitioner's Brief were **not** refuted by the Respondent.

1) The serious violations of law incurred by the auditor Ms.Cheryl Casey, and counselor for Medicaid Mr.Bruce Carter during the hearing held on October 31, 2012 in reference to providing untruthful testimony under oath. When discussing a case I filed as a sick visit 99215, Ms. Casey claimed under oath that she gave me a 99212, to match an unnamed undated Hc Pro form which Mr Bruce Carter under oath claimed basis for the audit, but the evidence in the record (detailed claim reports of 2/1/12 and 5/15/12) shows Ms. Casey did not give me a 99212 but a 99393 (EPSDT), and the form was not suitable for 99393, thus impossible to have been basis for the audit. The copies later submitted to the court had no signature or date and did not reflect changes made by the auditor after the informal hearing. These false statements and fraudulent evidence were not refuted by the Respondent.

Refer to Petitioner's brief Part 2: pages 6 to page 9.

2) Also against the law and rules of collection, Medicaid and the Hearing Officer coordinated

FILED
JUL 20 2015
SC ADMIN. LAW COURT

a judgement on a Sunday January 25, 2015, followed by a bill from SCDHHS for the amount of $11,199.49 dated January 27, 2015. The Chief Officer Mr. Robert French, overstretched rules for rendering a judgement, (90 days except in some individual cases that may be longer). The ruling comes two years, two months and twenty five days after the hearing held on October 31, 2012.

To have received a bill from SCDHHS for the amount of the judgement is also in clear violation of the rules of appeals and collection and in violation of my civil rights to appeal. These facts were not refuted by the Respondent.

Refer to Petitioner's brief last paragraph page 3 through page 4 before Argument, page 10 and 11, Part 4, and Appendix 2.

3) I have shown in the Petitioner's brief, how the Chief Officer Mr. French showed partiality in favor of SCDHHS. Mr. French ommitted evidence that was culpatory against SCDHHS, such as encounters medical records and Hc Pro forms introduced as evidence And by so doing he protected SCDHHS counsel and auditor on their untruthful statements under oath at the appellate Court Hearing on October 31, 2015.

See Petioner's Brief Appendix 3 example Bryan A.F., and last paragraph of Appendix 4 case M.Cook.

Another example of bias of the Chief Officer in favor of Scsubmitted DHHS, and against me is the fact that despite abundance of evidence presented by the Petitioner and within the record submitted to this court (detailed claim reports of 02/01/2012 with my commentary and copy of all records and commentaries on each instance), from page 55 to 71 of the ruling (R0061-R0077) he repeats " While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.", which is untrue.

See R1634- R1691(commentaries for each encounter); DCR 05/15/2012 R1697-R1750;DCR 02/01/2012with commentary (R1757-1805);R1855-R3072

The partiality by the Chief Officer, and illegal record manipulation are not refuted by the Respondent.

B- The Respondent ignores the repetitious intent of the auditor to demote well

documented office visits of sick children, to render me underpaid. It is also prejudiced the allegations by counsel Mr. Gessner that I unbundled, had insufficient documentation, and render unnecessary medical services.

EPSDT codes 99391-99394 inclusive of a Hematocrit (blood test to check for anemia paying less than $3.00 dollars), and hearing test (tone test audiometry at 25 and 40 decibels depending on age, paying at times $10.00 dollars up to $15.53 dollars) were not used . Most such instances incorrectly enforced by the auditor Ms. Casey as EPSDT were sick visits, and I was not an EPSDT provider at the time.

Refer to February and May 2012 detailed claim reports (DCR). A few examples are noted:

R1760(DCR of 02/01/2012, patient Y.C.S. date of birth 07/21/09 for service date 05/07/2010: the patient was seen sick yet the auditor enforces an EPSDT which would have rendered me a credit of $17.10, of course erased on the DCR of 05/15/2012 to $0.00. The allegation by counsel that I unbundled in order to bill more is in error.

At the informal hearing on March 2012, the insufficient documentation instances were shown not true when the auditor reviewed the scanned records; and the copies of medical records submitted into evidence (R1855-R3072) clearly show that medical services rendered were necessary and not fabricated.

Conclusion:

For the above mentioned serious illegalities by the Chief Hearing Officer, as well asSCDHHS counsel and auditor, as well as the unfounded allegations on the Respondent's brief, I stand firmly by the Petioner's brief, and call for this court to revoke the judgement for $11,199.49 overpayment dated January 25, 2015.

Sincerely,

Nilsa I. Nazario M.D. FAAP

Nilsa I. Nazario, M.D., F.A.A.P.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Laurens Pediatric Clinic

Appellant/Petitioner,

vs.

SCDHHS,

Respondent.

Docket No. 15-ALJ-08-0109-AP

CERTIFICATE OF SERVICE

I hereby certify that I am the Petitioner (Appellant/Petitioner/Respondent) in the above-captioned matter and that on the 20 day of July, 2015, in Laurens (city), South Carolina, I served a copy of the forgoing Rebuttal (type of document) on the following person(s) by depositing the same in the United States Mail, postage paid, and addressed as follows:

SCDHHS c/o Office of General Counsel
Name Mr. Evan Gessner
1801 Main St 6th Floor
Address PO Box 8206
Columbia, SC 29202-8206
City/State/Zip

Name
Address
City/State/Zip

Name
Address
City/State/Zip

Name
Address
City/State/Zip

Nilsa I. Nazario MDFAAP
(Print Name)

Nilsa I. Nazario MDFAAP
(Signature)

915 W. Main St
PO Box 1367
(Street)

Laurens SC 29360
(City, State, Zip Code)

FILED
JUL 20 2015
SC ADMIN. LAW COURT

-19-

SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
P.O. Box 8206 > Columbia, SC 29202
www.scdhhs.gov

July 8, 2015

The Honorable Deborah Brooks Durden
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

Re: *Laurens Pediatric Clinic v. SCDHHS*
ALC Docket No.: 15-ALJ-08-0109-AP

Judge Durden:

It appears that Petitioner has not yet received a copy of Respondent's Brief in the above referenced appeal. I have checked with staff in our office and I have been assured that a copy of Respondent's Brief was delivered to our mail room for delivery to Petitioner. The address I used was the same address Petitioner used in the signature block for her Brief.

Nevertheless, I am resending a copy to Petitioner by way of Certified Mail. In the event Petitioner requests an extension of time to file a Reply Brief with this Court, Respondent consents to an extension that would give Petitioner the ten (10) days from the receipt of Respondent's Brief for the filing of a Reply Brief, as stated in Rule 37A, Rules of Procedure for the Administrative Law Court.

If you have any questions, comments, or concerns, please do not hesitate to contact me. Thank you for your time and consideration.

Sincerely,

Evan M. Gessner

Enclosures

cc: Nilsa I. Nazario, M.D., F.A.A.P.

IN THE STATE OF SOUTH CAROLINA

IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Appeals and Hearings
South Carolina Department of Health and Human Services

Robert French, Hearing Officer

Docket Number: 15-ALJ-08-0109-AP

Laurens Pediatric Clinic,

Appellant,

v.

South Carolina Department of Health and Human Services,

Respondent.

RESPONDENT'S BRIEF

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STATEMENT OF THE ISSUES ON APPEAL

1. Substantial evidence in the record supports the hearing officer's Order
2. There has been no showing of a reversible error of law.

STATEMENT OF THE CASE

The Respondent in this case is the South Carolina Department of Health and Human Services (SCDHHS). SCDHHS is the single state agency that administers the South Carolina Medicaid Program and its functions include the provision of criteria for the enrollment of providers and the drafting and publication of manuals and information to members and providers outlining the requirements for participation in Medicaid. The Respondent's Division of Program Integrity is entrusted to "safeguard against unnecessary, harmful, wasteful, and uncoordinated utilization of services by Medicaid eligible recipients and health care providers." S.C. Code Reg. § 126-425. The Petitioner, Laurens Pediatric Clinic, is a health care provider enrolled in the Medicaid program.

The Respondent performed an audit of Medicaid services rendered by the Petitioner during the review period of September 1, 2009 through August 31, 2011. (R. p. 0007.) The audit consisted of a comprehensive review of twenty-nine (29) Medicaid recipients' records and found numerous errors, including: coding errors, duplicate billing, unbundling (provider services billed as separate components, resulting in a higher payment by Medicaid), medically unnecessary services, and insufficient documentation. (Id.) Following an informal conference with Petitioner, Respondent determined that Petitioner had been overpaid $11,199.49 in Medicaid payments during the review period, and this amount must be repaid to the Respondent. (Id.)

Petitioner then appealed the recoupment to SCDHHS's Division of Appeals and Hearings. After a hearing that was held on October 31, 2012, the hearing officer, Robert French, affirmed

SCDHHS's recoupment by Order dated January 25, 2015. (R. pp. 0007-0080.) Petitioner then filed the instant appeal.

SCOPE OF REVIEW – THE "SUBSTANTIAL EVIDENCE RULE"

This case is before the ALC as an appeal of an agency action. As such, the ALC sits in an appellate capacity under the Administrative Procedures Act (APA), rather than as an independent finder of fact. In South Carolina, the provisions of the APA – specifically S.C. Code Ann. § 1-23-380(5) – require a reviewing court to apply the "substantial evidence" rule. See e.g., Waters v. S.C. Land Resources Conservation Comm'n, 321 S.C. 219, 467 S.E.2d 913 (1996) and Palmetto Alliance, Inc. v. S.C. Public Service Comm'n, 282 S.C. 430, 319 S.E.2d 695 (1984).

A decision is supported by "substantial evidence" when the record as a whole allows reasonable minds to reach the same conclusion reached by the agency. Bilton v. Best Western Royal Motor Lodge, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984). The well-settled case law in this state has also interpreted the rule to mean that a decision will not be set aside simply because reasonable minds may differ on the judgment. Lark v. Bi-Lo, 276 S.C. 130, 276 S.E.2d 304 (1981). The fact that the record, when considered as a whole, presents the possibility of drawing two inconsistent conclusions from the evidence does not prevent the agency's finding from being supported by substantial evidence. Waters, 321 S.C. 219, 467 S.E.2d 913 and Grant v. S.C. Coastal Council, 319 S.C. 348, 461 S.E.2d 388 (1995), both citing Palmetto Alliance, 282 S.C. 430, 319 S.E.2d 695. See also, Miller v. State Roofing Co., 312 S.C. 452, 441 S.E.2d 323 (1994) and Bilton, 282 S.C. 634, 321 S.E.2d 63 (Ct. App. 1984).

In applying the substantial evidence rule, the factual findings of the administrative agency are presumed to be correct. Rodney v. Michelin Tire Co., 320 S.C. 515, 466 S.E.2d 357 (1996), citing Kearse v. State Health and Human Services Finance Comm'n, 318 S.C. 198, 456 S.E.2d 892 (1995). Furthermore, the reviewing court is prohibited from substituting its judgment for that of

the agency as to the weight of the evidence on questions of fact. Grant, 319 S.C. 348, 461 S.E.2d 388, citing Gibson v. Florence Country Club, 282 S.C. 384, 318 S.E.2d 365 (1984). Finally, the party challenging an agency action has the burden of proving convincingly that the agency's decision is unsupported by substantial evidence. Waters, 321 S.C. 219, 467 S.E.2d 913, citing Hamm v. AT&T, 302 S.C. 210, 394 S.E.2d 842 (1994).

Of course, the ALC may always reverse or remand a decision, which is affected by an error of law. Gilliam v. Woodside Mills, et al., 312 S.C. 523, 435 S.E.2d 872 (Ct. App. 1993), reversed on other grounds, 319 S.C. 385, 461 S.E.2d 818 (1995). However, in reviewing the errors of law asserted by the Appellant, the ALC does need to give deference to the Department's interpretation of its own rules and the relevant federal rules and manual provisions applied. Hampton Nursing Center v. State Health and Human Services Finance Comm'n, 303 S.C. 143, 399 S.E.2d 434 (Ct. App. 1990) and Ruocco v. S.C. Board of Registration for Professional Engineers and Land Surveyors, 314 S.C. 111, 441 S.E.2d 829 (Ct. App. 1994).

ARGUMENT

I. SUBSTANTIAL EVIDENCE IN THE RECORD SUPPORTS THE HEARING OFFICER'S ORDER

The main issue of this appeal is whether substantial evidence in the Record supports the hearing officer's Order. Substantial evidence in the Record supports the hearing officer's decision to find for SCDHHS. The hearing officer made numerous factual findings, all of which must be presumed correct, and this Court cannot substitute its judgment on the weight of the evidence. See Rodney, 320 S.C. 515, 466 S.E.2d 357; Grant, 319 S.C. 348, 461 S.E.2d 388.

As is clearly evident in the record, the hearing officer painstakingly reviewed all twenty-nine (29) Medicaid beneficiary files and analyzed the Respondent's findings on each file and further considered the testimony given by Petitioner's and Respondent's witnesses. (R. pp. 0028-

0077.) The hearing officer determined that Petitioner failed to meet her burden of proof insofar as she failed to show CPT-driven evidence that she properly billed Respondent. (R. p. 0079.) The hearing officer further determined that Respondent's findings were supported by CPT-driven evidence. (Id.) It was found that Petitioner "provid[ed] very general statements and in some instances incorrect statements" regarding proper billing practices and failed to provide any evidence that Respondent improperly determined to recoup money. (Id.)

The hearing officer, in applying the relevant laws, regulations, and Medicaid policies and procedures to reach the conclusion that Respondent's recoupment was not arbitrary or capricious and was in fact supported by South Carolina Medicaid policy, and State and Federal regulations. (R. p. 0080.)

Petitioner, in her brief before this Court, has failed to show that the hearing officer's order is not supported by substantial evidence in the record. Petitioner's brief contains numerous complaints about the Respondent's audit and findings and the hearing officer's Order. While it is certainly understandable that Petitioner disagrees with the audit findings and the hearing officer's Order, the fact remains that there is substantial evidence in the record to support the hearing officer's Order. As a result, this Court must find in favor of Respondent and affirm the hearing officer's Order.

II. THERE HAS BEEN NO SHOWING OF A REVERSIBLE ERROR OF LAW.

Because Petitioner cannot show that the hearing officer's Order is not supported by substantial evidence in the record, she must then attempt to show that the hearing officer erred as a matter of law. Petitioner, in her brief before this Court, has failed to show a reversible error of law and, as a result, this Court must find for the Respondent and affirm the hearing officer's Order.

CONCLUSION

For the reasons set forth above, the hearing officer's determination should be upheld. Substantial evidence exists in the Record to uphold the hearing officer's ruling in favor of SCDHHS. Additionally, there exists no reversible error of law in the hearing officer's Order. Therefore, this Court must find in favor of the Respondent, SCDHHS, and uphold the hearing officer's Order.

Respectfully Submitted,

SOUTH CAROLINA DEPARTMENT
OF HEALTH AND HUMAN SERVICES

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Attorney for Respondent

June 17, 2015
Columbia, South Carolina

CERTIFICATE OF MAILING

The undersigned hereby certifies that on this, the 17th day of June, 2015, I sent a copy of Respondent's Brief to Appellant's counsel by U.S. mail with first class postage affixed, addressed to:

Nilsa I. Nazario, M.D., F.A.A.P.
Laurens Pediatric Clinic
915 West Main Street
PO Box 1367
Laurens, SC 29360

SOUTH CAROLINA DEPARTMENT
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Attorney for Respondent

June 17, 2015
Columbia, South Carolina

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June 29, 2015

From: Petitioner Laurens Pediatric Clinic

To: The Honorable Judge Deborah Brooks Durden

Ref: ALC Docket No. 15-ALJ-08-0109-AP

Request for Motion Of Stay Of Proceedings

Honorable Judge Durden:

Yesterday I opened a letter from Evan Gessner, counsel for DHHS, with a copy of Amended Certificate Of Mailing. It is supposed to accompany a copy of the Respondent's Brief, but it did not. As of today I have not received the copy of their response in order to exercise my rights, if I deem necessary, to rebuttal within ten days. I am enclosing a copy of the envelope postmarked June 19. I am sending a copy of this letter by certified mail to DHHS, as well. I leave to this court to determine whether the way by which DHHS handle sending me copy of their response (regular mail not traceable) and not yet received by me, is proper and in compliance to court rules. I respectfully petition a stay of proceedings in order that I can receive and review the Respondent's Brief.

Sincerely,

Nilsa I. Nazario MD FAAP

Nilsa I. Nazario, M.D., F.A.A.P.

P.O. Box 1367

Laurens, SC 29360

P.S. Since the appeal process began in 2012, and for over twenty years DHHS has as my mailing address P.O. Box 1367. The envelope where the letter from DHHS was received, has the physical address of the clinic ahead of the P.O. Box.

SOUTH CAROLINA
Healthy Connections
MEDICAID

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June 18, 2015

The Honorable Deborah Brooks Durden
South Carolina Administrative Law Court
Edgar A. Brown Building
1205 Pendleton St., Suite 224
Columbia, SC 29201

Re: *Laurens Pediatric Clinic v. SCDHHS*
ALC Docket No.: 15-ALJ-08-0109-AP

Judge Durden:

Enclosed, please find the original and a copy of an Amended Certificate of Mailing, which I am filing in conjunction with Respondent's Brief in the above referenced administrative appeal. After filing Respondent's Brief, I failed to mail a copy to Petitioner by the final mail collection for yesterday, June 17, 2015. Consequently, the Certificate of Mailing initially included by me is inaccurate. By copy of this letter to Petitioner, I am serving her with a copy of the same.

If you have any questions, comments, or concerns, please do not hesitate to contact me. Thank you for your time and consideration.

Sincerely,

Evan M. Gessner

Enclosures

cc: Nilsa I. Nazario, M.D., F.A.A.P.

AMENDED CERTIFICATE OF MAILING

The undersigned hereby certifies that on this, the 18th day of June, 2015, I sent a copy of Respondent's Brief to Appellant's counsel by U.S. mail with first class postage affixed, addressed to:

Nilsa I. Nazario, M.D., F.A.A.P.
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Attorney for Respondent

June 18, 2015
Columbia, South Carolina

May 13,2015

BRIEF

To: Administrative Law Court
Edgar A. Brown
1205 Pendleton St., Suite 224
Columbia, SC 29201

Ref: Appeal Matter of Laurens Pediatric Clinic Clinic vs SCDHHS
Appeals Case # 12-PA-024
ALC Docket No. 15-ALJ-08-0109-AP

Pursuant to ALC Rule 37, the following brief is presented respectfully to Judge Deborah Brooks Durden.

1- Statements Of The Issues On Appeal

a) How is it posible to accept a ruling for overpayment, when both the Medicaid auditor (Ms. Cheryl Casey), and the appellate judge Mr. French on case # 12-PA-024, could repetitiously demote office visits to a lower CPT code,rendering me underpaid? How is it posible to allow them to contradict themselves when encounters accepted without change,were of same format for history, ~~full measures,full set of vital~~ signs,interventions,diagnosis,disposition as many demoted despite adequate CPT codes billed? How is it posible to allow such unfair, and at times grossly negligent, judgements leaving me underpaid?

b) How is it posible that serious inconsistencies from SCDHHS HCPro Forms (from the Medicaid Integrity Institute)presented under oath as basis for the audit during the hearing, be ignored by the Chief Officer in his ruling? How the untruthful nature of that statement and the serious inconsistencies of these be allowed to count against me?

c) Was the presider Mr. French unfair to me when he counts against me a previous audit, many years back which for lack of time, I did not contest?

d) Was the ruling rushed and biased against me, so as to allow SCDHHS to bill me ahead of an ACA enhanced payment I was to receive on January 30th,2015?

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2- Statement Of the Case:

On November of 2011, SCDHHS did an audit on 40 records of my office. After 8 hours,a total of 29 records were scanned in their entirety. Office visits of 2009 through 2011 were reviewed, and although many, those audited were not the entire record.

A detailed claim report on office visits audited was issued on February 2012. An informal hearing was held in March 2012. The majority of the 2 hours was dedicated to proof that tests ordered but deemed by the auditor not documented, were shown present in the record and all were found except one hearing test, that was billed but record showed the patient was uncooperative. To the informal hearing I brought an internal review of each visit, in commentaries written on the detailed claim report. (See pages of the record R1757-R1805). Another detailed claim report was issued in May 2012 with few changes that lower the judgement of overpayment by about $1,000 dollars to $11,199.49.

I chose to appeal, and the case was seen on October 31,2012. Case #12-PA-024, with Chief Officer of Hearings and Appeals Mr.Robert French presiding. SCDHHS (by court decision) presented first and only brought seven office visits for evidence, (nothing else), claimimg lack of documentation, incorrect coding all based on an HcPro form attached to each visit (Respondent Exhibit 2 pp R0192-R0227). The visits had erased names but can be traced to the originals by date of birth and date of encounter. I strongly objected as I had never seen,nor been told about this HCPro form, from the Medicaid Integrity Institute at the National Advocacy Center. Refer to the record (ppR0094-line 11;
pp R0101 line 17).
On the other hand, I introduced as evidence copies of all the office visits in the detailed claim report and a detailed summary of each visit including commentary on content and assessment of coding and payment. After that extensive review I agreed to an overpayment of $1,601.19. I stated I was ready to discuss case by case,but was not allowed by the court to do so because of time restraints.

Cases accepted by the auditor, of same content as those demoted, were brought to the court attention. Record R3073-R3182. Mr. French tried to alert Mr.Carter of

SCDHHS, of the abundant documentation. I advised Mr.French, presider, that SCDHHS was well aware of it as they scanned the entirety of the medical record but I only brought the encounters on the detailed claim report. That alone filled a letter size storage cardboard box which I introduced as evidence. Refer to record ppR1855-R3072(includes all encounters audited, accepted and demoted to lower CPT).

I commented on unfair demoting of coding thus lower payment, in cases that were very sick, yet were successfully stabilized preventing hospitalization. At the end Mr. French asked Mr Carter of SCDHHS about the HCPro forms:"so you based the audit on this form?, Mr Carter replied "yes" and Mr. French asked Mr Carter: "so how soon can you forward me a copy? Mr. Carter hesitated and said I will need about two weeks. About one month later I received these copies for an opinion. They were not signed or dated, nor reflective of the audit's first detailed claim report in February 2012. I sent my comments to Mr. French, and Mr. Carter replied. Mr. French advised I need not to reply further. See Appendix 4.

In February 2014, Mr. French requested to SCDHHS by e-mail the medical records in their entirety. SCDHHS forwarded 29 records by e-mail to Mr. French. Mr. French wanted me to accept them as evidence after I review them (about 1,400 pages). I objected as Mr. French required and instructed before the appellate court hearing that anything intended as evidence must be brought in letter size paper with copy to the judge and the other party. And that I did, SCDHHS chose not to bring but few office visits out of 29 records, as evidence. Mr. French sustained the objection. Note that Mr Carter first replied to Mr. French by e-mail: "Does your request as outlined in the e-mail of February 17,2014, constitute a re-opening of this case?"; (copy of these e-mails are on appendix 1). No further communications occurred until the ruling of January 2015.

I had not received the ACA(Affordable Care Act)enhanced payment, (to match Medicaid providers to Medicare pay), for the first semester of 2014. SCDHHS claimed in September 2014 I will get the payment. But at that time they claimed they did not have all the claims to process, which I gave them copy of. In December 2014 SCDHHS kept saying they have computer problems, thus no payment received. On January 15,2015, Mr. Jon Tapley of Medicaid called my cell phone at 8:30am and advised me the computer was not fixed, likely I will get paid in March 2015. I told him, then you will be audited by IG (Inspector General). That afternoon at 4:30pm Ms. Deidra Singleton (Medicaid Director aid), and Mr. Jon Tapley called me to the office

in conference call, advising me that ACA payment of January through September 2014 of about $42,000 dollars will be sent to Molina HMO the following week, for them to pay me. An e-mail by Mr. Jon Tapley on January 16,2015, confirmed it, and stated "...we completed the paperwork for an adjustment to Molina in the amount of $41,932.54 for your ACA enhanced payment for the time period January 1,2014 to September 30, 2014." On January 21st another e-mail said "...the keying of the ACA adjustment for Molina on your behalf did not get processed in our payment system until yesterday. Therefore Molina will receive the funds from SCDHHS on the 30th of January and not the 23rd of January."

On January 25,2015 (a Sunday), the ruling is made on case 12-PA-024, and it is mailed certified mail on January 26,2015 to my PO Box 1367 in Laurens,SC. A bill for the judgement of $11,199.49 from SCDHHS was mailed by regular mail on January 27,2015. I received the bill on January 29th. I immediately left messages with April Wilson (who sent the bill from SCDHHS), Counsel Mr. Bruce Carter, and Chief Officer Mr. Robert French advising that they need to remove it from my record as that was an amount for suppose overpayment, under appeal and no judgement had been made. Then the ruling was received on January 30th,2015 via certified mail to my PO Box address.

I chose to appeal to ALC on February 23rd,2015. (see Appendix 2 for ACA enhanced pay related e-mails, copy of envelope of ruling postmarked 1/26/15 and copy of the bill sent by SCDHHS dated 1/27/2015). The ruling itself has already been sent to the court.

3- Argument (4 parts):

Part 1-

Concerning CPT codes, and encounters audited (submitted as evidence at the hearing):

CPT codes definitions clearly state that you need to meet 2 of 3 criteria: comprehensive history, physical exam, and decision making of low complexity(15 minutes encounter)99213; moderate complexity(25 minutes)99214; and high complexity (40 minutes)99215. Although complexity is the most determining factor for code decision; a lengthy visit could bump the CPT code chosen based on time and not complexity. These three codes comprise the majority of the office visits audited, and which I discussed on my extensive review.

On Appendix 3 see enclosed copies of CPT codes definitions, examples of office visits accepted by the

auditor, followed by examples of other office visits deemed overpaid for lack of documentation, thus demoted to a lesser CPT code by the auditor.

Note the history is the same for all patients and encounters. It has aspects of past history, allergies, school history, social issues such as lead risk factors, immunizations, alertness to upper airway obstruction/sleep apnea by asking for snoring, and takes about ten minutes to complete, followed by reason for the visit and a full set of vital signs, and measurements. Then follows a full exam, pertinent,interventions, diagnosis, and when pertinent prescriptions. These parts can take between 20 minutes to over an hour.

The review I did denotes content by the following legend: Q(questions);E(exam);I(interventions);Rx(prescriptions) Dx(diagnosis) and a (+)for present on the office note; (-)for not present and(+/-)present but incomplete. In addition to my review the office note is also available as evidence on the record . (pages R1633-1691 of the record). The physical exams have full vital signs and measures, which take time to do, and the receipt and prescription copies are considered part of the progress note and they include, history, vital signs, measurements, full exam, diagnosis,interventions,prescriptions and dispositions.

Discertations on medical literature for medical decisions are not needed as I am a post doctoral degree pediatrician graduated in 1986, Board Certified and Fellow of the American Academy of Pediatrics. I have the knowledge to make a medical diagnosis and disposition. This audit is not about fraud, but about review of the medical record to decide if the CPT code billed for each encounter fit the documentation, and to determine if overpayment occured. Please note that pediatricians have a bigger challenge as children and babies cannot express well their problems. To achieve at times an apparently simple diagnosis (i.e.Sinusitis) require a careful exam and expertise.

Auditor's and Chief Officer Mr. French misjudged ill children encounters billed properly 99214 or 99215 unfairly, demoting them to a 99213 or 99212, despite adequate documentation. Please note that by demoting these high complexity cases, clearly on record very ill, with multiple interventions, multiple prescriptions,and lengthy visit, they are saying that such encounter is worth only the pay given to a very low complexity 99212(focused history and exam, about 10 minutes) or the pay for a low

complexity 99213(meeting 2 of 3 components: history,exam,decision making, about 15 minutes) thus rendering the encounter underpaid. A 99212 paid $29.82; 99213 paid $48.53, 99214 paid $75.37 and a 99215 paid $98.86. See examples of Y.C.G. DOB 02/04/06, and T.N.J. DOB:10/15/09 on Appendix 3.

Mr. French supported the argument brought by the auditor that I never billed as EPSDT. But at the time I was not an EPSDT provider,even though I did meet requirements for EPSDT, and many patients were ill also. I billed these cases the only posible legal way; as established office visit. And there was not much difference in pay. Thus I was not trying to overcharge. In the case B.A.F. DOB10/08/09; date of service 08/05/2011, Medicaid ID 0781077476, the auditor gave a $4.04 credit on the detailed claim report of 02/2012 but took it away to a $0 difference on the detailed claim report of May 2012. On the ruling (pp22-23) this date of service, is not mentioned (refer also to the record, pp R0028,R0029). When Mr. Carter forwarded HCPro forms to the court, I commented that the form for this encounter of 08/05/2011 is missing. See Appendix 3. This is a judgement of overpayment for $11,199.49. Arguments about EPSDT billing brought by SCDHHS Medicaid and Chief Officer Of Hearings and Appeals,Mr. French, are unfounded, and in error.

The auditor was also upset about so many breathing treatments, implying I was trying to overcharge. The rescue breathing treatments given with medicine paid by me and not billable, reimbursed $10.11 regardless of units, yet this intervention saved thousands of dollars to Medicaid as the children were stabilized of respiratory conditions thus preventing hospitalizations. (Breathing treatments are coded 94640). The same examples mentioned above on Appendix 3 (Y.C.G. And T.N.J.) had breathing rescue treatments and Mr. French by agreeing with the auditor, renders a grossly inadequate judgement.

Part 2-

The HcPro form was attached to the few cases brought by SCDHHS as evidence, and under oath Mr. Carter on their behalf stated they were the basis for the audit. The forms requested by the Chief Officer Mr. French had no signature, no date of completion, and in instances where an adjustment was made by the auditor from the first detailed claim report in February 2012 to the second in May 2012, such change is not showing on the form. No mentioned of such flawed evidence is noted by the presider

in the ruling. The best example of SCDHHS not being truthful about the HCPro form being the basis of the audit is the case presented in the hearing P.A.F.,DOB 11/06/03 Date of service 08/06/2010. SCDHHS on the hearing had erased the name of the patient from the office visit and attached an unnamed (not a name cover or erased), with no date of service either HCProform. This encounter was billed as a 99215, for the multiple interventions and complexity of the illness. The unname HCProform attached to it concluded it was a 99212; and when asked to submit copies of these forms to the court there was a name on it, and date of service (the copy). In my comments sent on December 26, 2012 to Mr. French, I used the case presented in court for commentary on the problems with accuracy of the form. I later found
among the HCPro forms sent late November 2012. That HcPro now had a name and date of encounter. But neither of the forms submitted : in court hearing(unnamed)claimimg 99212, and the later copy (named) which also claims 99212, match the detailed claim reports of February and May 2012 which preceded the October 31, 2012 hearing, which claimed a 99393 by the auditor and the HCPro form does not have EPSDT codes. That proves that the statement by counsel under oath that they used the form as basis for the audit is false!

This encounter is also a good example of how a complex visit billed correctly 99215(moderate or high complexity, about 45 minutes) with full history,full measurements, vital signs, full physical exam, breathing treatment for rescue, training in a nebulizer given to the patient to continue treatments at home and prevent hospitalization, guidance on avoidance of allergens, weight management, vision check, hearing tone test, urine, blood work, and prescriptions), was demoted to 99212 (only 10 minutes focused exam), on testimony the auditor Ms.Cheryl Casey said the cae was a 99212. She insisted the case should have been an EPSDT, and that I did not meet this criteria. Evidence discussed in the court proved I met criteria but I billed it as a sick visit, which prevailed over the EPSDT, but most important I was not then an EPSDT provider. Although a diagnostic code is available for uncomplicated check up (reason for the visit), the illness detected and treated on the child had more weight for filing than the check up. See record page R0133 lines 22-29. Thus, even if I was an EPSDT provider, having seen the patient ill, I can choose how to file the visit (EPSDT vs. sick visit of an established patient). As advised there is a big discrepancy on the HCProform submitted in court to

the detailed claim reports of Feb and May 2012. In the latter, the auditor forces an EPSDT code 99393 wanting reimbursement for the visit coded 99215, thus paying only $74.34 for the encounter, making it grossly underpaid for services rendered. The respiratory illness was stabilized and counseling given, at least 45 minutes encounter, of moderate to high complexity 99215, as I billed it. Even worse when the auditor forced a 99212 per HCPro form brought to the court hearing. A 99212 pays only $29.82, completely underpaying a well worked,over 45 minutes encounter. Such low reimbursement will not keep me afloat. I pay for some of the medicines used to stabilize patients. In this case I paid for the Pulmicort at a rate of $176.55 a box of 30 ampules. This patient needed 2 ampules for an office expense of $11.77, just on that medicine, not counting office overhead (see page R1810 of the record). The rescue breathing treatment for the patient's Bronchitis was 20 minutes, added to all the other things done, time spent was about 55 minutes, and as mentioned above, makes this encounter a 99215, certainly neither a 99212(focused exam, 10 minutes, low complexity) nor a 99393 (EPSDT). Detailed claim reports of February and May 2012 do not match the HCPro forms (both unnamed at the hearing and named on the HCPro forms sent later in November 2012)as they say 99393 on comment column from the auditor on the detailed claims reports of February and May 2012, but 99212 on HCPro forms. See record page R1774 and page R1090. Please note in Appendix 4 the copy of this encounter given to me at the hearing by SCDHHS is of a patient DOB 11/06/03, DOS 08/06/10. It has an attached HCPro form, unnamed, and undated, and concludes the visit is a 99212. Looking for this document in the record, I noticed the receipt of another case seen 04/20/10 DOB 10/15/09 that belongs to the previous case is interrupting the unnamed, undated HCPro form of the case discussed above seen 08/06/10, of DOB 11/06/03.(pp R0196-R0202). But on appendix 4 copies as received in the court hearing are available for review. All encounters presented by SCDHHS in the court hearing as evidence by SCDHHS were a total of 7 cases. All these cases had attached unnamed, undated HCPro forms (contrary to the office notes that had a white line over the name). All of these forms unfairly demote the CPT code of the visit, thus lowering the pay, in contradiction to the level of illness and documentation submitted(pp. R0192-R0227). When the court requested in the hearing copy of all the HCPro forms from SCDHHS, they all came with name and date of service, including the cases used as example with erased names. See record pages R0267-R1073. On the example above seen 08/06/10, see pages

R0498,R0499. The original HCPro form is one page front and back, and the name is put on the front not the back. On the example presented above, seen on 08/06/10 DOB 11/06/03; Mr. French in his ruling, and myself(on my extensive record review (pages R1633-R1691), based the commentaries on a judgement of 99393(EPSDT code)stated by the auditor on comment column of detailed claim reports. That judgement is present on both February and May 2012 detailed claim reports. Note SCDHHS provided the court only with the detailed claim report of May 2012 upon request by Mr French, and it was received at his office Feb 06,2013. The detailed claim report of 02/01/2012 with my comments which was submitted at the informal hearing in March was also introduced as evidence at the court hearing in October (but by me) and can be found in the record pp. R1757-R1805. The original auditor judgements of February are not reflected on the HCPro forms submitted. On Appendix 4 see example of M.C.case: DOB 02/02/09, DOS 02/05/10; billed by me 99215 for Bronchospasm, Tonsillitis, Enlarged Tonsils, Otitis Media. It was changed by the auditor after the informal hearing of March 2012. Originally in the detail claim report of February 2012, she had demoted it to 99213(low complexity, 15 minutes) . After the informal hearing of March 2012, she changed it to 99214(25 minutes,moderate complexity), (see ppR1958,R1957). The HcPro form submitted by SCDHHS concludes 99214 and doesn't show the changes to bring it up from a 99213 to a 99214. The office notes shows a child with significant decreased air entry, otitis media, severe tonsillitis with enlarged tonsils, multiple interventions (breathing treatment, Rocephin shot, ENT referral, multiple prescription medicines detailed for the mother on an instruction sheet). The length of this encounter can be estimated by times stated on the interventions, plus the time to complete history, full measures, vital signs, physical exam, monitoring after interventions, prescriptions, instructions. The time was well over 45 minutes of moderate to high complexity 99215 as billed, certainly not 99213 (15 minutes, low complexity) as judge in February 2012 detailed claim report, nor 99214(25 minutes, moderate complexity) as changed on the detailed claim report of May 2012.

SCDHHS was intentionally in error to say under oath that the HCPro form (of the Medicaid Integrity Institute),was used as basis for the audit, which began in November 2011.

See Appendix 4 ; also refer to the record pp R3183-R3224; and Respondent Exhibit7 on the record pp R0266-R1073. Note that the M.C. Case above mentioned could not be found among

the HCPro forms put in the record (Respondent Exhibit 7), but since these forms were sent to me by Mr. French for review and commentary, I kept copies. It is my copy that I enclosed with the example.

Part 3-

A previous audit, which I mentioned as correction to counsel for Medicaid who said "that is because you have never been audited", is mentioned with a negative tone against me by Mr. French on page 73 of the ruling. That audit was more than ten years ago and the judgement was for $1,500 dollars, which I mentioned during the appellate hearing. The connotation is that I am constantly overbilling and that is unfair to me. As I stated after my extensive review and because of errors within human nature I agree to an overpayment of $1,601.19, not what the ruling states: $11,199.49. It is also made clear on page 73 of the ruling that the respondent did not see this case as a case of fraud. I have practiced medicine in South Carolina since 1988 with a clear record, and following the law. I am exerting my right to appeal as I feel strongly my records sustain documentation for codes billed.

Part 4-

I believed the ruling was rushed in order to have Medicaid bill me before the ACA payment, because over two years after the hearing, a ruling is made on a Sunday, and Medicaid forwards a bill for the exact amount of the judgement two days later, while the ACA payment was to come 3 days later. Copy of the bill dated 01/27/15 is on Appendix 2, the court has the ruling dated 01/25/2015-a Sunday. Also on Appendix 2 is the copy of the postmarked envelope in which the ruling was mailed-01/26/15. Even Medicaid had considered the case closed as of last year (see e-mail from Mr. Carter to Mr. French on Appendix 1). Two things are unfair; first: the rules say a judge has 90 days to render a ruling except when a case merits longer time. What is longer time?; and second:forwarding the bill was intimidating and totally out of order, as I have the right to appeal further. That the ruling mailed on 1/26/15, followed with a bill mailed 1/27/15 is why I

believe the ruling was rushed for purpose of Medicaid collecting from the ACA payment I was to receive a few days later.

4-Conclusion:

The encounters audited have adequate documentation to sustain the CPT code billed. They had questions of pertinent history, full set of vital signs, measures and full exam, as well as medical decision with diagnosis,pertinent interventions and prescriptions, and recommended follow up. CPT codes were met in most instances. I had agreed at the informal hearing that after an extensive review I calculated no more than $1,601.19 overpayment. In this judgement SCDHHS claims overpayment by $11,199.49. That conclusion is based on an auditor that erroneously for the most part demotes almost every encounter to a lower CPT code from that billed. Both the auditor, Ms Cheryl Casey and the Chief Officer Mr. French in his ruling, rendered grossly inadequate judgements when very ill visits are deemed low complexity. By doing so they are forcing me to be underpaid for services rendered legally.

SCDHHS introduced HCPro forms in the hearing as the basis for audit. Examples discussed above, clearly show that the statement is intentionally in error. I have presented examples that show the forms do not reflect the audit process that began in November 2011 changes made to the detail claim reports from February to May 2012.

The ruling was rendered on a Sunday January 25, 2015, 5 days ahead of a payment rightfully earned by me for ACA enhanced pay of January through September 2014. A bill was sent to me from SCDHHS Medicaid 2 days later for the exact amount of the judgement $11,199.49. This ruling is contrary to the evidence presented, ill intended, and with the specific purpose of depriving me of money legally earned by me. Concerning the time they presented this ruling: two years,two months , and twenty five days after the Court Hearing of October 31, 2012, and time of the bill to collect; the former violates or overstretches statutes of limitations for rendering a judgement, and the latter violates my right to appeal further. These actions by SCDHHS denote ill intend and bias against me.

I respectfully asked the judge of Administrative Law Court, based on the evidence, and the above facts, to overrule the

SCDHHS Medicaid ruling of Sunday, January 25, 2015 for overpayment of $11,199.49 against me; and, stop collection attempts from SCDHHS Medicaid for this amount.

Respectfully submitted to ALC Honorable Judge Durden,

Nilsa I. Nazario MD FAAP

Nilsa I. Nazario, M.D., F.A.A.P.
Laurens Pediatric Clinic
915 West Main St.//P.O.Box 1367
Laurens, SC 29360
(864)984-4263, fax(864)984-4158
cell:(864)483-0234

Laurens Pediatric Clinic v. SCDHHS

Docket Number 15-ALJ -08-0109-AP

APPENDIX 1

Exchange of e- mails February through March 2014 concerning request for records from Mr. French

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Re: Request for Documents and Objection

From: Nilsa I Nazario <ninazario@aol.com>
To: Robert French <FRENCHR@scdhhs.gov>
Date: Tue, Mar 4, 2014 5:53 pm

Thank you.

Sent from my iPhone

On Mar 3, 2014, at 9:13 AM, Robert French <FRENCHR@scdhhs.gov> wrote:

> Dear Mr. Carter and Dr. Nazario,
>
> Since both parties were able to present their cases through documentary and testimonial evidence at the hearing, I will make my decision based on that evidence and I will not reopen the record for additional testimony and documentary evidence. Please disregard the previous request for the records used by SCDHHS in their proposed recoupment.
>
> Sincerely,
>
> Robert French

Robert French
Chief Hearing Officer
FRENCHR@scdhhs.gov
803.898.2714
cell: 803.413.3275
1801 Main Street
Columbia, SC - 29201
www.scdhhs.gov

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From: Bruce Carter
Sent: Tuesday, February 25, 2014 3:20 PM
To: Robert French; Nilsa Nazario, M.D. (ninazario@aol.com)
Subject: Request for Documents and Objection

Mr. French:

In reviewing your e-mail request of February 17th and the subsequent correspondence, I realized that I have a question that I should have asked you after the first message. Does your request as outlined in the e-mail of February 17, 2014, constitute a re-opening of this case? Our submission of the records and any questions, concerns or comments on these records by Dr. Nazario would appear to be additional testimony and the parties then would have the right to provide supporting testimony and cross-examine each other's witnesses related to these records. An additional hearing would need to be scheduled for that purpose. As an aside, the records you requested from SCDHHS were provided in electronic format as that is the format in which we obtained the records. As Dr. Nazario pointed out, Program Integrity staff spent 8 hours scanning these records at Dr. Nazario's office. They were never introduced at the hearing and, therefore, were not printed on 8.5 x 11 inch paper as required by the Office of Appeals and Hearings for submission as an exhibit at the hearing. The electronic version remains the most reliable record we have since printing and copy the records could result in blank sheets, missing pages or misfed sheets. We will comply with your request for the print version unless we hear from you otherwise. Thank you for your attention to this matter. I look forward to hearing from you regarding my question regarding the posture of the case? Please do not hesitate to contact me with any questions or if there is additional information that you need.

Bruce D. Carter
Assistant General Counsel
CARTERBD@scdhhs.gov
803.898.2793 / 803.898.2795
cell: 803.360.3543
1801 Main Street
Columbia, SC - 29202

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Appeals case # 12-PA-024

From: Robert French <FRENCHR@scdhhs.gov>
To: Bruce Carter <CARTERBD@scdhhs.gov>
Cc: Nilsa Nazario (ninazario@aol.com) <ninazario@aol.com>; Kathleen Snider <SNIDERK@scdhhs.gov>; Cheryl Casey <CASEY@scdhhs.gov>
Date: Mon, Feb 17, 2014 11:31 am

Dear Mr. Carter,

This email concerns the hearing held on October 31, 2012 in the matter of Laurens Pediatric Clinic v. SCDHHS. The SCDHHS proposed recoupment was based on the examination of medical records of twenty-nine (29) Medicaid recipients. In reviewing the records, I see that I do not have a copy of the medical records that SCDHHS used to base their recoupment. In Petitioner's exhibit #13, Dr. Nazario has included medical records on the recipients; however, I need to make sure that I have a copy of all medical records used by SCDHHS (I do not need the HCPro worksheets or Detailed Claims Reports).

Please send me a copy of all of Dr. Nazario's medical records that were used in the recoupment determination.

Please be sure to copy Dr. Nazario with those medical records so that she may examine them for completeness.

If either party has any questions, please do not hesitate to contact me.

Sincerely,

Robert French
Chief Hearing Officer
FRENCHR@scdhhs.gov
803.898.2714
cell: 803.413.3275
1801 Main Street
Columbia, SC - 29201
www.scdhhs.gov

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Records you provided

From: Robert French <FRENCHR@scdhhs.gov>
To: Nilsa Nazario (ninazario@aol.com) <ninazario@aol.com>
Cc: Bruce Carter <CARTERBD@scdhhs.gov>
Date: Wed, Feb 19, 2014 12:05 pm

Dr. Nazario,

I have received approximately 1,400 pages of your medical records electronically from SCDHHS. I will be glad to copy them and send them to you if you like. You did provide me with a large box of your records (Petitioner's exhibit #13). If you included all of your records in that exhibit, it seems pointless to send you another copy; however, if you did not include all of the records used by SCDHHS to make their proposed recoupment determination, then I will need to send you this copy. What would you like for me to do?

Sincerely,

Robert French

Robert French
Chief Hearing Officer
FRENCHR@scdhhs.gov
803.898.2714
cell: 803.413.3275
1801 Main Street
Columbia, SC - 29201
www.scdhhs.gov

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RE: Records you provided/ objection

From: Robert French <FRENCHR@scdhhs.gov>
To: Bruce Carter <CARTERBD@scdhhs.gov>
Cc: Nilsa I Nazario <ninazario@aol.com>; Kathleen Snider <SNIDERK@scdhhs.gov>; Cheryl Casey <CASEY@scdhhs.gov>
Date: Thu, Feb 20, 2014 5:57 am

Mr. Carter,

Please see Dr. Nazario's email below. I am sustaining Dr. Nazario's objection to SCDHHS' submission of electronic records for the following reasons:

Dr. Nazario was required to bring a hard copy of the records she wished to have admitted; therefore, SCDHHS must present me with a hard copy of the records used in their proposed recoupment determination and they must send a copy of those records to Dr. Nazario.

SCDHHS based their recoupment decision on the totality of Dr. Nazario's medical records and in order for me to make an informed and fair determination, I must have a copy of the records that SCDHHS used, it is improper for me to make a copy of the records that SCDHHS wishes me to use.

Dr. Nazario states that she did not proffer a complete copy of her medical records that were used by SCDHHS in the proposed recoupment determination and it is clear based on my very preliminary look at the electronic records that those provided to me by SCDHHS are much more voluminous than those provided by Dr. Nazario.

Therefore, please provide me and Dr. Nazario with a complete hard copy record of those medical records that SCDHHS examined to determine that Dr. Nazario should repay $11,199.49 to SCDHHS.

Sincerely,

Robert French

Robert French
Chief Hearing Officer
FRENCHR@scdhhs.gov
803.898.2714
cell: 803.413.3275
1801 Main Street
Columbia, SC - 29201
www.scdhhs.gov

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From: Nilsa I Nazario [mailto:ninazario@aol.com]
Sent: Wednesday, February 19, 2014 6:33 PM
To: Robert French
Subject: Re: Records you provided/ objection

In reconsideration perhaps I should review
all records sent to which I have to
respectfully object.
I find that DHHS could have followed
court instructions for the appellate hearing.
The Court Officer and I should have
received a paper copy of records
DHHS wanted to introduce as evidence at the
the time of the hearing. It
could misrepresent the truth and
adversely affect my case now
if any
documentation submitted electronically
by DHHS is missing.
Be known to the court that all records of
encounters in the detailed claim report,
were properly copied from the originals, and
I could meet with all parties with the originals.

It is overwhelming in flu season to be
forced to further review these records for

comparison.

I strongly object to accept after the fact electronically sent records. I much rather show the court the original records.

Sent from my iPhone

On Feb 19, 2014, at 5:21 PM, Nilsa I Nazario <ninazario@aol.com> wrote:

> Dear Mr French: DHHS came to my office in November of 2011 with a list of 40 records to scan. It took 8 hours to scan 29 charts, which they used for the audit. You probably received the entire chart, but I submitted to the court only the office visits chosen in the detailed claim report for each patient. Following instructions of the court, I submitted paper copy 81/2 by 11 to you the Chief Officer and the other party, as the court would not accept computer discs of scanned documents as evidence. I have all original records they scanned. My copies presented are true copies of the originals and a small sampling of your choosing would be enough for me to review, if so the court allows. Thank you
>
> Sent from my iPhone
>
> On Feb 19, 2014, at 3:05 PM, Robert French <FRENCHR@scdhhs.gov> wrote:
>
> > Dr. Nazario,
> >
> > I have received approximately 1,400 pages of your medical records electronically from SCDHHS. I will be glad to copy them and send them to you if you like. You did provide me with a large box of your records (Petitioner's exhibit #13). If you included all of your records in that exhibit, it seems pointless to send you another copy; however, if you did not include all of the records used by SCDHHS to make their proposed recoupment determination, then I will need to send you this copy. What would you like for me to do?
> >
> > Sincerely,
> >
> > Robert French

Robert French
Chief Hearing Officer
FRENCHR@scdhhs.gov
803.898.2714
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Docket Number 15-ALJ-08-0109-AP

APPENDIX 2

-e-mails from Mr. Jon Tapley December 2014 through January 21, 2015 ref: ACA enhanced pay

-copy of envelope from Appeals and Hearings SCDHHS with the ruling, postmarked 01/26/2015

-copy of the bill from SCDHHS Medicaid for the amount of the amount of $11,199.49; matching the ruling's decision, dated 01/27/2015

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RE: ACA Payment

From: Jon Tapley <tapley@scdhhs.gov>
To: Nilsa I Nazario <ninazario@aol.com>
Cc: Stephen Boucher <BOUCHER@scdhhs.gov>; Nathaniel J. Patterson, DrPH <PATTNAT@scdhhs.gov>; Kathie Reed Wanket <Reed@scdhhs.gov>
Date: Wed, Jan 21, 2015 5:26 am

Dear Dr. Nazario,

I wanted to let you know that the keying of the ACA adjustment for Molina on your behalf did not get processed in our payment system until yesterday. Therefore Molina will receive the funds from SCDHHS on the 30th of January and not the 23rd of January. I apologize that the keying did not make it into the system last Friday as I originally anticipated. This should not materially impact when you receive your payment from Molina and I have discussed this with Molina and they are aware that they will not receive this payment from SCDHHS this Friday but next. Since this is a single file and they are aware it is on the way they are working on processing the file as quickly as possible when they receive it from us. Since this was a change to my original email I wanted to ensure you had the latest information regarding what is occurring with the transfer of funds from SCDHHS to Molina. Thank you.

Jon Tapley
Program Coordinator II
tapley@scdhhs.gov
803.898.3914
1801 Main Street
Columbia, South Carolina - 29202-8206
www.scdhhs.gov

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From: Jon Tapley
Sent: Friday, January 16, 2015 1:32 PM
To: 'Nilsa I Nazario'
Cc: Stephen Boucher; Nathaniel J. Patterson, DrPH; Nichole Melton mitchell ; Kathie Reed Wanket
Subject: ACA Payment

Dear Dr. Nazario,

First, as I have mentioned in the past we are sorry that there have been delays in the process for receiving the ACA enhanced PCP funds. As I promised though I am following up with you today to let you know that we completed the paperwork for an adjustment to Molina in the amount of $41,932.54 for your ACA enhanced payment for the time period of January 1, 2014 to September 30, 2014. Molina should receive these funds from SCDHHS on the 23rd of January. I will keep you in the loop if I find there was a delay in payment to Molina. Molina then has to process this file tying payment back to your FEIN number. The plans are allotted 30 days for this process which means you should receive your payment towards the end of the month of February.

Please keep in mind that SCDHHS considers this payment to be an interim payment until we can reconcile the encounter data we receive from the health plan. After we are able to receive and adjudicate encounters correctly from the health plan we will be reconciling this interim payment against the approved encounter records. This reconciliation could lead to us needing to adjust these amounts that are being paid to you at this time. If you have additional questions or concerns please let me know. Thank you.

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From: Jon Tapley <tapley@scdhhs.gov>

To: Nilsa I Nazario <ninazario@aol.com>

Cc: Stephen Boucher <BOUCHER@scdhhs.gov>; Nathaniel Patterson <PATTNAT@scdhhs.gov>; Nicholas Thacker <THACKER@scdhhs.gov>; Jason Taylor <Jason.Taylor@scdhhs.gov>

Subject: ACA Payments

Date: Fri, 12 Dec 2014 4:53 am

Dear Dr. Nazario,

I received your issue from the provider service center yesterday and wanted to respond formally. As you know we have been in contact over the past several months regarding the issues SCDHHS had gathering data from Molina, WellCare and Advicare and getting it processed correctly in the SCDHHS information system. When these three plans originally entered the state the agency made a decision to use a national standard process to receive data from these three plans. The agency has had challenges in both getting that data initially and then correctly mapping that data so that our reporting mirrors what the Managed Care Organizations (MCO's) have sent us. In late September and early October SCDHHS became aware of errors in the process the agency was using to gather the MCO's data. Since that time the agency has been working to correct the problem and replace the incorrect data. Recently through testing the agency has verified with these MCO's that the process is now working as it should. Below are the steps the agency now has to take to make sure we have complete and accurate data.

Reprocess all encounters from these MCO's to ensure SCDHHS data is accurate.

Send any data that SCDHHS cannot accurately process back to the MCO's to add additional information.

The MCOs will need to send the additional information back to SCDHHS along with the original data so that SCDHHS can incorporate that data into its system to have a full compliment of claims level data from each MCO

Voided and/or replacement claims will need to be received from the MCO's

We will be reprocessing encounters we have already received over the next month to month and a half for all the data back to the original entry date of each MCO. The MCO's will still need to make system adjustments that may take some time on their end in order for SCDHHS to get a full load of all encounter data. Once these steps have been completed we will be able to begin the ACA payment process again. I am sorry for the hardship and pain these delays have caused you and your practice but SCDHHS has to ensure going forward that we have paid providers correctly for this process. As I have mentioned to you in past conversations when the agency is able to make these payments the payments will be for claims back to 1/1/14 to ensure that you are paid for anything that we might have missed when initial payments were made. If you have additional questions or concerns please do not hesitate to contact me.

Healthy Connections MEDICAID

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From: tapley@scdhhs.gov **Sent:** 12/3/2014 9:04:46 AM

To: ninazario@aol.com
Cc:
Subject: RE: [secure]ACA Fee For Service Payments
Digital Signature is VALID

Hi Dr. Nazario,

So the good news is that we just received test files from our reprocessing of encounters. The test files were for dates of service between 1/1/14 and 6/30/14 and that showed you appearing much more often than the original files we processed. I am getting off the test files about $11,000 in payments for you now whereas before it was I think just a couple of hundred dollars. Right now the MCO's are reviewing these files to ensure that we have true matches and everything looks accurate from what they submitted. If we can confirm the data is true with the MCO's over the next week we will be loading the files up over the next month to month and a half for all the data back to 1/1/14 forward and at that point hopefully we will be able to begin the routine payment process again. So the bad news is that it might be a few months until the data is in our system and can be utilized but right now things are looking better than they were back in September and October as far as data accuracy. When we do make payment the payment will be for claims back to 1/1/14 to ensure that you are paid for anything that we missed the first time that payment though if I had to guess probably won't be made until sometime in March.

Jon Tapley
Program Coordinator II
tapley@scdhhs.gov
803.898.3914
1801 Main Street
Columbia, South Carolina - 29202-8206
www.scdhhs.gov

SOUTH CAROLINA Healthy Connections MEDICAID

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From: Nilsa I Nazario [mailto:ninazario@aol.com]
Sent: Wednesday, December 03, 2014 11:41 AM
To: Jon Tapley
Subject: Re: [secure]ACA Fee For Service Payments

PLACE STICKER AT TOP OF ENVELOPE TO THE RIGHT OF THE RETURN ADDRESS. FOLD AT DOTTED LINE

CERTIFIED MAIL



9171 9690 0935 0070 2079 86

SOUTH CAROLINA
Healthy Connections MEDICAID

Department of Health and Human Services
Post Office Box 8206
Columbia, South Carolina 29202-8206

APPEALS

CERTIFIED

Nilsa I Nazario
Laurens Pediatric Clinic
PO Box 1067
Laurens SC 29360

NAME
1st Notice
2nd
3rd

8/m
1/29

APPEALS AND RECAIMS

SOUTH CAROLINA
Healthy Connections
MEDICAID

Date: 1/27/2015

Department of Accounts Receivable

Invoice To: NILSA I NAZARIO MD FAAP
915 WEST MAIN STREET
LAURENS , SC 29360

Invoice Number: 2000279493

Account Balance:	$11199.49
Current Amount Due:	$11199.49
Date Due:	2/27/2015

Please remit payment in the form of a check, money order, cashier's check or certified check along with this invoice to our office by the due date listed above.

Please make checks and money orders payable to:
South Carolina Department of Health and Human Services or SCDHHS

Please reference your invoice number on your check or money order. Please detach the bottom portion of this letter and remit with payment. Should you have any questions concerning this information, please do not hesitate to contact April Wilson at (803) 8981087.

Invoice To: NILSA I NAZARIO MD FAAP

Invoice Number: 2000279493

Amount Enclosed:

Contact: April Wilson

The Department of Health and Human Services
P.O. Box 8297
Columbia, SC 29202-8297
Phone (803) 898-1087
Fax (803) 255-8231

Laurens Pediatric Clinic v. SCDHHS

Docket Number 15-ALJ-08-0109-AP

APPENDIX 3

-CPT codes definitions

-Examples 99213 accepted by the auditor, followed by examples of 99214 accepted, totality cases accepted 99213, 99214, 99204 are in the record pp R1462-R1632; format of history, exam with full measures and vital signs, interventions, prescriptions, disposition comparable to all other in the audit. A 99204 history format is different for being a first visit.

-Example of Bryan A. F. DOB 10/08/09; DOS 08/05/11: check up and sick also filed as 99214 for the moderate at least 25 minutes encounter. Auditor wants EPSDT 99392 which in the detailed claim report of February 2012 showed a credit of $4.04, later erased in the detailed claim report of May 2012. It shows how I do not intend to overcharge by filing a sick visit, as an EPSDT I would have gotten more pay. This encounter was omitted from the ruling (pages 22-23 pertaining this patient), on the record pages R0028, and R0029. Also no HCPro form available, for this encounter. Office note after detailed claim reports of 02/12 and 05/12.

-Example of Yandel C.G. DOB 02/04/06 for DOS 11/01/10 and 05/12/11

My review, office notes , ruling, , detailed claim reports 02/12, 05/12.

For DOS 11/01/10 comprehensive exam, urine, flu shot, multiple prescription medicines, decision making at least a 25 minutes

moderate complexity(99214), not a focused exam, 10 minutes low complexity demoted by SCDHHS. For DOS 05/12/11, sick visit with Croup and Pharyngitis. history, comprehensive exam, rescue breathing treatment, training on nebulizer, multiple medicines prescribed, clearly high complexity over 45 minutes, not a 15 minutes low complexity. Ruling is absurd when it claims only two diagnosis, ignoring Croup is a serious life threatening condition, which i succesfully rescued on time to prevent hospitalization.

- Example of T. N. Jackson DOB 10/15/09; DOS 12/01/09

My review, office notes, detailed claim reports 02/12 & 05/12, this case HCPro form commentaries, and the ruling are enclosed. This case was very ill with Bronchiolitis, high complexity over 45 minutes billed correctly 99215. The detailed claim report of 02/12 demotes it to a 99213 (15 minutes, low complexity), and the detail claim report of 05/12, upgrades it to a 99214 (25 minutes, moderate complexity). the transition from one decision to another is not showing in the HCPro form , claimed to have been used for this audit.

2012

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99201-99215 Outpatient and Other Visits

CMS 100-3,70.3 Physician's Offices Within an Institution–"Incident-to" Provision

CMS 100-4,12,30.6.7 Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits

INCLUDES Established patients: received prior professional services from the physician or another physician in the practice of the same specialty and subspecialty in the previous three years (99211-99215)

New patients: have not received professional services from the physician or any other physician in the same practice within the exact same specialty and subspecialty in the previous three years (99201-99205)

Office visits

Outpatient services prior to formal admission to a facility

EXCLUDES *Services provided in:*
Emergency department (99281-99285)
Hospital observation (99217-99220)
Hospital observation or inpatient with same day admission and discharge (99234-99236)

99201 **Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 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 and/or family.** V 80 MP

0.76 1.25 Global Days XXX

AMA: 2009, Mar, 3,4&7; 2009, Jan, 11-31; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, March, 9-11; 2007, April, 11-12; 2007, January, 13-27

99202 **Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded 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 of low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.** V 80 MP

1.44 2.13 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 7; 2009, Jul, 8-9; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, March, 9-11; 2007, January, 13-27; 2007, April, 11-12

99203 **Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. 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 of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.** V 80 MP

2.20 3.09 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, January, 13-27; 2007, April, 11-12; 2007, March, 9-11

99204 **Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. 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 of moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.** V 80 MP

3.73 4.72 Global Days XXX

AMA: 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jan, 11-31; 2009, Jul, 7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, January, 13-27; 2007, April, 11-12; 2007, March, 9-11

99205 **Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. 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 of moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.** 80 MP

4.78 5.86 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, March, 9-11; 2007, April, 11-12; 2007, January, 13-27

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.** V 80 MP

0.27 0.58 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 7; 2009, Jul, 8-9; 2008, Jan, 10-25; 2008, Mar, 3&7; 2007, Jul, 1-4; 2007, March, 9-11; 2007, January, 13-27; 2007, Dec, 9; 2007, April, 11-12

99212 **Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 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 and/or family.** V 80 MP

0.74 1.25 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2008, Mar, 3&7; 2007, Jul, 1-4; 2007, January, 13-27; 2007, April, 11-12; 2007, March, 9-11

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99213 **Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and 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 of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.** V ⊠ ⊠ PQRS

1.46 2.07 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2008, Mar, 3&7; 2007, Jul, 1-4; 2007, March, 9-11; 2007, April, 11-12; 2007, January, 13-27

99214 **Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. 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 of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.** V ⊠ ⊠ PQRS

2.24 3.06 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Mar, 3,4&7; 2009, Jul, 8-9; 2009, Jul, 7; 2008, Jan, 10-25; 2008, Mar, 3&7; 2008, Jun, 12&15; 2007, Jul, 1-4; 2007, April, 11-12; 2007, January, 13-27; 2007, March, 9-11

99215 **Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity. 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 of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.** ⊠ ⊠ ⊠ PQRS

3.15 4.11 Global Days XXX

AMA: 2009, Mar, 3,4&7; 2009, Jul, 7; 2009, Jul, 8-9; 2009, Jan, 11-31; 2008, Mar, 3&7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, January, 13-27; 2007, March, 9-11; 2007, April, 11-12

99217-99220 Facility Observation Visits: Initial and Discharge

CMS 100-1,5,70 Definition of Physician
CMS 100-2,15,30 Physician Services
CMS 100-3,70.1 Consultations with a Beneficiary's Family and Associates
CMS 100-4,12,30.6.8 Payment for Hospital Observation Services

INCLUDES Services provided on the same date in other settings (e.g, emergency department, physician's office) associated with the observation status admission

Services provided to new and established patients admitted to a hospital specifically for observation (not required to be a designated area of the hospital)

EXCLUDES *Services provided by physicians other than the admitting physician ([99224, 99225, 99226], 99241-99245)*

Services provided to patients who are admitted and discharged from observation status on the same date (99234-99236)

99217 **Observation care discharge day management (This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])** ⊠ ⊠ ⊠ PQRS

INCLUDES Discussing the observation admission with the patient
Final patient evaluation
Discharge instructions
Sign off on discharge medical records

Do not report with hospital discharge day management services (99238-99239)

Do not report with observation/inpatient admission/discharge on the same date (99234-99236)

2.06 2.06 Global Days XXX

AMA: 2009, Jul, 7; 2007, Jul, 1-4; 2007, March, 9-11

▲ **99218** **Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. 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 problem(s) requiring admission to "observation status" are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.** ⊠ ⊠ ⊠ PQRS

2.77 2.77 Global Days XXX

AMA: 2009, Jan, 11-31; 2009, Jul, 7; 2008, Jan, 10-25; 2007, Jul, 1-4; 2007, January, 13-27; 2007, March, 9-11

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Examples

99213 accepted

Excludes cases 27-29

(Partial sampling)

315 Clemson ST Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

09/30/04

Name Chabrell Rodriguez

Patient's Receipt

Service Given	Code	Paid
4		
___ Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
___ Immunization Type		
___ Antibiotic Type		
___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/inhaler		
___ Other		

Date 03/11/11 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2 weeks ___ Check ✓ Medicaid

Diagnoses Bilateral Bronchiolitis + Viral Pharyngitis Amount Paid ___

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic

913 West Main Street Laurens, S.C. 29360
Tel - Fax (864) 984-4158 Tel (864) 984-4363

Date of service: 03/11/11
Accompanying Adult: M
Last OV: ___/___/___
Patient's Name: Yahzeel Rodriguez DOB: 09/30/04
Tel. 681 0696
Address: 510 Clemson St Laurens SC 29360
ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: ϕ
Current Medications: ϕ
Chronic Illnesses:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: ϕ
Blood Transfusions: Year ϕ, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead
Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: K5; Grade Avg: ___ Problems? Yes No
Adolescent females only: LMP month ___ /Year ___
4 y/o or older: Bedwetting? NO ___ YES ___ (Day/ Night)
Snoring? No Yes (How long? ___)
Reason for this visit: Recheck, Better

Physical Exam-Pertinent VS and Findings:
HR 84/min, RR 16/min, Temp. 98.1 F (ax., oral, rectal), BP ___/___
Wt. 40 lb 7 Ht. 42 5/8 v, HC ___
Pertinent Findings:
Gen: A & Ox3
Positive for:
___Head and Neck
___Respiratory:
___Cardiovascular:
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System: WNL
___Skin:
___Psychiatric:
Interventions:

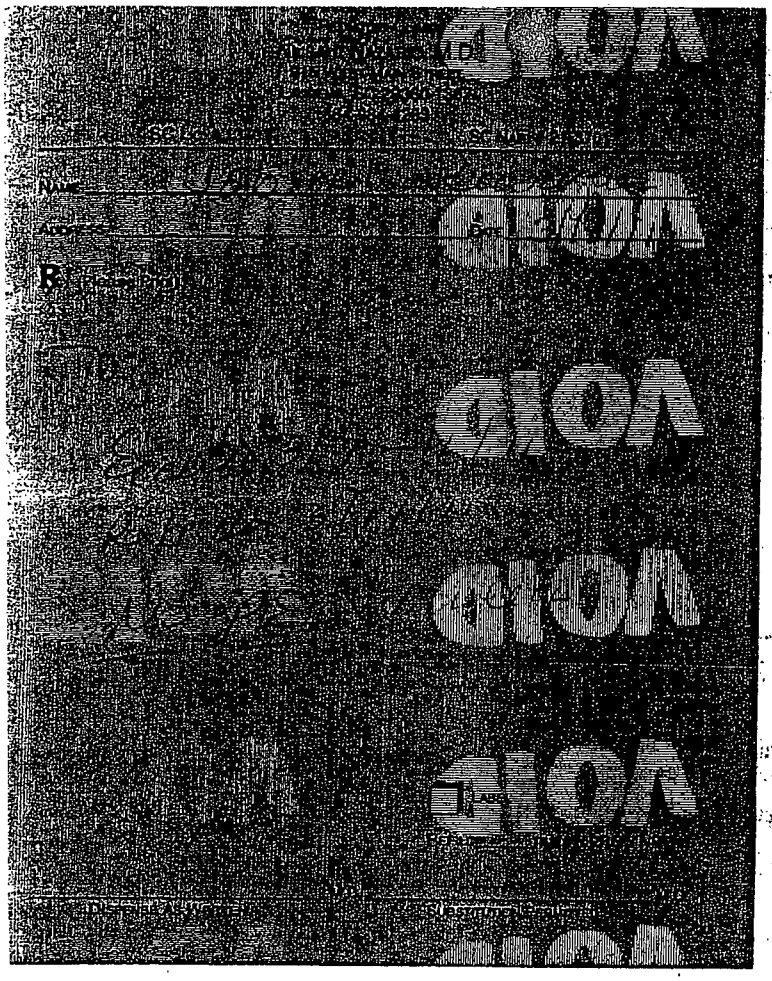
Diagnosis(es):

Plan: Allergy recheck

TIPPS: YES NO
Anticipatory Guidance YES NO

Same meds

TD @ 12°



621 Mckamie Rd. Lindy Six SC 29666

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

11/29/10

Name Ramiro Alexander

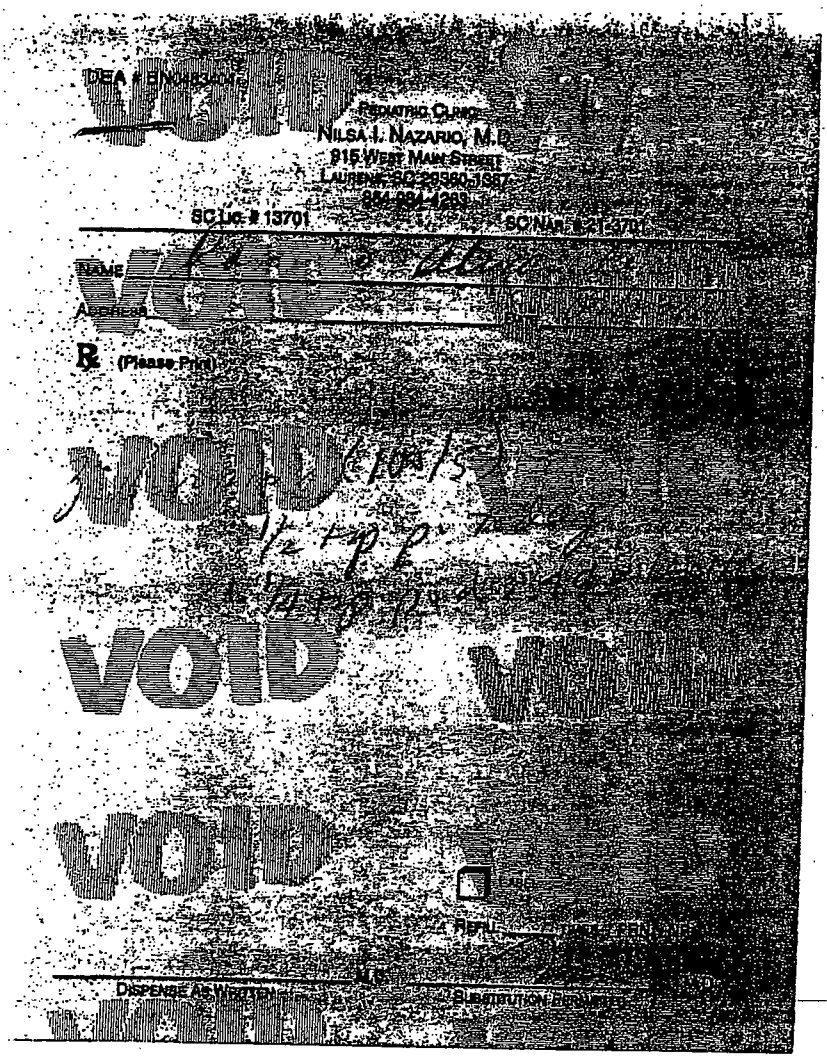
Patient's Receipt

Service Given	Code	Paid
✓ Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
___ Immunization Type ___		
___ Antibiotic Type ___		
___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 02/03/11 Method of Payment ___ Cash ___ VISA/MC

Follow-up Prn. ___ Check ✓ Medicaid

Diagnoses (R/O) Asthma. Amount Paid ___


VOID
VOID
VOID
Pediatric Clinic
Nilsa I. Nazario, M.D.
915 West Main Street
Laurens, SC 29360-1867
SC Lic. # 13701
Name
Address
Rx (Please Print)
Refill
Dispense As Written
Substitution Allowed

137 Lee St
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

2-12-10

Name David Tomas Pedro

Patient's Receipt

Service Given	Code	Paid
L Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
___ Immunization Type ___		
___ Antibiotic Type ___		
___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 3/22/10 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2 wks ___ Check ✓ Medicaid

Diagnoses Improved Bronchitis Amount Paid ___

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic

915 West Main Street Laurens, S.C. 29360
Tel · Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 3/22/10 Last OV: 3/15/10
Accompanying Adult: M
Patient's Name: David Tomas Pedro DOB: 2/12/10
Tel. 981-7419
Address: 137 Lee St Laurens SC 29360
ALLERGIES TO MEDS: **Current Medications:**
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: Ø
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: Ø
Blood Transfusions: Year Ø, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: **UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither**
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: —; Grade Avg: Problems? Yes No
Adolescent females only: LMP month — /Year
4 y/o or older: Bedwetting? NO —, YES (Day/ Night)
Snoring? No ✓, Yes (How long?)
Reason for this visit:

1mo

ver doing better

Physical Exam-Pertinent VS and Findings:
HR 128 /min, RR 40 /min, Temp. 97.5 F(ax), oral, rectal), BP T
Wt. 9# 7oz, Ht. 20¼, HC 14 7/8
Pertinent Findings:
Gen: NAD
Positive for:
Head and Neck: ok
Respiratory: sl wheezing few rales
Cardiovascular:
Gastrointestinal:
Genito-Urinary:
Musculoskeletal:
Nervous System: ok
Skin:
Psychiatric:
Interventions:

Diagnosis(es):
Plan: Isolcyn MS + Rx 3/10/10

TIPPS: YES NO
Anticipatory Guidance YES NO

Flu Vax

Samples of
99214 accepted

Excludes cases 27-29

(Partial sampling)

920 Lebanon Church Rd
Liberty SC 29646

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

09-26-97

Name Vanessa Miranda

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
Blood Drawing		
Hematrocrit		
Hearing Test		
Vision Screening		
Tympanometry		
Blood Sugar (Accu-Check)		
Resp Treatment x $10.00 each tx		
Urine Cath		
EKG, LLII		
Immunization Type		
Antibiotic Type		
X Urine		
Cognitive Assessment		
Train or nebulizer/Inhaler		
Other #66		

Refill to Dr. Cain - vaginal infection
ENT - hearing
Refill for further

Date 11/22/2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up January 2011 - 3rd wk ___ Check ___ Medicaid

Diagnoses Urinary/Sinus Amount Paid

Vaginitis

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic
915 West Main Street Laurens, S.C. 29360
Tel.; Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 11/22/10 Last OV: ___/___/___
Accompanying Adult: M
Patient's Name: Vanessa Macedo DOB: 09/26/97
Tel. 337-1690 / 229-2708
Address: 920 Lebanon Church Rd Windy Fix SC 29646
ALLERGIES TO MEDS: Current Medications:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: ∞
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: Appendix
Blood Transfusions: Year ∞, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: 8th; Grade Avg: ___ Problems? Yes No
Adolescent females only: LMP month ___ Year ___
4 y/o or older: Bedwetting? NO YES (Day/ Night)
Snoring? No ___, Yes ___ (How long? ___) loud snoring gets like SOB
Reason for this visit: Frequency Urinary, Pt ccd refer Gynecology
white vaginal discharge, itching

Physical Exam-Pertinent VS and Findings:
HR 68 /min, RR 16 /min, Temp. 96.7 F (ax., oral, rectal), BP 121/68
Wt. 136.2 Ht. 64 1/2" , HC ___
Pertinent Findings:
Gen: A & O x 3, overwt.
Positive for:
___Head and Neck: Tender ex m turbs, erythematous @ TM
___Respiratory:
___Cardiovascular:
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System: DTR
___Skin:
___Psychiatric:
Interventions: urine HCG Hearing Passed all tones @ 40 dB bilateral ears

Diagnosis(es): see copy Rx + receipt
Plan:

TIPPS: YES NO
Anticipatory Guidance YES NO

Refer to Dr. Forest
Refer to ENT
Twin. 2 wks rev + on Jan 2011 - 3rd HPV

PEDIATRIC CLINIC
NILSA I. NAZARIO, M.D.
915 WEST MAIN STREET
LAURENS, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC Nar. # 21-3701

NAME Vanessa Maceda

ADDRESS DATE 11/22/2010

℞ (Please Print) TO SCHOOL

Please Excuse today
11/22/2010

Return 11/23

Thank You!

LABEL

REFILL ____ TIMES PRN NR

DISPENSE AS WRITTEN M.D. M.D.

HCG-Neg

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LAURENS, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC Nar. # 21-3701

NAME Vanessa Maceda

ADDRESS DATE

℞ (Please Print)

LABEL

REFILL ____ TIMES PRN NR

DISPENSE AS WRITTEN M.D. SUBSTITUTION PERMITTED M.D.

MULTISTIX 10 SG

22/10 Vanesa Maceda 8:17am

LEUKOCYTES	NEGATIVE		TRACE	SMALL +	MODERATE ++	LARGE +++	
NITRITES	NEGATIVE			POSITIVE			
UROBILINOGEN	NORMAL			2	4	8	
PROTEIN	NEGATIVE	TRACE		30	100	300	2000 or More
pH	5.0	6.0	6.5	7.0	7.5	8.0	8.5
BLOOD	NEGATIVE	NON-HEMOLYZED TRACE	MODERATE	HEMOLYZED TRACE	SMALL +	MODERATE ++	LARGE +++
SPECIFIC GRAVITY	1.000	1.005	1.010	1.015	1.020	1.025	1.030
KETONES	NEGATIVE		TRACE 5	SMALL 15	MODERATE 40	80	LARGE 160
BILIRUBIN	NEGATIVE				SMALL +	MODERATE ++	LARGE +++
GLUCOSE	NEGATIVE		100	250	500	1000	2000 or More

207 Dow Market St
Gwol, SC 29646

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

01-09-10

Name Ashley Topaz

Patient's Receipt

Service Given	Code	Paid
✓ Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
X Immunization Type ~~flu shot~~ 0.25c - Refused ~~0 Synvis Hyalgan~~		
___ Antibiotic Type ___		
___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 12, 04, 2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up 1 month ___ Check ✓ Medicaid

Diagnoses R O M / Visual Phenomena Amount Paid ___

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic

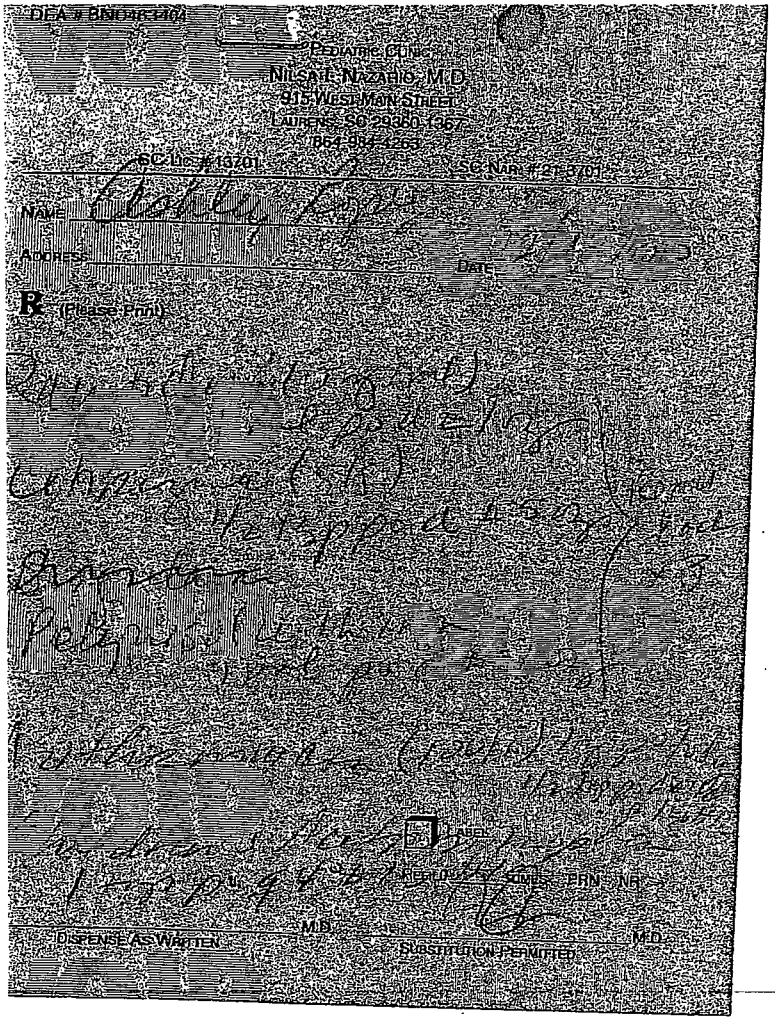
915 West Main Street Laurens, S.C. 29360
Tel · Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 12/4/10 Last OV: ___/___/___
Accompanying Adult: M
Patient's Name: Ashley Lopez DOB: 01/08/2010
Tel. 344-1337
Address: 207 New Market St Apt 51F Gwd, SC 29646
ALLERGIES TO MEDS: Current Medications:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: K
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: C
Blood Transfusions: Year C, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade:_____; Grade Avg:_____ Problems? Yes No
Adolescent females only: LMP month_____/Year_____
4 y/o or older: Bedwetting? NO_____, YES_____(Day/ Night)
Snoring? No_____, Yes ✓ (How long? Some time)
Reason for this visit: 2nd flu shot
ROS C

Physical Exam-Pertinent VS and Findings:
HR 112/min, RR 32/min, Temp. 97.9 F (ax., oral, rectal), BP ___/___
Wt. 19 7/32 Ht. 29 5/8 in, HC 17 3/4 in
Pertinent Findings:
Gen: A & O x 3
Positive for:
___Head and Neck Erythematous TM, lesions on R side throat
___Respiratory:
___Cardiovascular:
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System:
___Skin: clear
___Psychiatric:
Interventions: H/N1 AB 0.25cc flu shot prefilled syringe.

Diagnosis(es):
Plan: Give copy Rx + Receipt TIPPS: YES NO
Anticipatory Guidance YES NO

Flu vac/imd.


DEA # BN0463404

PEDIATRIC CLINIC
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915 W. (S.) MAIN STREET
LAURENS, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC NAR # 215701

NAME

ADDRESS DATE

℞ (Please Print)

DISPENSE AS WRITTEN M.D.

SUBSTITUTION PERMITTED M.D.

109 Williams St
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

04-24-06

Name Viviana Reyna

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x ___ $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLI		
___ Immunization Type ___		
___ Antibiotic Type ___		
X Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 10, 21 2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2 weeks. ___ Check ← Medicaid

Diagnoses Urticaria Amount Paid ___
Pharyngitis
allergy to chocolate.

For 2 days
For 4 days

Preheat milk
No peanuts, fish, wheat, chocolate, oranges, yogurt..

-76-

Nilsa F. Nagario, M.D., F.A.A.P.

Pediatric Clinic

915 West Main Street Laurens, S.C. 29360
Tel Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 02/1/10 Last OV: ___/___/___

Accompanying Adult: M

Patient's Name: Viviana Reyna DOB: 04/24/05

Tel. 345-0615

Address: 108 Williams St Laurens SC 29360

ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: ___

Current Medications: ___

Chronic Illnesses:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other ___

Operations: ___

Blood Transfusions: Year ___, Type: RBC'S, Plasma, Platelets, Whole Blood

Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither

Frequent travel to Asia, Latin America Yes No

Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay

School history: Grade: 5K ; Grade Avg: ___ Problems? Yes No

Adolescent females only: LMP month ___ /Year ___

4 y/o or older: Bedwetting? NO ___, YES ___ (Day/ Night)

Snoring? No ___, Yes ___ (How long? ___)

Reason for this visit: Yesterday ~~After~~ School Allergic (Rash) all Body Mother Bring Emergency room Ate chocolate cake at school yesterday

Physical Exam-Pertinent VS and Findings:

HR 104 /min, RR 20 /min, Temp. 97.2 F(ax., oral, rectal), BP 88/52

Wt. 42 3/4 Ht. 45 1/8", HC ___

Pertinent Findings:

Gen: A A NP

Positive for:

___Head and Neck: Erythematous

___Respiratory: ___

___Cardiovascular: ___

___Gastrointestinal: ___

___Genito-Urinary: ___

___Musculoskeletal: WNL

___Nervous System: ___

___Skin: Rash

___Psychiatric: ___

Interventions: 11:00am ~~Keflex~~ Xyzal + Singulair Susp. po

Urine

Diagnosis(es):

Plan: See symptom Receipt

TIPPS: YES NO
Anticipatory Guidance YES NO

Restart Daily use of Zyrtec, Singulair Ranitidine, Zantac

DEA # BN0463404

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LAURENS, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC NAR. # 21-3701

NAME

ADDRESS DATE

℞ (Please Print)

REFILL ____ TIMES PRN NR

DISPENSE AS WRITTEN M.D. SUBSTITUTION PERMITTED M.D.

DEA # BN0463404

PEDIATRIC CLINIC
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LAURENS, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC NAR. # 21-3701

NAME

ADDRESS DATE

℞ (Please Print)

LABEL

REFILL ____ TIMES PRN NR

DISPENSE AS WRITTEN M.D. SUBSTITUTION PERMITTED M.D.

6/21/10 Vivana Reyna 11:18am

MULTISTIX 10 SG

LEUKOCYTES	NEGATIVE	TRACE	SMALL *	MODERATE **	LARGE ***	
NITRITES	NEGATIVE	POSITIVE				
UROBILINOGEN	NORMAL	2	4	8		
PROTEIN	NEGATIVE	TRACE	30	100	300	2000 or More
	5.0	6.0	6.5	7.0	7.5	8.0	8.5
BLOOD	NEGATIVE	NON-HEMOLYZED TRACE	MODERATE	HEMOLYZED TRACE	SMALL *	MODERATE **	LARGE ***
SPECIFIC GRAVITY	1.000	1.005	1.010	1.015	1.020	1.025	1.030
KETONES	NEGATIVE	TRACE 5	SMALL 15	MODERATE 40	80	LARGE 160	
BILIRUBIN	NEGATIVE	SMALL *	MODERATE **	LARGE ***			
GLUCOSE	NEGATIVE	100	250	500	1000	2000 or More	

Case of Bryan Andres Felipe

DoB 10-08-09

Medicaid ID # 0781077476

DOS 08-05-11
- my case review
- not commented on ruling
- no HC Proform submitted, only screening age guidelines
- 08/05/11 present with credit on detail claim (→DCR) report 2/12
- 08/05/11 present with $0 (credit removed) on DCR of 5/12.
- office notes of this encounter
- Commentaries about this case HCPro form missing + form not suitable for coding of EPSDT as they claimed.

GCR NHHS

1- Antonio Andres Felipe-04/17/08DOB

DOS: 04/16/10 Dx: Acute Gastroenteritis, Pharyngitis, Rt OTM
Q+, E+, I: Hematocrit, 3 vaccines, diet instructions, Rx +
At least 25 minutes, moderate complexity, full exam
Thus meets criteria for 99214 NOT 99213
DISAGREE to disallow $ 25.34

DOS: 01/03/11 Dx: Sinusitis
Q+, E+, Interventions: Hematocrit, flu shot, Rx +
At least 25 minutes, moderate complexity, full exam
Thus meets criteria for 99214 NOT 99213
DISAGREE to disallow $25.34

DOS: 08/04/11 Dx: Bronchitis, Allergies
Q+, E+, I: vision, hearing, blood drawn, urine, instructions on diet and meds, Rx +
At least 25 minutes, moderate complexity, full exam
Thus meets criteria for 99214 NOT 99213
DISAGREE to disallow $23.87

2- Bryan Andres Felipe- 10/08/09DOB

DOS: 10/11/10 Dx: Eczema, OTM, Sinusitis
First office visit, 1 year old, Q++, E+,
I: Developmental Screening, allergen exposure prevention
Rx explained; Rx +
At least 45 minutes, first visit of moderate complexity
Thus meets criteria for 99204 NOT 99203
DISAGREE to disallow $41.15 for visit and Developmental Screen for $ 7.55

DOS: 01/03/11 Dx: Check up V20.2, Pharyngitis
Q+, E+, I: vaccines, Hematocrit, Rx +
At least 25 minutes full exam
Thus 99214 NOT 99212 (10 minutes focused exam)
DISAGREE to disallow $45.55

DOS: 01/15/11 Dx: Bronchitis, OTM, Pharyngitis
Q+, E+, I: detailed explanation of meds in Spanish
At least 25 minutes, moderate complexity, full exam
Thus meets criteria for 99214 NOT 99213
DISAGREE to disallow $25.34

DOS: 08/05/11 Dx: Sinusitis, Pharyngitis
Q+, E+, I: vaccines, Hematocrit, management of allergies, Avoidance of allergen list
At least 25 minutes, moderate complexity, full exam
A credit of $4.04 disappeared on revision even though the exam is both 99214 and EPSDT 99392, but not yet an EPSDT provider, thus correctly billed 99214

notes upon which the Respondent based its recoupment are found in Petitioner's exhibit #13. This Hearing Officer will structure his analysis based on the statements by the Petitioner in addition to relevant policy and regulations with regard to the Petitioner's individual recoupment arguments (Petitioner's exhibit #12, 29 Cases Reviewed) and the actual office notes (Petitioner's exhibit #13).

1) A.A.F., Medicaid Recipient # 8780864014

DOS: 04/16/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam but the Respondent has asserted via testimony that this was a Comprehensive exam. The Petitioner diagnosed three (3) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up and shots, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed one (1) condition in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 08/04/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

2) B.A.F., Medicaid Recipient # 0781077476

DOS: 10/11/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; therefore, this Hearing Officer cannot make an initial determination with regard to this CPT descriptor.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal or no data was reviewed or that the data was more than minimal or no complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was staightforward.

DOS: 01/15/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, I must assume that the Petitioner is referring to a CPT-driven "Detailed" exam. This visit was a follow-up visit after an emergency room visit. The Petitioner diagnosed three (3) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

3) Y.C.G., Medicaid Recipient # 7780561792

DOS: 08/12/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. There is no indication as to the reason for this visit; however, the Petitioner was given a flu shot and was diagnosed with tonsillitis; therefore, it appears that this was a sick child visit for the tonsillitis. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since it appears that this child was seen for tonsillitis, at most this exam is a problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

Bryan Andre[redacted] Felipe DOB 10/08/[redacted]
Date of Service: 08-05-11

Credit given in February erased in May
no HCPro form, only age appropriate guidelines
Not present initial evaluation form, versus (of Feb 2012)
corrected form of May 2012

Case of full exam on school entrance
with illness Billed as established pt visit 99214 correctly
Medicaid wants EPSDT 99392

Extensive Exam
Decision Making of Moderate complexity
Time spent on counseling of avoidance
of allergens.

Hematocrit done + read at the office
vaccines due given
Condition of sinusitis & excoriation
on leg given prescription medication

The HCPro form is missing. (On the hearing
an HCPro form was shown on a complex
Case of Bronchitis + Sinusitis with ample
Counseling on avoidance of allergens, weight
Control diet and training on nebulizer
machine) yet this case the form HCPro
IS missing for both dates February +
May detailed/claim reports. Also note
* the HCPro form does not accommodate
for any of the EPSDT codes 99381→84
and 99391→99394. In this case a credit in Feb
* of $4,04 was erased on revision in May 2012. No telling how
this Case + other [illegible] with Screening age guidelines

e copies on
defendant
this
use

-83-

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SCREENING AGE GUIDELINES

AGE	2 wk	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20 yr
HISTORY Initial or Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEAD CIRCUMFERENCE	X	X	X	X	X	X	X	X	X											
BLOOD PRESSURE										X	X	X	X	X	X	X	X	X	X	X
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IMMUNIZATION ASSESSMENT*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT				X		X			X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAMINATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DENTAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEARING SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HCT OR HGB **				X																
HEALTH EDUCATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
URINALYSIS ***											X									
LEAD Assessment ****					X			X												

* Immunization schedule may vary according to recommendations from the American Academy of Pediatrics (AAP) and the Advisory Committee.

** Test should be performed between 6 - 9 months and at least once for menstruating females.

*** A urinalysis should be performed on all children at five years of age and a dipstick urinalysis should be performed for leukocytes for sexually active male and female adolescents.

**** Assessment of individual/family history of lead exposure/symptoms, environment, and personal risk factors should be obtained and documented at 9 months to 12 months and again at 24 months.

South Carolina Department of Health and Human Services
Detailed Claims Report

Medicaid ID: 0781077476 ANDRES FELIPE, BRAYAN -Missing SSN: 664341387 DOB: 10/8/2009 County Elig: LAURENS
Household ID: 100895118 Gender: M Race: 4 Phone: 8642003995 Street: P.O.BOX 1213 City: LAURENS Zip: 29360

137015 NILSA I NAZARIO MD FAAP	137015	10/11/10	10/11/10	20	11	3829	Otitis Media NOS	99204	E/M OFFICE/OP SERV NEW PATIENT	0	1.00	$150.00	$115.43	D6	$64.12	Documentation reviewed supports 99202 Stays 99204	12/10/10	10340007718104000A
137015 NILSA I NAZARIO MD FAAP	137015	10/11/10	10/11/10	20	11	3829	Otitis Media NOS	96110	DEVELOP TETING LIMITED W/INTER	0	1.00	$25.00	$7.55	C1	$7.55	Documentation does not support service billed was rendered	12/10/10	10340007718104000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90655	FLU VAC,SPLIT VIRUS,PRES FREE	0	1.00	$0.00	$0.00				02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90700	IMMUN ACTIVE DTAP VACCINE, <7	0	1.00	$0.00	$0.00				02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$7.98				02/04/11	11030000328116000A
137015 NILSA I NAZARIO MD FAAP	137015	01/15/11	01/15/11	20	11	490	Bronchitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213 Stays 99214	03/04/11	11059004468100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00				08/26/11	11233004598100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$70.99	D1	($4.04)	Incorrect code billed, doc. supports 99392	08/26/11	11233004598100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.70				08/26/11	11233004598100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				08/26/11	11233004598100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90633	HEP A VACCINE PED/ADOL DOS (2	0	1.00	$0.00	$0.00				08/26/11	11233004598100000A
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90461	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				08/26/11	11233004598100000A

TOTAL DISALLOWED $138.52

Claim Count: 4
Medicaid Total Paid: [redacted]
HMO Total Paid: [redacted]
Medicaid and HMO Total Paid: [redacted]
MIN/MAX DOS: [redacted]
MIN/MAX PAID DT: [redacted]

Brayan Andres Felipe

Disallow 4

a credit was given in Feb 2012

Billed Moderate Complexity of time approximately 25 minutes but less than 45 minutes.

1-85-1

SCDHHS

2/1/2012

South Carolina Department of Health and Human Services
Detailed Claims Report

Medicaid ID: 0781077476 ANDRES FELIPE, BRAYAN –Missing SSN: 654341387 DOB: 10/8/2009 County Elig: LAURENS
Household ID: 100895118 Gender: M Race: 4 Phone: 8642003995 Street: P.O.BOX 1213 City: LAURENS Zip: 29360

PROVIDER ID AND NAME	PAYTO# MEDICID	FDOS	LDOS	TY PE	POS REF	DX CD RW	DIAG DESC DEA CHAS	PROC CD NRC	PROCEDURE DRUG NAME	MOD	UOS QTY	CHARGE	PAID	PAYMENT PERIOD	DISALLOW	COMMENT	PAID DT	CCN
137015 NILSA I NAZARIO MD FAAP	137015	10/11/10	10/11/10	20	11	3829	Otitis Media NOS	99204	E/M OFFICE/OP SERV NEW PATIENT	0	1.00	$150.00	$115.43	(D6)	$41.15	Documentation reviewed supports 99202 (ALLOW 99203)	12/10/10	10340007718104
137015 NILSA I NAZARIO MD FAAP	137015	10/11/10	10/11/10	20	11	3829	Otitis Media NOS	96110	DEVELOP TETING LIMITED W/INTER	0	1.00	$25.00	$7.55	(C1) A1	$7.55	Documentation does not support service billed was rendered (insufficient justification in the medical record for procedures and/or tests rendered)		
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	12/10/10	10340007718104
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90655	FLU VAC,SPLIT VIRUS,PRES FREE	0	1.00	$0.00	$0.00				02/04/11	1103000
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				02/04/11	1103000
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90700	IMMUN ACTIVE DTAP VACCINE, <7	0	1.00	$0.00	$0.00				02/04/11	11030000328116
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	462	Acute Pharyngitis	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				02/04/11	11030000328116
137015 NILSA I NAZARIO MD FAAP	137015	01/15/11	01/15/11	20	11	490	Bronchitis NOS	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				02/04/11	11030000328116
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	02/04/11	11030000328116
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4799	Chronic Sinusitis NOS	90707	IMMUNIZATION MMR LIVE	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	02/04/11	11030000328116
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$0.00	$0.00				03/04/11	11059004468100
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$100.00	$70.99	(D1)	$0.00	ncorrect code billed, doc. supports 99392	08/26/11	11233004598100
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$10.00	$2.70				08/26/11	11233004598100
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90633	HEP A VACCINE PED/ADOL DOS (2	0	1.00	$20.00	$12.61				08/26/11	11233004598100
137015 NILSA I NAZARIO MD FAAP	137015	08/05/11	08/05/11	20	11	4739	Chronic Sinusitis NOS	90461	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$0.00	$0.00				08/26/11	11233004598100
										0	1.00	$20.00	$12.61				08/26/11	11233004598100

REVISED TOTAL DISALLOWED $119.59

Claim Count:
5

Medicaid Total Paid:
401.61

HMO Total Paid:
REFI

Medicaid and HMO Total Paid:
521.20

MIN/MAX DOS:
1/11/2010 8/5/2011

MIN/MAX PAID DT:
1/10/2010 8/26/2011

a credit was eliminated in May

IHS

5/15/201

304 D Broyles Dr
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

10-8-09

Name Brayan Andre's - Felipe

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
___ Blood Drawing		
X Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
X Immunization Type Hep A #1		
MMR #1		
Varicella #1		
___ Antibiotic Type ___		
___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 8/5/11 Method of Payment ___ Cash ___ VISA/MC

Follow-up Prn ___ Check X Medicaid

Diagnoses Asthma Bs V20.2 Amount Paid ___

Small education (R) Knee

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic
915 West Main Street Laurens, S.C. 29360
Tel Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 8/5/11 Last OV: 1/15/11
Accompanying Adult: F
Patient's Name: Brayan Andres Felipe DOB: 10/8/09
Tel. 200-0920
Address: 304 D Bronco Dr. Laurens SC 29360
ALLERGIES TO MEDS: **Current Medications:**
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: Ø
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: Ø
Blood Transfusions: Year Ø, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: **UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither**
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay 2 mo
School history: Grade: —; Grade Avg: Problems? Yes No
Adolescent females only: LMP month —/Year
4 y/o or older: Bedwetting? NO —, YES (Day/Night)
Snoring? No —, Yes (How long?)
Reason for this visit:
Check up Rose

Physical Exam-Pertinent VS and Findings:
HR 120 /min, RR 24 /min, Temp. 98.0 F (ax, oral, rectal), BP T
Wt. 26# , Ht. 31 7/8 , HC 18 1/2
Pertinent Findings:
Gen: A & D
Positive for:
Head and Neck: postnasal drip; post erythematous throat.
Respiratory:
Cardiovascular:
Gastrointestinal:
Genito-Urinary:
Musculoskeletal:
Nervous System: Ok
Skin:
Psychiatric:
Interventions:
Hct 34%. MMR #1
Varicella #1.
Hep A #1

Diagnosis(es):
Plan: /see copy Rx + receipt

TIPPS: (YES) NO
Anticipatory Guidance (YES) NO

Flu in July

BN0463404

PEDIATRIC CLINIC
NILSA I. NAZARIO, M.D.
915 WEST MAIN STREET
LAURENS, SC 29360-1367
864-984-4263

SC LIC. # 13701 SC NAR. # 21-3701

VOID

Name Priya - Nadan Felipe

Address _____ Date 08/11/11

(Please Print)

VOID

VOID

VOID

VOID

VOID

LABEL

REFILL ___ TIMES PRN NR

M.D.

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

M.D.

DEA # BN0463404

PEDIATRIC CLINIC
NILSA I. NAZARIO, M.D.
915 WEST MAIN STREET
LAURENS, SC 29360-1367
864-984-4263

SC LIC. # 13701 SC NAR. # 21-3701

VOID

Name Brayan Andres Felipe

Address _____ Date 08/05/11

VOID

Rx (Please Print)

VOID

VOID

VOID

VOID

LABEL

REFILL ___ TIMES PRN NR

M.D.

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

M.D.

Broyan Andres.
10/08/09

Avoidance of Allergens

No peanuts
fish
wheat
chocolate
oranges
yogurt

Ok
Cheese, vanilla or strawberry ice cream
pre heated milk.

No pets.
Fume
Smoking
grass pollen
dust
mildew

Parents initials J & B
or guardian
date 8/5/11

Addendum to Bryan Andres Felipe

- codes of HC proforma
& case of check up + illness where an HC proforma was used + age appropriate guidelines for screening of development

History not usable for EPSDT
Codes 99381→84 and 99391→94
Many instances sick also + auditor incorrectly lower coding to 99213 (brief encounter)

OUTPATIENT, CONSULTS (Outpatient, Inpatient)

	New Office/Consults					Established Office				
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of MDM	SF	SF	L	M	H		SF	L	M	H
New Office Visit	99201	99202	99203	99204	99205					
Inpatient Consultation	99251	99252	99253	99254	99255	99211	99212	99213	99214	99215
Office or Outpt. Consultation	99241	99242	99243	99244	99245					

INPATIENT

	Initial Hospital/Observation			Subsequent Inpatient/ Observaton Care		
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of MDM	SF or L	M	H	SF or L	M	H
Hospital Admission	99221	99222	99223	99231	99232	99233
Hospital Observation	99218	99219	99220	99224	99225	99226
Admit/Discharge same day	99234	99235	99236			

NURSING FACILITY

	Initial Nursing Facility			Subsequent Nursing Facility			
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.			
History	D or C	C	C	PF interval	EPF interval	D int.	C int.
Examination	D or C	C	C	PF	EPF	D	C
Complexity of MDM	SF or L	M	H	SF	L	M	H
	99304	99305	99306	99307	99308	99309	99310

mergency Dept

	New/Established								
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.								
story	PF	EPF	EPF	D	C				
amination	PF	EPF	EPF	D	C				
mplexity of MDM	SF	L	M	M	H				
	99281	99282	99283	99284	99285				

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

provider documents total time and documents that counseling or coordinating care dominates
s than 50% the encounter, time may determine the level of service. Documentation may refer
rognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk
tion or discussion with another health care provider.

documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)? ☐ Yes: ☐ No:
documentation reveal that more than half of time was counseling/coordination of care? ☐ Yes: ☐ No:
documentation describe the content of counseling/coordination of care? ☐ Yes: ☐ No:
ium face-to-face or unit/floor

If all answers are "Yes", then level may be selected based on time.

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

CPro

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Case of Yardell Cabanas GARRAY

DOB 02-04-06

Y.C.G. Medicaid # 7780561792

DOS 11-01-10

DOS 05-12-11

3- Yandell Cabanas Garay- 02/04/06DOB

DOS:08/12/10 Dx: Sinusitis, Rt OTM
Q+, E+, I: Hematocrit, urine, vision, hearing, vaccines
Rx ++
Not EPSDT provider yet, at least 25 minutes, moderate complexity, full exam
Thus 99214 NOT 99213 (15 minutes, low complexity)
DISAGREE to disallow $25.34

* DOS:08/24/10 Dx: Sinusitis
Q+, E+ , I: none, Rx +
Billed 99214 but AGREE to disallow to 99213
AGREE to disallow $25.34

##DOS:11/01/10 Dx: Tonsillitis
Q+, E+, I: urine, flu shot
At least 25 minutes, moderate complexity, full exam
Thus 99214 NOT 99212(focused, 10minutes exam)
STRONGLY DISAGREE to disallow $45.55

**DOS:01/03/11 Dx: V20.2 Check up
Q+, E+, I: Hematocrit, flu shot, Rx +
Billed 99214, due to length of visit but agree complexity is low thus agree to 99213
DISAGREE to disallow to 99212 $45.55
ONLY AGREE to disallow $25.37

*DOS:04/07/11 Dx: Pharyngitis
Q+, E+,I: none, Rx +
Billed 99214 for time allotted and full exam
but agree low complexity, thus AGREE to 99213
AGREE to disallow $25.34

##DOS:05/12/11 Dx: Croup
Q+, E+, I: Racemic Epinephrine, 2 Budesonides, 10L indirect oxygen:
Meds not billable, also trained in the nebulizer use,Rx +
Over 45 minutes, full exam, high complexity
Thus 99215 not 99213
STRONGLY DISAGREE to disallow $ 50.33

##DOS:06/23/11 Dx: OTM, Sinusitis
Q+, E+, I: blood work, urine, vision, hearing, Rx +
5 year old check up prior to school entrance
Over 25 minutes, moderate complexity
Thus 99214 NOT 99213(15 minutes, low complexity)
STRONGLY DISAGREE to disallow $24.58

TOTAL AGREED TO DISALLOW: $76.05

129 Marion St
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

02-04-06

Name Yandell Cabanas

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
___ Resp Treatment x $10.00 each tx ___		
___ Urine Cath		
___ EKG, LLII		
V ___ Immunization Type 0.5cc H1N1		
___ Antibiotic Type ___		
X ___ Urine		
___ Cognitive Assessment		
___ Train or nebulizer/Inhaler		
___ Other ___		

Date 11,01,2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2 weeks. ___ Check ✓ Medicaid

Diagnoses Tonsillitis Amount Paid ___

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915 West Main Street Laurens, S.C. 29360
Tel.: Fax (864) 984-4158 Tel (864) 984-4763

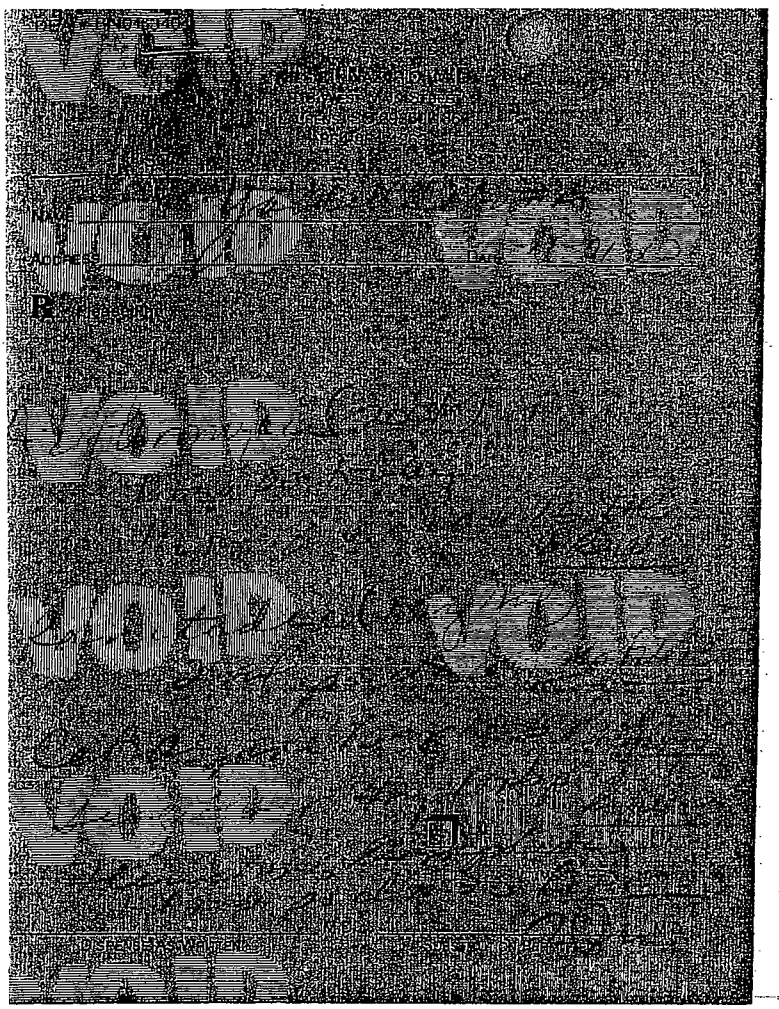
Date of service: 11/01/10
Accompanying Adult: Aunt
Last OV: ____/____/____
Patient's Name: Vonsavi Cabuñas DOB: 02/04/06
Tel. 871-3133 / 209-9650
Address: 129 Marion St Laurens, SC 29360
ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Current Medications:
Other: ø
Chronic Illnesses:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: ø
Blood Transfusions: Year ø Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead
Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: ____ Grade Avg: ____ Problems? Yes No
Adolescent females only: LMP month ____ Year ____
4 y/o or older: Bedwetting? NO ____ YES ____ (Day/Night)
Snoring? No ____ Yes ____ (How long? ____)
Reason for this visit:

Physical Exam-Pertinent VS and Findings:
HR 118/min, RR 28/min, Temp. 97.7 F(ax, oral, rectal), BP 88/55
Wt 39 1/4 lbs Ht 42 1/4" HC ____
Pertinent Findings:
Gen: A A N D
Positive for:
___Head and Neck: right throat tonsils 2+
___Respiratory: clear
___Cardiovascular: RRR no m
___Gastrointestinal: SNT no mass
___Genito-Urinary:
___Musculoskeletal:
___Nervous System:
___Skin:
___Psychiatric:
Interventions: flu shot IM IAB.

Diagnosis(es):
Plan: See copy Rx + Receipt

Flu in 2wks.

TIPPS: YES NO
Anticipatory Guidance YES NO



MULTISTIX 10 SG

11/01/10 Yandell Cabarras 4:33

LEUKOCYTES	NEGATIVE ☑			TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐			
NITRITES	NEGATIVE ☒				POSITIVE ☐					
UROBILINOGEN	NORMAL ☑				2 ☐	4 ☐	8 ☐			
PROTEIN	NEGATIVE ☐	TRACE ☑		30 ☐	100 ☐	300 ☐	2000 or More ☐			
PH	5.0 ☐	6.0 ☐	6.5 ☐	7.0 ☐	7.5 ☐	8.0 ☑	8.5 ☐			
BLOOD	NON-HEMOLYZED NEGATIVE ☑	TRACE ☐	MODERATE ☐	HEMOLYZED TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐			
SPECIFIC GRAVITY	1.000 ☐	1.005 ☑	1.010 ☐	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐			
KETONES	NEGATIVE ☑	TRACE 5 ☐	SMALL 15 ☐	MODERATE 40 ☐	80 ☐	LARGE 160 ☐				
BILIRUBIN	NEGATIVE ☑	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐						
GLUCOSE	NEGATIVE ☑	100 ☐	250 ☐	500 ☐	1000 ☐	2000 or More ☐				

523 Conway Ave
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

02/04/06

Name Yandal Tabanas

Patient's Receipt

Service Given	Code	Paid
✓ Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
✓ Resp Treatment x $10.00 each tx	1 Racemic Epi + 1 DL + 2 Budesonide Neb	
___ Urine Cath		
___ EKG, LLII		
___ Immunization Type		
___ Antibiotic Type		
___ Urine		
___ Cognitive Assessment		
✓ Train or nebulizer/Inhaler		
✓ Other		

Date 05,12,11 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2 wks ___ Check ✓ Medicaid

Diagnoses Croup Pneumonia Amount Paid ___

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic

915 West Main Street Laurens, S.C. 29360
Tel.: Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 05/12/11 Last OV: 04/07/11
Accompanying Adult: (F) Aunt (Lobo cabrera)
Patient's Name: Vandell Cabrera DOB: 02/04/06
Tel. 8713138 (F)
Address: 523 Conway Ave Laurens SC 29360
ALLERGIES TO MEDS: **Current Medications:**
Penicillin, Erythromycin, Sulfa,Cephalosporins
Other: ø
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: ø
Blood Transfusions: Year ø, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: **UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither**
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: 4K; Grade Avg: Problems? Yes (No)
Adolescent females only: LMP month /Year
4 y/o or older: Bedwetting? (NO), YES (Day/ Night)
Snoring? (No), Yes (How long?)
Reason for this visit: Coughing

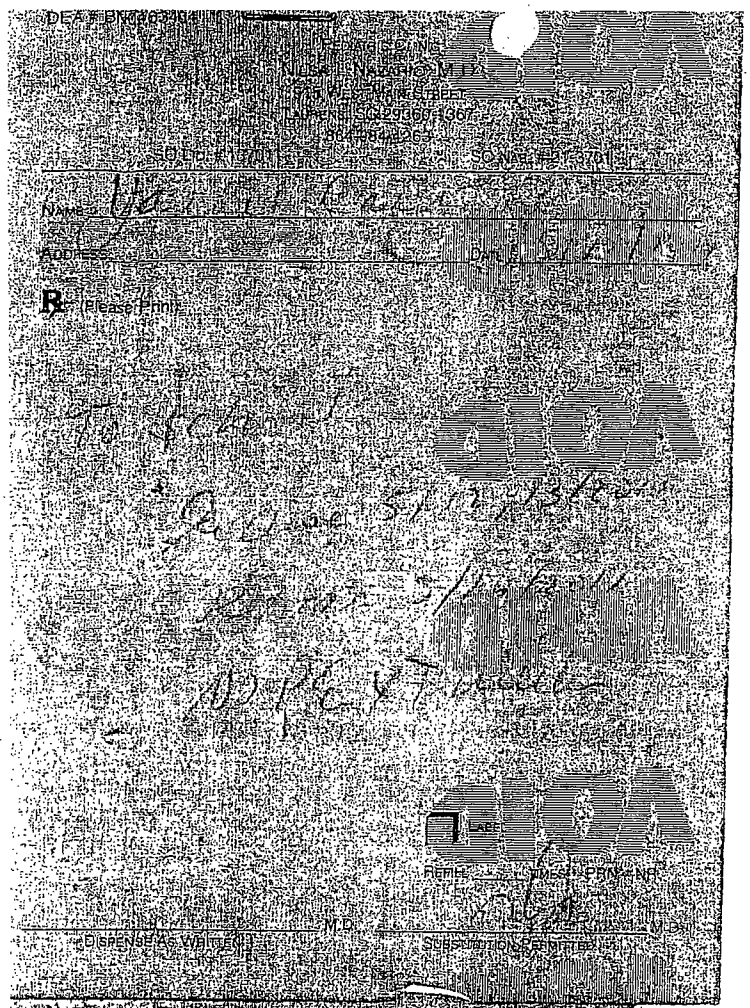
Physical Exam-Pertinent VS and Findings:
HR 94 /min, RR 24 /min, Temp. 98.1 F(ax., oral, rectal), BP 92/54
Wt. 45.7 Ht. 43 3/4" , HC
Pertinent Findings:
Gen: A & N x 3
Positive for:
___Head and Neck: Clear throat.
___Respiratory: Croupy, cough, not clear
___Cardiovascular:
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System: Ok
___Skin:
___Psychiatric:

Interventions: Racemic epi + 2 Budesonide 0.5cc + 10cc Ind O2
9:54am Train on Neb

Diagnosis(es):

Plan: See copy Rx Receipt.
TIPPS: YES NO
Anticipatory Guidance YES NO

Thank You.



DEA # BN0463409

PEDIATRIC CLINIC

NISSAN NAZARIO, M.D.

900 WEST MAIN STREET

LAURENS, SC 29360 (864) 984-0253

SC LIC # 21701

SC NAT'L PI # 3701

Name

Address

Date

℞ (Please Print)

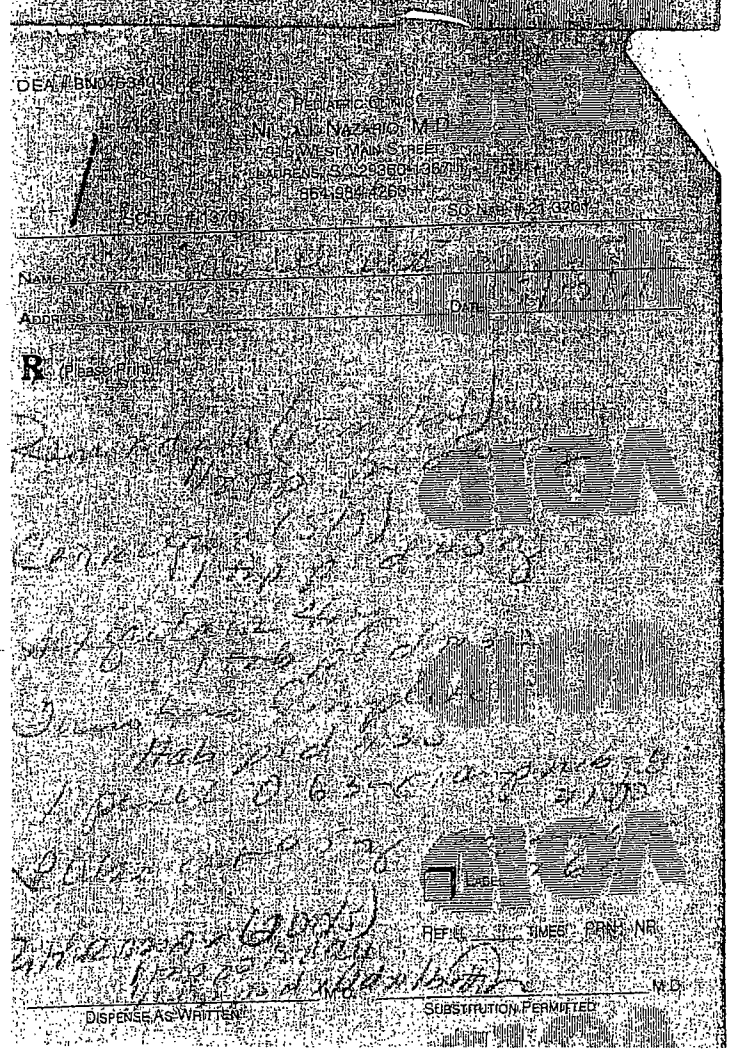
Label

Refill Times PRN NR

Dispense As Written

M.D.

Substitution Permitted



DEA # BN0463409

PEDIATRIC CLINIC

NISSAN NAZARIO, M.D.

900 WEST MAIN STREET

LAURENS, SC 29360 (864) 984-0253

SC LIC # 21701

SC NAT'L PI # 3701

Name

Address

Date

℞ (Please Print)

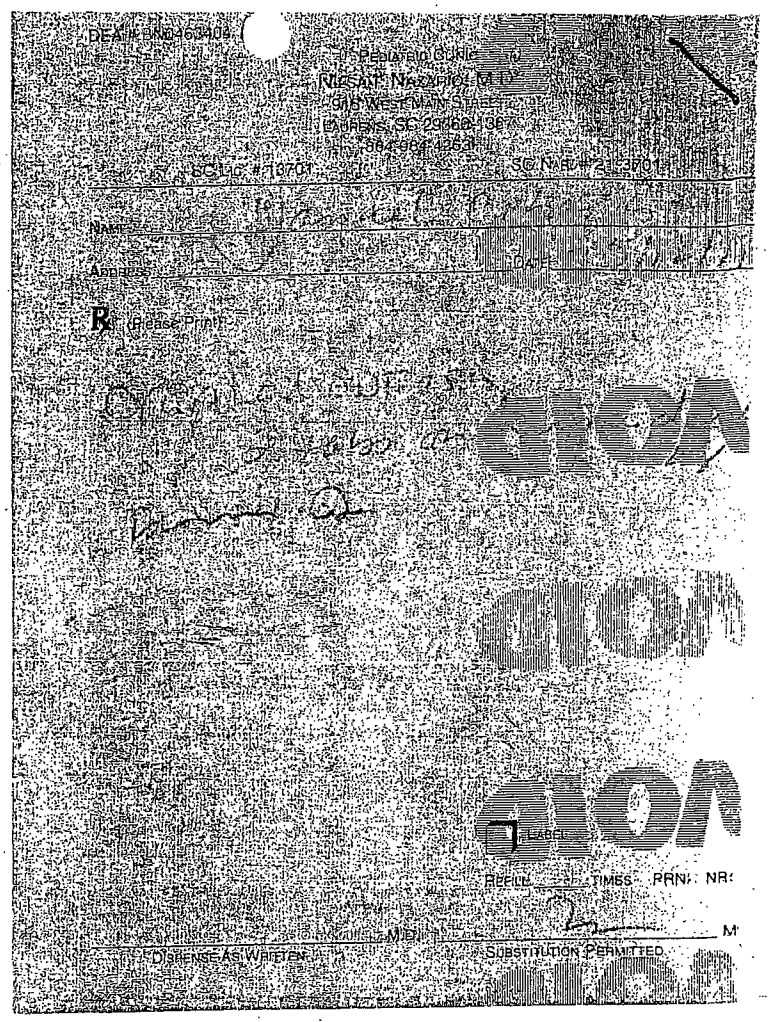
Label

Refill Times PRN NR

Dispense As Written

M.D.

Substitution Permitted



DEA # BN0463409

PEDIATRIC CLINIC

NISSAN NAZARIO, M.D.

900 WEST MAIN STREET

LAURENS, SC 29360 (864) 984-0253

SC LIC # 21701

SC NAT'L PI # 3701

Name

Address

Date

℞ (Please Print)

Label

Refill Times PRN NR

Dispense As Written

M.D.

Substitution Permitted

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal or no data was reviewed or that the data was more than minimal or no complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was staightforward.

DOS: 01/15/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, I must assume that the Petitioner is referring to a CPT-driven "Detailed" exam. This visit was a follow-up visit after an emergency room visit. The Petitioner diagnosed three (3) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

3) Y.C.G., Medicaid Recipient # 7780561792

DOS: 08/12/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. There is no indication as to the reason for this visit; however, the Petitioner was given a flu shot and was diagnosed with tonsillitis; therefore, it appears that this was a sick child visit for the tonsillitis. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since it appears that this child was seen for tonsillitis, at most this exam is a problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/03/11- This child was seen in order to obtain a second flu shot. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for only a flu shot and no particular diagnosis was given, at most this exam is a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 05/12/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 45 minute exam, it appears that the Petitioner is referring to a CPT-driven "Comprehensive" exam; however, since this child was seen for acute coughing, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 06/23/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the CPT descriptor for the type of exam done; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a check-up prior to entering school, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

4) Y.C., Medicaid Recipient # 0781042174

DOS: 09/05/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; however, since it is alleged that this should be coded as 99204, it appears that the Petitioner feels that the exam was a comprehensive exam. The Petitioner was diagnosed with three (3) conditions. There is no evidence that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was greater than low; therefore, the complexity of medical decision making was low complexity.

DOS: 09/25/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since this child was seen for a recheck and shots, at most this exam is an Expanded problem

South Carolina Department of Health and Human Services
Detailed Claims Report

-103-

icaid ID: 7780561792 CABANAS GARAY, YANDELL ~Missing SSN: 656229244 DOB: 2/4/2006 County Elig: LAURENS
sehold ID: 101104755 Gender: M Race: 10 Phone: 8648713138 Street: 523 CONWAY AVE City: LAURENS Zip: 29360

DISPENSING PROVIDER	PROVIDER	DOS	DOS	POS	TOS	DX CD	DX CD DESC	PROC CD	PROCEDURE DESC	MOD	UNITS	CHARGE	PAID	PAYMENT FLAG CD	PAYMENT FLAG DESC	COMMENT	PAID DT	CLM
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00				09/10/10	10248003928760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				09/10/10	10248003928760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				09/10/10	10248003928760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				09/10/10	10248003918760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00				09/10/10	10248003918760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$16.01				09/10/10	10248003918760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				09/10/10	10248003918760000A
LS NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	(D6)	$25.34	Documentation reviewed supports 99212 (Allow 99213)	09/10/10	10248003918760000A
LS NILSA I NAZARIO MD FAAP	137015	08/24/10	08/24/10	20	11	4739	Chronic Sinusitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	09/10/10	10248003948760000A
S NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	12/03/10	10332000418109000A
S NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00				12/03/10	10332000418109000A
S NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				12/03/10	10332000418109000A
S NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22	(C1)	$0.00	Documentation does not support service billed was rendered (Doc submitted supports service billed)	12/03/10	10332000418109000A
S NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00				01/21/11	11017006778100000A
S NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				01/21/11	11017006778100000A
S NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	01/21/11	11017006778100000A
S NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				01/21/11	11017006778100000A
S NILSA I NAZARIO MD FAAP	137015	04/07/11	04/07/11	20	11	462	Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	(D6)	$25.34	Documentation reviewed supports 99212 (Allow 99213)	04/22/11	11105005828129000A
S NILSA I NAZARIO MD FAAP	137015	05/12/11	05/12/11	20	11	4644	Croup	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.62				06/10/11	11155000388111000A
S NILSA I NAZARIO MD FAAP	137015	05/12/11	05/12/11	20	11	4644	Croup	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$98.86	D6	$50.33	Documentation reviewed supports 99213	06/10/11	11155000388111000A
S NILSA I NAZARIO MD FAAP	137015	05/12/11	05/12/11	20	11	4644	Croup	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$9.81				06/10/11	11155000388111000A
S NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$15.53				07/29/11	11202002288101000A
S NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$78.11	(D6)	$24.58	Documentation reviewed supports 99212 (Allow 99213)	07/29/11	11202002288101000A
S NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.12				07/29/11	11202002288101000A
S NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.50				07/29/11	11202002288101000A

REVISED TOTAL DISALLOWED $242.03

properly billed

Count:
[redacted]
aid Total Paid:
[redacted]
otal Paid:
[redacted]
aid and HMO Total Paid:
[redacted]

AX DOS:
[redacted]
AX PAID DT:
[redacted]

5/15/201

South Carolina Department of Health and Human Services
Detailed Claims Report

Medicaid ID: 7780561792 CABANAS GARAY, YANDELL --Missing SSN: 656229244 DOB: 2/4/2006 County Elig: LAURENS
Household ID: 101104755 Gender: M Race: 10 Phone: 8648713138 Street: 523 CONWAY AVE City: LAURENS Zip: 29360

137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00					09/10/10	10248003928760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00					09/10/10	10248003928760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00					09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22					09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00					09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$16.01					09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98					09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/12/10	08/12/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212		09/10/10	10248003918760
137015 NILSA I NAZARIO MD FAAP	137015	08/24/10	08/24/10	20	11	4739	Chronic Sinusitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213		09/10/10	10248003948760
137015 NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212		12/03/10	10332004181090
137015 NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00					12/03/10	10332004181090
137015 NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00					12/03/10	10332004181090
137015 NILSA I NAZARIO MD FAAP	137015	11/01/10	11/01/10	20	11	463	Acute Tonsillitis	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22	C1	$3.22	Documentation does not support service billed was rendered		12/03/10	10332004181090
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00					01/21/11	11017006778109
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98					01/21/11	11017006778109
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	99213 diff 25.37	01/21/11	11017006778109
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00					01/21/11	11017006778109
137015 NILSA I NAZARIO MD FAAP	137015	04/07/11	04/07/11	20	11	462	Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	99213 diff 25.37	04/22/11	11105005828120
137015 NILSA I NAZARIO MD FAAP	137015	05/12/11	05/12/11	20	11	4644	Croup	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.62					06/10/11	11155000388111
137015 NILSA I NAZARIO MD FAAP	137015	05/12/11	05/12/11	20	11	4644	Croup	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$98.86	D6	$50.33	Documentation reviewed supports 99213		06/10/11	11155000388111
137015 NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$9.81					06/10/11	11155000388111
137015 NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$15.53					07/29/11	11202002288101
137015 NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$44.18	Documentation reviewed supports 99212		07/29/11	11202002288101
137015 NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.12					07/29/11	11202002288101
137015 NILSA I NAZARIO MD FAAP	137015	06/23/11	06/23/11	20	11	3829	Otitis Media NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.50					07/29/11	11202002288101

TOTAL DISALLOWED $305.27

+Sinusitis +OTM Stay 99214

+Sinusitis

+Pharyngitis

+Sinusitis +V20.2 stay 99214.

Claim Count: [redacted]
Medicaid Total Paid: [redacted]
HMO Total Paid: [redacted]
Medicaid and HMO Total Paid: [redacted]

MIN/MAX DOS:
8/12/2010 - 8/29/2011
MIN/MAX PAID DT:
9/10/2010 - 9/29/2011

Yandell Cabanas
Ok to disallow

08/24/10 $ 25.34

01/03/11 $ 25.37

Duplicate $ 25.37

CDHHS

//1/201

Case of Tyounna N. Jackson

DoB 10-15-09

Medicaid ID # 4781079479

DOS 12-01-09

- my case review
- my office notes
- DCR* of 5/12 claimed 99214 (a change from Feb DOS)
- DCR* of 7/12 claimed 99213
- NC Proform commentaries (change 99213 to 99214 doesn't show)
- ruling

*DCR = detail claim report

11- Michelle Jaimes Garduno-04/11/02DOB

DOS 07/31/10 Dx: Tonsillitis, Enlarged Tonsils, WBC's in urine, Overweight
Q+, E+, I: urine, Rx+
Thus 99214 NOT 99213
DISAGREE to disallow $20.21

DOS 12/11/10 Dx: Overweight, V20.2
Q+, E+, I: vaccines, urine, Rx+
Thus 99214 NOT 99213
DISAGREE to disallow $ 25.34

12- Tyounna N. Jackson-10/15/09DOB

DOS 10/29/09 DX:URI, Pharyngitis, Mild Bronchitis
Q++, E+, I: Xopenex(sample), Pulmicort (not billable), Rx+
ACCEPTED 99204

DOS 12/01/09 Dx: Bronchiolitis, AGE, Pharyngitis
Q+, E+, I:Xopenex(sample), Pulmicort (not billable), trained on nebulizer
8L indirect oxygen
Thus 99215 NOT 99214
DISAGREE to disallow $ 26.55

DOS 01/07/10 Dx: Severe Milk Allergy, Eczema, Vomiting, RAD
Q+, E+, I: Xopenex(sample), Pulmicort (not billable), 8L oxygen,vaccines, Hematocrit, Rx+
Thus truly 99215 not just EPSDT but not a provider
DISAGREE to disallow: $34.82

DOS 01/25/10 Dx: Anal Fissure, Candidiasis, Umbilical Hernia, GE Reflux
Q+, E+, I: meds explained, Rx+
Thus 99214 NOT 99213
DISAGREE to disallow $25.34

DOS 02/09/10 Dx: Bronchiolitis, Umbilical Hernia
Q+, E+, I: Xopenex(sample), Pulmicort (not billable), Rx+
Thus 99215 but billed as 99214
DISAGREE to disallow $ 25.34

DOS 04/08/10 Dx: Pharyngitis, URI
Q+, E+, I: vaccines , Rx+
Thus 99214 NOT 99213
DISAGREE to disallow $25.34

12- Tyounna N. Jackson-(continues)

DOS 04/20/10 Dx: Bronchitis
Q+, E+, I: Xopenex(sample), Pulmicort
(not billable), 10L indirect oxygen
NOTE: I had agreed to 99214 but disagree after
revision of the visit.
Truly a 99215, NOT 99213
STRONGLY DISAGREE to disallow $51.89

##DOS 10/28/10 Dx: V20.2, Allergies
Q+,E+, I: vaccines, Hematocrit, Rx+
EPSDT but not a provider yet
Thus 99214 NOT 99213
STRONGLY DISAGREE to disallow $25.34

DOS 11/16/10 Dx: OTM, Allergy to Milk Protein
Q+,E+, I: changed to Peptamen Jr, Rx+
AGREE to 99213
AGREE to disallow $ 25.34

DOS 01/03/11 ## Dx: Bronchiolitis, Viral pharyngitis, Hernia
Q+,E+, I: Xopenex(sample), 2 Pulmicort
(not billable), 8 L indirect oxygen
Thus 99215 NOT 99213
STRONGLY DISAGREE to disallow $51.89

@DOS 01/06/11 Dx: Improved Bronchiolitis
Q+,E+, I: none
ACCEPTED 99213

DOS 06/30/11 Dx: Severe Pharyngitis, Fever
Q+, E+, I: Maalox, Tylenol, Pedialyte
(not billable), urine, Rx+
ACCEPTED 99214

##DOS 08/23/11 Dx: V20.2
Q+, E+, I: vaccines, Hematocrit
Either 99392 EPSDT, or 99214
NOT 99212
STRONGLY DISAGREE to disallow$42.90

TOTAL AGREED TO DISALLOW $ 25.34

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

12-15-09

Name Na'Quaria Jackson

Patient's Receipt

Service Given	Code	Paid
1 Medical Exam		
___ Blood Drawing		
___ Hematrocrit		
___ Hearing Test		
___ Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
2 Resp Treatment x 1 X $10.00 each tx 1 P		
___ Urine Cath		
___ EKG, LLJI		
___ Immunization Type ___		
___ Antibiotic Type ___		
___ Urine		
___ Cognitive Assessment		
2 Train or nebulizer/Inhaler		
___ Other ___		

Date 12, 1, 09 Method of Payment ___ Cash ___ VISA/MC

Follow-up 1 week. ___ Check ✓ Medicaid

Diagnoses Bronchiolitis. Amount Paid ___

DCE
Phrenyg dis

Nilsa F. Nazario, M.D., F.A.A.P.
Pediatric Clinic
915 West Main Street Laurens, S.C. 29360
Tel: Fax (864) 984-4158 Tel (864) 984-4263

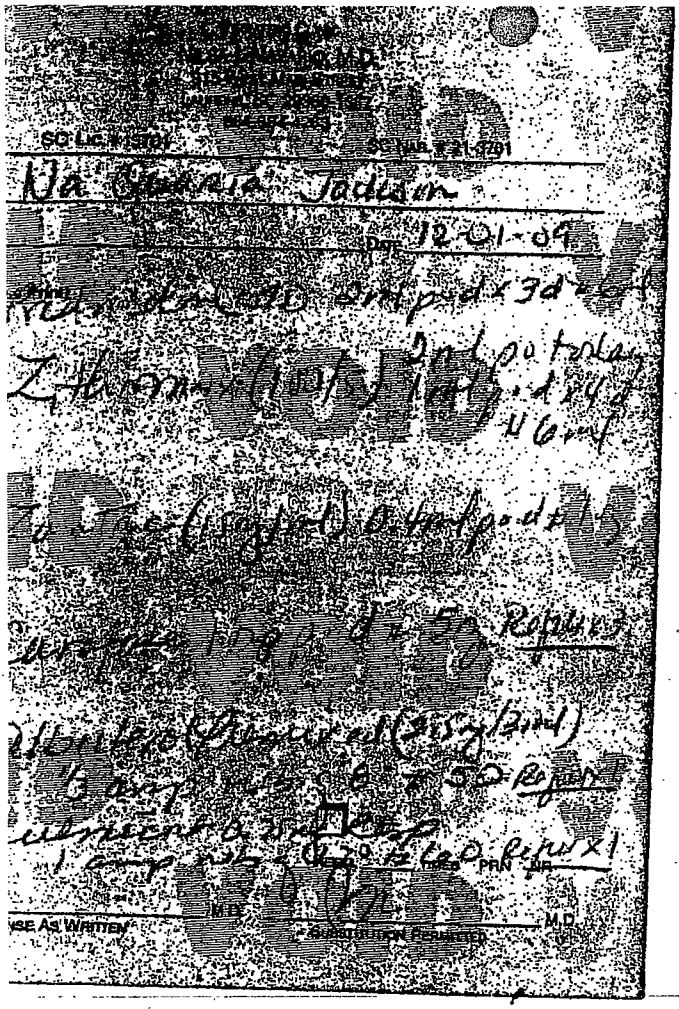
Date of service: 12/1/09 Last OV: 10/29/09
Accompanying Adult: M
Patient's Name: Na'Quaria Jackson DOB: 10/15/09
Tel. 408-9614
Address: 102 Tifton Ct. Ft. Inn SC 29644
ALLERGIES TO MEDS: **Current Medications:**
Penicillin, Erythromycin, Sulfa,Cephalosporins
Other: Ø
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: Ø
Blood Transfusions: Year Ø, **Type: RBC'S, Plasma, Platelets, Whole Blood**
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead
Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: —; **Grade Avg:** **Problems? Yes No**
Adolescent females only: LMP month — /**Year**
4 y/o or older: Bedwetting? NO —, **YES** (Day/ Night)
Snoring? No —, **Yes** (How long?)
Reason for this visit:
now w/ nebs per phone recommendation Crying a lot, vomiting w/ cold 7 days Having diarrhea

Physical Exam-Pertinent VS and Findings:
HR 144 **/min, RR** 44 **/min, Temp.** 98.3 **F (ax.) oral, rectal), BP** T
Wt. 9# 7oz, **Ht.** 21 1/8, **HC** 14 1/4
Pertinent Findings:
Gen: A in mild distress crying
Positive for:
Head and Neck congested nares, eryth throat
Respiratory: + BS & rales
Cardiovascular: RR WNL
Gastrointestinal: Liver bruit. Resp.
Genito-Urinary: Female Tanner I
Musculoskeletal: Ø Orthotics
Nervous System: Good mvmt, grasp + suck
Skin:
Psychiatric: WNL
Interventions: 4:25 PM Xopenex 0.63mg + Pulmicort 0.5mg + 8 Lpm O2 via face mask pt well nebulized no vomiting, tx more crying.

Diagnosis(es):

Plan: See copy Rx + Receipt
Pediatyte tonight
TD 6 8
Start po meds this evening

TIPPS: YES NO
Anticipatory Guidance YES NO



Detailed Claims Report

Medicaid ID: 4781079479 JACKSON, TYOUNNA N SSN: 654343477 DOB: 10/15/2009 County Elig: LAURENS
Household ID: 100848293 Gender: F Race: 2 Phone: 8643850285 Street: PO BOX 758 City: GRAY COURT Zip: 29645

PROVIDER ID AND NAME	PAYTO# PREV ID	FDOS	TDOS	TY	POS REF	DX CD DIAG CLASS	DIAG DESC	PROC CD PROC MODIFIER	PROCEDURE	MOD 1 MOD 2 MOD 3 MOD 4	UOS QTY	CHARGE	PAID	PAY METH ERROR KEY	REJECT CDE	REMARK CODE COMMENT	PAID DT	ECN
37015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490	Bronchitis NOS	99204	E/M OFFICE/OP SERV NEW PATIENT	0	1.00	$150.00	$115.43				01/01/10	093610092681070
37015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				01/01/10	093610092681070
37015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	(D6)	$26.55	Documentation reviewed supports 99213 (Allow 99214)	01/01/10	093610092681070
37015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95				01/01/10	093610092681070
37015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D1	$34.82	Incorrect code billed, doc. supports 99391	01/29/10	100200022981250
37015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				01/29/10	100200022981250
37015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				01/29/10	100200022981250
37015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				01/29/10	100200022981250
37015 NILSA I NAZARIO MD FAAP	137015	01/25/10	01/25/10	20	11	5650	Anal Fissure	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	02/12/10	100380061387500
37015 NILSA I NAZARIO MD FAAP	137015	02/09/10	02/09/10	20	11	46619	Acu Brnchits d/t Oth Org	94640	AIRWAY INHALATION TREATMENT	0	1.00	$20.00	$10.11				03/05/10	100590071981130
37015 NILSA I NAZARIO MD FAAP	137015	02/09/10	02/09/10	20	11	46619	Acu Brnchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.97	D6	$25.34	Documentation reviewed supports 99213	03/05/10	100590071981130
37015 NILSA I NAZARIO MD FAAP	137015	04/08/10	04/08/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	2.00	$20.00	$13.00				05/07/10	101210089481010
37015 NILSA I NAZARIO MD FAAP	137015	04/08/10	04/08/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	05/07/10	101210089481010
37015 NILSA I NAZARIO MD FAAP	137015	04/20/10	04/20/10	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				05/07/10	101210089381010
37015 NILSA I NAZARIO MD FAAP	137015	04/20/10	04/20/10	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	05/07/10	101210089381010
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00				12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90698	DTAP-HIB-IP VACCINE, INTRAMUSC	0	1.00	$0.00	$0.00				12/03/10	103320009681090
37015 NILSA I NAZARIO MD FAAP	137015	11/16/10	11/16/10	20	11	9829	Otitis Media NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	12/24/10	103540089481000
37015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	46619	Acu Brnchits d/t Oth Org	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	01/28/11	110170067881000
37015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	46619	Acu Brnchits d/t Oth Org	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11				01/28/11	110170067881000
37015 NILSA I NAZARIO MD FAAP	137015	01/06/11	01/06/11	20	11	46619	Acu Brnchits d/t Oth Org	99213	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$50.00	$50.00				02/04/11	110300010281160
37015 NILSA I NAZARIO MD FAAP	137015	06/30/11	06/30/11	20	11	78060	Fever NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.12				07/22/11	111970081600
37015 NILSA I NAZARIO MD FAAP	137015	06/30/11	06/30/11	20	11	78060	Fever NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11				07/22/11	111970081600
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90461	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				09/16/11	112530000481110
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$70.99	D6	$42.90	Documentation reviewed supports 99212	09/16/11	112530000481110
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00				09/16/11	112530000481110
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00				09/16/11	112530000481110
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.70				09/16/11	112530000481110
37015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				09/16/11	112530000481110

Claim Count:
9

Medicaid Total Paid:
1,247.45

REVISED TOTAL DISALLOWED $334.75

DHHS

5

Medicaid ID: 4781079479 JACKSON, TYOUNNA N SSN: 654343477 DOB: 10/15/2009 County Elig: LAURENS
Household ID: 100848293 Gender: F Race: 2 Phone: 8643850285 Street: PO BOX 758 City: GRAY COURT Zip: 29645

PROVIDER ID AND NAME	PATIENT / PROC CD	FDOS	LDOS	TY	POS / TOS	DX CD / MOD	DIAG DESC / DX CLASS	PROC CD / NDC	PROCEDURE / DRUG NAME	MOD / BMPC	UOS / QTY	CHARGE	PAID	PAYMENT PROC CD	DISALLOW AMT	COMMENTS	PAID DT	CCN
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490	Bronchitis NOS	99204	E/M OFFICE/OP SERV NEW PATIENT	0	1.00	$150.00	$115.43				01/01/10	09361009268107OOA
137015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				01/01/10	09361009268107OOA
137015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	01/01/10	09361009268107OOA
137015 NILSA I NAZARIO MD FAAP	137015	12/01/09	12/01/09	20	11	490	Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95				01/01/10	09361009268107OOA
137015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D1	$34.82	Incorrect code billed, doc. supports 99391	01/29/10	10020002981250OA
137015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				01/29/10	10020002981250OA
137015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				01/29/10	10020002981250OA
137015 NILSA I NAZARIO MD FAAP	137015	01/07/10	01/07/10	20	11	78703	Vomiting Alone	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				01/29/10	10020002981250OA
137015 NILSA I NAZARIO MD FAAP	137015	01/25/10	01/25/10	20	11	5650	Anal Fissure	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	02/12/10	10038006138737OOA
137015 NILSA I NAZARIO MD FAAP	137015	02/09/10	02/09/10	20	11	46619	Acu Bmchits d/t Oth Org	94640	AIRWAY INHALATION TREATMENT	0	1.00	$20.00	$10.11				03/05/10	10059007198113OA
137015 NILSA I NAZARIO MD FAAP	137015	02/09/10	02/09/10	20	11	46619	Acu Bmchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	03/05/10	10059007198113OOA
137015 NILSA I NAZARIO MD FAAP	137015	04/08/10	04/08/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	2.00	$20.00	$13.00				05/07/10	10121008948101OOA
137015 NILSA I NAZARIO MD FAAP	137015	04/08/10	04/08/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	05/07/10	10121008948101OOA
137015 NILSA I NAZARIO MD FAAP	137015	04/20/10	04/20/10	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				05/07/10	10121008938101OOA
137015 NILSA I NAZARIO MD FAAP	137015	04/20/10	04/20/10	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	05/07/10	10121008938101OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00				12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98				12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00				12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV	0	1.00	$0.00	$0.00				12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	10/28/10	10/28/10	20	11	V202	Routin Child Health Exam	90698	DTAP-HIB-IP VACCINE, INTRAMUSC	0	1.00	$0.00	$0.00				12/03/10	10332000968109OOA
137015 NILSA I NAZARIO MD FAAP	137015	11/16/10	11/16/10	20	11	3829	Otitis Media NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	12/24/10	10354008948100OOA
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	46619	Acu Bmchits d/t Oth Org	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	01/28/11	11017006788100OOA
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	46619	Acu Bmchits d/t Oth Org	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11				01/28/11	11017006788100OOA
137015 NILSA I NAZARIO MD FAAP	137015	01/06/11	01/06/11	20	11	46619	Acu Bmchits d/t Oth Org	99213	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$50.00	$50.00				02/04/11	11030001028116OOA
137015 NILSA I NAZARIO MD FAAP	137015	06/30/11	06/30/11	20	11	78060	Fever NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.12				07/22/11	11197008168120OOA
137015 NILSA I NAZARIO MD FAAP	137015	06/30/11	06/30/11	20	11	78060	Fever NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11				07/22/11	11197008168120OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90461	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				09/16/11	11253000048111OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$70.99	D6	$42.90	Documentation reviewed supports 99212	09/16/11	11253000048111OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00				09/16/11	11253000048111OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV	0	1.00	$0.00	$0.00				09/16/11	11253000048111OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.70				09/16/11	11253000048111OOA
137015 NILSA I NAZARIO MD FAAP	137015	08/23/11	08/23/11	20	11	V202	Routin Child Health Exam	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61				09/16/11	11253000048111OOA

TOTAL DISALLOWED $360.09

Claim Count:
33
Medicaid Total Paid:
$1,247.45

SCDHHS

2/1/

Tyounna Naquazia Jackson
DOB 10/15/09

This case is an example
Of a Revision from 99213 in Feb 2012
to 99214 in May 2012 yet
only HCPro form with judgement
call of May is available. The
form doesn't depict any changes
from 99213 to 99214(?)

Note that even 99214 is wrongly
concluded by auditor's
mishandling of the form + form's
fatal errors in history taking
instructions; when I do the
form conclusion is 99215 → the code billed.

Chief Complaint: YES X NO Pt. Name: Jackson, T. MRN: 12/1/09

HISTORY

HPI (History of Present Illness)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Quality ☑ Duration ☐ Context ☑ Associated signs and symptoms

	None	Brief (1-3 elements)		Extended (≥4 elements or status of 2-3 chronic/ inactive conditions)

ROS (Review of Systems)

☑ Constitutional (wt. Loss, etc) ☐ Ears, nose mouth, throat ☐ GI ☐ Integumentary (skin, breast) ☐ Endo
☐ Eyes ☐ Card/vasc ☐ GU ☐ Hem/lymp
☐ Resp ☐ Musculo ☐ Neuro ☑ Allergy/Immunological
☐ Psych ☐ "All others negative"

	None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"

PFSH (past medical, family and social history)

☑ Past medical history
☐ Family history
☐ Social history

No PFSH required for 99231-33, 99307-10

		None	1 history area	2 or 3 history areas
Established/ Subsequent/ED				
New/Initial		None	1 or 2 history area(s)	3 history areas

To determine History level, draw a line down the column with the circle farthest to the left.

PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPREHENSIVE

EXAM

1997 General Multi-System Exam

Problem Focused (1-5 elements)	Exp. Prob Focused (≥ 6 elements)	Detailed (≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas)	Comp (≥ 2 elements in 9 areas)

1995 Body Areas

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Genitalia, groin, buttocks
☐ Neck ☐ Abdomen ☐ Back, including spine
☐ Each extremity

Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	8 or more body areas/ systems

1995 Organ Systems

☑ Constitutional (vitals, gen app, etc) ☐ Ears, nose, mouth, throat ☑ Resp ☐ Musculo ☐ Psych
☐ Eyes ☑ Cardiovascular ☐ GI ☐ Skin ☐ Hem/lymph/ Immuno
☑ GU ☐ Neuro

System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system

PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPREHENSIVE

MEDICAL DECISION MAKING

A Number of Diagnoses or Treatment Options

Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	= 1
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			3

Should be a (4)

B Amount and/or Complexity of Data to be Reviewed

Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2
TOTAL (TRANSFER TO MDM Summary section below)	4

Should be 4

C Risk of Complications and/or Morbidity or Mortality

MIN	One self-limited or minor problem, e.g. cold, insect bite tinea corporis	Laboratory tests requiring venipuncture Chest x-rays KOH prep EKG/EEG Urinalysis Ultrasound e.g. echo	Rest Gargle Elastic Bandages Superficial dressings
LOW	2 + self-limited or minor problems 1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Physiologic test not under stress e.g. pulmonary function tests. Non-cardio. Imaging studies with contrast e.g. barium enema. Superficial needle bxs. Clinical Lab test requiring arterial puncture. Skin biopsies.	Over-the-counter drugs Minor surgery with no identified risk factors. Physical therapy Occupational therapy IV fluids w/o additives Push Pedialyte
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis e.g. lump in breast Acute illness with systemic symptoms e.g. pyelonephritis Acute complicated injury e.g. head injury with brief loss of consciousness	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional bx Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open percutaneous or endoscopic) with no identified risk factors Prescription drug mgmt Therapeutic nuc med IV fluids with additives Closed treament of fracture or dislocation without manipulation F/U 1 wk. Reso Tx
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment. Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary emboli, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurological status e.g. seizure, TIA	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open percutaneous or endoscopic) with identified risk factor Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or de-escalate care because of poor prognosis

MDM SUMMARY

	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
A Number of diagnoses or treatment options				
B Amount and Complexity of Data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

Should be 4 Status Post 4 Moderate Complex

HCPro

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OUTPATIENT, CONSULTS (Outpatient, Inpatient)

	New Office/Consults If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					Established Office If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of MDM	SF	SF	L	M	H		SF	L	M	H
New Office Visit	99201	99202	99203	99204	99205					
Inpatient Consultation	99251	99252	99253	99254	99255	99211	99212	99213	99214	99215
Office or Outpt. Consultation	99241	99242	99243	99244	99245					

INPATIENT

	Initial Hospital/Observation If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Inpatient/ Observaton Care If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of MDM	SF or L	M	H	SF or L	M	H
Hospital Admission	99221	99222	99223	99231	99232	99233
Hospital Observation	99218	99219	99220	99224	99225	99226
Admit/Discharge same day	99234	99235	99236			

NURSING FACILITY

	Initial Nursing Facility If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Nursing Facility If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.			
History	D or C	C	C	PF interval	EPF interval	D int.	C int.
Examination	D or C	C	C	PF	EPF	D	C
Complexity of MDM	SF or L	M	H	SF	L	M	H
	99304	99305	99306	99307	99308	99309	99310

Emergency Dept

	New/Established If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.								
History	PF	EPF	EPF	D	C				
Examination	PF	EPF	EPF	D	C				
Complexity of MDM	SF	L	M	M	H				
	99281	99282	99283	99284	99285				

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

TIME

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If all answers are "Yes", then level may be selected based on time.

Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)?	☐ Yes:	☐ No:
Does documentation reveal that more than half of time was counseling/coordination of care?	☐ Yes:	☐ No:
Does documentation describe the content of counseling/coordination of care?	☐ Yes:	☐ No:

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

HCPro

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feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

12) T.N.J., Medicaid Recipient # 4781079479

DOS: 12/01/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and the child was seen for an acute illness and the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 01/07/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and as the child was seen for an acute illness, the exam given does appear to be comprehensive. There is no indication that extensive data was reviewed or that the data was of extensive complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was high; therefore, Complexity of Medical Decision Making for this billed visit is not of high complexity. The Petitioner was not precluded from performing an EPSDT examination.

DOS: 01/25/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 02/09/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and the child was seen for an acute illness and the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

Laurens Pediatric Clinic v. SCDHHS

Docket Number : 15-ALJ-08-0109-AP

APPENDIX 4

-Letter from Chief Officer Mr. French requesting commentary on HcPro forms sent by SCDHHS; a blank HcPro form, my commentaries, some examples sent with the commentaries; two cases as follow:

-Case of Felipe, P.A. DOB 11/06/03 DOS 08/06/10

Enclosed are detailed claim reports of 05/2, 02/12, copy of office notes from original record, copy brought to the hearing as example by SCDHHS with name erased,with screening age guidelines, and unnamed HCPro form, followed by the named HcPro form sent in the package with the others upon court request. Next is my review, HcPro form commentary, my ruling. Again an ill child with a check up, whose respiratory illness had priority for coding , plus I was not an EPSDT provider. Billed correctly 99215 (moderate to high complexity, over 45 minutes. Demoted to 99212 (10 minutes, focused exam) by HcPro form but detailed claim reports of 02/12 and 05/12 with a judgement of 99393. Again proving that statements made by SCDHHS in the hearing, as being the tool for this audit were false!

- Case of M. Cook DOB 02/02/09; DOS 02/05/10

Enclosed are the office notes, detailed claim reports of 02/12 and 05/12 and the HCPro form. Again I billed correctly for high complexity, over 45 minutes, but the auditor in Feb 2012 demoted to 99213 (15minutes, low complexity), and in May 2012, upgrade it to 99214 (25 minutes moderate complexity). The change does not show in the HcPro form. For Judge Durden to know, I had a copy of the HCPro forms because I had to comment about them. The copy I am enclosing is my copy, as I could not find Malaysia Cook among the HCPro forms (pages R0266-R1073) in the record.

South Carolina Department of
Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

December 3, 2012

INTRA-AGENCY MAIL

Bruce Carter, Esquire
SCDHHS, Office of General Counsel
1801 Main Street, Suite 901
Columbia, South Carolina 29201

RE: Fair Hearing of Laurens Pediatric Clinic v. SCDHHS
Appeals' Case # 12-PA-024 (Program Assessment)

Dear Mr. Carter:

On November 29, 2012, I was forwarded the attached information from Pheobia Cooper in the SCDHHS Bureau of Rehabilitative and Medical Support Services. It appears that this is information that Dr. Nazario wished for me to review after the hearing on October 31, 2012. **Please send me any written comments about those records on or before December 31, 2012**. As soon as I receive your comments or after December 31, 2012, I will issue my Final Administrative Decision.

If you have any questions, you may call me at 1-800-763-9087.

Sincerely,

Robert French, Chief Hearing Officer
Division of Appeals and Hearings

Enclosure

cc: Dr. Nilsa Nazario, Laurens Pediatric Clinic, P.O. Box 1367, Laurens, SC 29360 (via Regular First Class mail)

Chief Complaint: YES NO **Pt. Name:** **MRN:**

HISTORY

HPI (History of Present Illness) ☐ Location ☐ Severity ☐ Timing ☐ Modifying factors ☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms						Brief 1-3 elements	Extended ≥4 elements or status of 2-3 chronic/ inactive conditions
ROS (Review of Systems) ☐ Constitutional (wt. Loss, etc) ☐ Eyes ☐ Ears, nose mouth, throat ☐ Card/vasc ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Integumentary (skin, breast) ☐ Neuro ☐ Psych ☐ Endo ☐ Hem/lymp ☐ Allergy/Immunological ☐ "All others negative"						None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"
PFSH (past medical, family and social history) ☐ Past medical history ☐ Family history ☐ Social history **No PFSH required for 99231-33, 99307-10**	Established/ Subsequent/ED					None	1 history area	2 or 3 history areas
	New/Initial					None	1 or 2 history area(s)	3 history areas
To determine History level, draw a line down the column with the circle farthest to the left.						PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

EXAM

1997 General Multi-System Exam						Problem Focused 1-5 elements	Exp. Prob Focused ≥ 6 elements	Detailed ≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas	Comp ≥ 2 elements in 9 areas
1995 Body Areas ☐ Head, including face ☐ Neck ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Genitalia, groin, buttocks ☐ Back, including spine ☐ Each extremity						Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	8 or more body areas/ systems
1995 Organ Systems ☐ Constitutional (vitals, gen app, etc) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/ Immuno						System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system
						PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

MEDICAL DECISION MAKING

A Number of Diagnoses or Treament Options

Problems to Exam Provider	Number	Points	Results
Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	=
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			

B Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2
TOTAL (TRANSFER TO MDM Summary section below)	

C Risk of Complications and/or Morbidity or Mortality

Risk Level*	Presenting Problem(s)	Diagnostic Procedure(s) Ordered		Management Options Selected
MIN	One self-limited or minor problem, e.g. cold, insect bite tinea corporis	Laboratory tests requiring venipuncture		Rest
		Chest x-rays	KOH prep	Gargle
		EKG/EEG	Urinalysis	Elastic Bandages
		Ultrasound e.g. echo		Superficial dressings
LOW	2 + self-limited or minor problems	Physiologic test not under stress e.g. pulmonary function tests.		Over-the-counter drugs
	1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH	Non-cardio. Imaging studies with contrast e.g. barium enema.		Minor surgery with no identified risk factors.
		Superficial needle bxs.		Physical therapy
	Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Clinical Lab test requiring arterial puncture.		Occupational therapy
		Skin biopsies.		IV fluids w/o additives
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test		Minor surgery with identified risk factors
	Two or more stable chronic illnesses	Diagnostic endoscopies with no identified risk factors		Elective major surgery (open percutaneous or endoscopic) with no identified risk factors
	Undiagnosed new problem with uncertain prognosis e.g. lump in breast	Deep needle or incisional bx		Prescription drug mgmt
	Acute illness with systemic symptoms e.g. pyelonephritis pneumonitis, colitis	Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath		Therapeutic nuc med
				IV fluids with additives
		Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis		Closed treament of fracture or dislocation without manipulation
	Acute complicated injury e.g. head injury with brief loss of consciousness			
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment.	Cardiovascular imaging studies with contrast with identified risk factors		Elective major surgery (open percutaneous or endoscopic) with identified risk factor
	Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure.	Cardiac electrophysiological tests		Emergency major surgery (open, percutaneous or endoscopic)
		Diagnostic endoscopies with identified risk factors		Parenteral controlled substances
		Discography		Drug therapy requiring intensive monitoring for toxicity
	An abrupt change in neurological status e.g. seizure, TIA			Decision not to resuscitate or de-escalate care because of poor prognosis

MDM SUMMARY

A Number of diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
B Amount and Complexity of Data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

HCPro

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OUTPATIENT, CONSULTS (Outpatient, Inpatient)

	New Office/Consults If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					Established Office If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of MDM	SF	SF	L	M	H		SF	L	M	H
New Office Visit Inpatient Consultation Office or Outpt. Consultation	99201 99251 99241	99202 99252 99242	99203 99253 99243	99204 99254 99244	99205 99255 99245	99211	99212	99213	99214	99215

INPATIENT

	Initial Hospital/Observation If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Inpatient/ Observaton Care If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of MDM	SF or L	M	H	SF or L	M	H
Hospital Admission Hospital Observation Admit/Discharge same day	99221 99218 99234	99222 99219 99235	99223 99220 99236	99231 99224	99232 99225	99233 99226

NURSING FACILITY

	Initial Nursing Facility If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Nursing Facility If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.			
History	D or C	C	C	PF interval	EPF interval	D int.	C int.
Examination	D or C	C	C	PF	EPF	D	C
Complexity of MDM	SF or L	M	H	SF	L	M	H
	99304	99305	99306	99307	99308	99309	99310

Emergency Dept

	New/Established If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.								
History	PF	EPF	EPF	D	C				
Examination	PF	EPF	EPF	D	C				
Complexity of MDM	SF	L	M	M	H				
	99281	99282	99283	99284	99285				

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

TIME

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If all answers are "Yes", then level may be selected based on time.

- Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)? ☐ Yes: ☐ No:
- Does documentation reveal that more than half of time was counseling/coordination of care? ☐ Yes: ☐ No:
- Does documentation describe the content of counseling/coordination of care? ☐ Yes: ☐ No:

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

HCPro

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December26, 2012

To: Chief Officer Mr. Robert French

Ref: Appeals case # 12-PA-024

Dear Mr. French:

I received package postmarked November 28, 2012 with 29 cases not all with HCPro form.

The following fatal errors are noted on the form HCPro, which could lead to the wrong CPT conclusion:

1- The bottom fine print of each form reads: "No claim asserted to CPT or any materials

copyrighted by the American Medical Association".

This audit refers to claims by DHHS of overpayment based on CPT guidelines and definitions, which I am appealing. Both parties gave to the court CPT codes definitions approved by the American Medical Association and these were introduced as evidence on the hearing of October 31, 2012.

2- The form on established patient office visits concludes that two of three elements give a code but ignores CPT code variations, like moderate to high complexity for a 99215. With the same guidelines the form renders a history not comprehensive if review of systems is less than four items. This is absurd when the scope of the questions goes from chronic illness, allergies, lead risk factors, operations, immunizations, snoring, in female adolescents- last menstrual period, blood transfusions, school history. For any pediatric standards the questions section in the progress notes submitted as evidence is comprehensive. For new patient encounters also the form errs on history and despite detailed complex history of birth, hospitalization, developmental milestones, family and social history deems all simple if review of systems has less than 10points which is absurd, and forces the least complex code when asking to choose theitem farthest to the left. The auditor consistently fails to properly credit points on part A and B of the Medical Decision Making (see enclosed examples).
It appears the form is a guideline at best to better document but does not comply with true CPT code definitions. Nowhere does it specify and mandate that it should be used for auditing purposes. HCPro is a for profit company helping health facilities prepare for joint commission reviews.

3- All forms where a change on the detailed claim report was granted after the informal hearing in March only reveal one CPT conclusion mostly the one revised in May 2012. It should be two forms one of February and one of May according to the detailed claim reports, added and presented by me to the court. The one HCPro form included in the package received for cases with revision, does not show the upgrade or changes from February vs May detailed claim reports .

4- In cases where an original credit was given to me in February and later removed and left as 0 on revision in May, the HCPro form is missing, as no EPSDT codes are in the form, but alternate coding guided form stating the credit and later the undoing of such is not available for either detailed claim report dates of February 2012 and May2012. Only a screening age appropriate form is given. (see enclosed examples)

5- The forms have no signature or initials of the person completing them nor do they have date of completion.

6- As I testified during the hearing in October 31st, I had never seen the form nor was it brought to my attention at the informal hearing.

7- The interpretation of the auditor in section C, is faulty at best in many instances of severe pediatric cases, extremely ill requiring respiratory rescue and /or injectable antibiotics or hydration. The form was meant for adults. As it is known in pediatric medicine, respiratory problems or dehydration could lead to life threatening shock in children, yet not detailed in the high risk column.

8- On medical decision making the section A is also quite consistently misinterpreted and many new problems with prescription (part of a work up planned), which gives a 4 rating are ignored, and deemed as 1 or 0. (see attached cases chosen as examples of faulty conclusions made by the auditor with this form).

9- On the medical decision making section B the auditor systematically ignores that the history was obtained from someone other than the patient-the guardian or parent , that breathing treatments and/ or injectables are part of order of test in the medicine section of CPT (for example: code 94640 is for breathing treatment and code J0696 for Rocephin (antibiotic)injectable).

10- On the MDM summary: the form also penalizes points by number of diagnoses. This is absurd as a simple diagnosis of Croup or one of Pneumonia for example do not make the decision making less complex, yet three simple diagnoses (eg. Pharyngitis, eczema, genital candidiasis) gain more points in decision making. Also, scores carried from section A to decide level of Medical Decision Making were wrongly chosen by the auditor, in many instances.

11- The back page describes for time of encounter in bold letters "Minimum face to face or unit/floor time"
It notes that codes of 99214 are 25minutes and 99215 are 40 minutes (yet CPT code definition says 45 minutes).
CPT codes allow by length of time to bill a higher code which is the way established patient visits were billed instead of EPSDT for checkups (many also with illness). In those visits, guidelines of EPSDT were followed, and in many instances it almost matched expected payment (eg.: if billed as 99214 the difference was $8.04 overpayment and if billed 99213 a credit of $17 was due to me). The few instances where by length of time I billed 99215 (about 45 minutes),without illness, I chose to correct down to 99214 or EPSDT coding yet at times the auditor incorrectly wanted to downgrade further to 99212(10 minutes) or 99213(15minutes). The auditor was unable to extrapolate from all the documentation approximate length of time that by common sense must have been taken with the patient in order to complete all documented items, even in sick visits with documented times in multiple interventions. Checkups without associated illness are lengthy, yet of low complexity – 99213, but by time of encounter they are 99214-25minutes or 99215-45minutes.

12- In summary, the form was consistently filled out wrongly by the auditor and CPT codes are hindered by the process of choosing the element in the middle or farthest to the left, and also variations are not allowed. The form is a tool for health facilities to improve documentation, thus, it downgrades and penalizes based on the missing element, rendering a lesser CPT code. This form states in fine print "no claim asserted to CPT", nor does it claim to be suitable for audit determinations.

The court has as evidence my records and extensive analysis of each visit based on CPT guidelines. A blank HCPro form was introduced as evidence with my objections at the hearing, but these filled out HCPro forms reviewed, were not presented as evidence at the time of the hearing on October 31st, except for just a few unnamed cases. The enclosed examples show how the forms were filled out in error by the auditor, achieving the wrong conclusion, but I had filed correctly to DHHS. Although I am presenting a few samples, the same errors systematically repeat throughout the cases.

I strongly object for DHHS to recoup $11,199.49, but only agree to disallow $1,396.76.

I appreciate the opportunity to make comments on the HCPro forms sent by DHHS.

Sincerely,

Nilsa I. Nazario, MD, FAAP
PO Box 1367, Laurens, SC 29360
864-483-0234 cell -best contact number due to the holidays

South Carolina Department of Health and Human Services
Detailed Claims Report

caid ID: 1780225362 FELIPE, PASCUAL ANDRES SSN: 657160818 DOB: 11/6/2003 County Elig: LAURENS
sehold ID: 100895118 Gender: M Race: 10 Phone: 8642003995 Street: P.O.BOX 1213 City: LAURENS Zip: 29360

IDER ID AND NAME	PAY TO# / PRESC ID	FDOS	LDOS	TY	POS / REF	DX CD / RX#	DIAG DESC / DEA CLASS	PROC CD / NDC	PROCEDURE / DRUG NAME	MOD / BMN	UOS / QTY	CHARGE / METRIC	PAID / METRIC	PAYMENT ERROR KEY	DISALLOW	COMMENT	PAID DT	CCN
15 NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.58				07/16/10	10193007908131 00A
15 NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				07/16/10	10193007908131 00A
015 NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	07/16/10	10193007908131 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95				08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.58				08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11				08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D1	$27.58	Incorrect code billed, doc. supports 99393	08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$10.00	$10.00	H1	$10.00	Included in EPSDT visit	08/20/10	10228006848105 00A
015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	4644	Croup	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	(D6)	$26.55	Documentation reviewed supports 99213 (Allow 99214)	01/28/11	11017006768100 00A
015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	4644	Croup	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				01/28/11	11017006768100 00A
015 NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$13.00				03/11/11	11064004708102 00A
015 NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00				03/11/11	11064004708102 00A
015 NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	03/11/11	11064004708102 00A
015 NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				03/11/11	11064004708102 00A
015 NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$95.99	D6	$67.90	Documentation reviewed supports 99212	08/26/11	11233004618100 00A
015 NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$2.92				08/26/11	11233004618100 00A
015 NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$15.08	A1	$15.08	Insufficient justification in med record for procedure/test	08/26/11	11233004618100 00A

REVISED TOTAL DISALLOWED $244.55

im Count:

dicaid Total Paid:
64.11

AO Total Paid:
EFI

edicaid and HMO Total Paid:
08.66

IN/MAX DOS:
24/2010 8/4/2011

IN/MAX PAID DT:
16/2010 8/26/2011

-421-

Page 1 of 1 5/15/201

South Carolina Department of Health and Human Services
Detailed Claims Report

d ID: 1780225362 FELIPE, PASCUAL ANDRES SSN: 657160818 DOB: 11/6/2003 County Elig: LAURENS
old ID: 100895118 Gender: M Race: 10 Phone: 8642003995 Street: P.O.BOX 1213 City: LAURENS Zip: 29360

PROVNAME	FROM	TO	ADM	DIS	AGE	DX	DESC	PROC	DESC	UNITS	ALLOW	PAID	TYPE	PAID	REMARKS	PAID	CLAIM
NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.58			07/16/10	10193007908131 00A
NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$9.22			07/16/10	10193007908131 00A
							+ sinusitis		ok 99214 diff 26.55								
NILSA I NAZARIO MD FAAP	137015	06/24/10	06/24/10	20	11	3829	Otitis Media NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	07/16/10	10193007908131 00A
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95				08/20/10	10228006848105 00A
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	36415	COLLECTION OF VENOUS BLOOD/VEN	0	1.00	$10.00	$2.58				08/20/10	10228006848105 00A
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11				08/20/10	10228006848105 00A
							+ sinusitis		ok 99215 complex + resp sx								
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D1	$27.58	Incorrect code billed, doc. supports 99393	08/20/10	10228006848105 00A
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				08/20/10	10228006848105 00A
									before 2/11 = not EPSDT pay								
NILSA I NAZARIO MD FAAP	137015	08/06/10	08/06/10	20	11	490	Bronchitis NOS	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$10.00	$10.00	H1	$10.00	Included in EPSDT visit	08/20/10	10228006848105 00A
							+ sinusitis + croup		ok 99214 diff 26.55								
NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	4644	Croup	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213	01/28/11	11017006768100 00A
NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	4644	Croup	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11				01/28/11	11017006768100 00A
NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	90460	IMMUN ADMIN <=AGE 18) ANY ROUT	0	1.00	$20.00	$13.00				03/11/11	11064004708102 00A
NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	90658	FLU VAC,SPLIT VIRUS,3YRS&UP,IN	0	1.00	$0.00	$0.00				03/11/11	11064004708102 00A
							+ HTN 25A		stopped 99214								
NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$45.55	Documentation reviewed supports 99212	03/11/11	11064004708102 00A
NILSA I NAZARIO MD FAAP	137015	01/29/11	01/29/11	20	11	27800	Obesity NOS	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$3.22				03/11/11	11064004708102 00A
							+ V20.2		99214 diff 26.55								
NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$95.99	D6	$67.90	Documentation reviewed supports 99212	08/26/11	11239004618100 00A
NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	81002	UA/DIP STK-TBLT W/O MICRO NONA	0	1.00	$10.00	$2.92				08/26/11	11239004618100 00A
							+		before school exam								
NILSA I NAZARIO MD FAAP	137015	08/04/11	08/04/11	20	11	27802	Overweight	92552	PURE TONE AUDIOMETRY AIR ONLY	0	1.00	$20.00	$15.08	A1	$15.08	Insufficient justification in med record for procedure/test	08/26/11	11239004618100 00A

TOTAL DISALLOWED $269.89

Count:
Paid Total Paid:
Total Paid:
Paid and HMO Total Paid:

MAX DOS:
MAX PAID DT:

Felipe, Pascual Andres

Ok to disallow

06/24/10 $26.55

01/03/11 $26.55

08/04/11 $26.55

Total $79.65 ok to disallow

-125-

2/1/2012

3041 D Bianco Dr
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

11-06-03

Name Pascual Andres-Felipe

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
X Blood Drawing		
___ Hematrocrit		
X Hearing Test		
X Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
X Resp Treatment x $10.00 each tx 1x 2P		
___ Urine Cath		
___ EKG, LLII		
___ Immunization Type ___		
___ Antibiotic Type ___		
X Urine		
___ Cognitive Assessment		
X Train or nebulizer/Inhaler		
___ Other ___		

Pranza, Chicken, Fish, Wheat, No yogurt
Leche (Breakfast) Arroz

Date 08/06/2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2wks PPV23 ___ Check = Medicaid

Diagnoses Sequela Inf/Bronchitis Amount Paid ___

lung Albuterol + Budesonide 1 Pulmicort AM/PM

Cetirizine/Singulair

Nilsa I. Nazario, M.D., F.A.A.P.
Pediatric Clinic

915 West Main Street Laurens, S.C. 29360
Tel Fax (864) 984-4158 Tel (864) 984-4263

Date of service 08 06 10
Accompanying Adult: F
Patient's Name: Pascual Andres Felipe
Tel. 200-0920
Address: 304 D Bronco Dr Laurens SC 29360
DOB: 11/06/03 7yo
Last OV: / /

ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa,Cephalosporins
Other: ∅
Current Medications:

Chronic Illnesses:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: ∅
Blood Transfusions: Year ∅, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead
Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: 5k ; Grade Avg:_____ Problems? Yes No
Adolescent females only: LMP month_____/Year_____
4 y/o or older: Bedwetting? (NO)_____, YES_____(Day/ Night)
Snoring? No Yes_____(How long?_____)
Reason for this visit: Check, Because start school in next week

Physical Exam-Pertinent VS and Findings:
HR 76/min, RR 16 /min, Temp. 98.2 F(ax, oral, rectal), BP 90/50.
Wt. 70 3/4 # Ht. 46" , HC
Pertinent Findings:
Gen: A & N 10 overweight
Positive for:
___Head and Neck Tender & enlarged.
___Respiratory: bilateral rales + prolonged expiration at bases
___Cardiovascular: RR no M
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System:
___Skin: Obese Large purpuric lesions. marks on legs
___Psychiatric:
Interventions: Vision: OU 20/20, OD, OS 20/30 Not color blind.
Hearing: Passed all all tones @ 25dBHL
Urine:

allergies reviewed

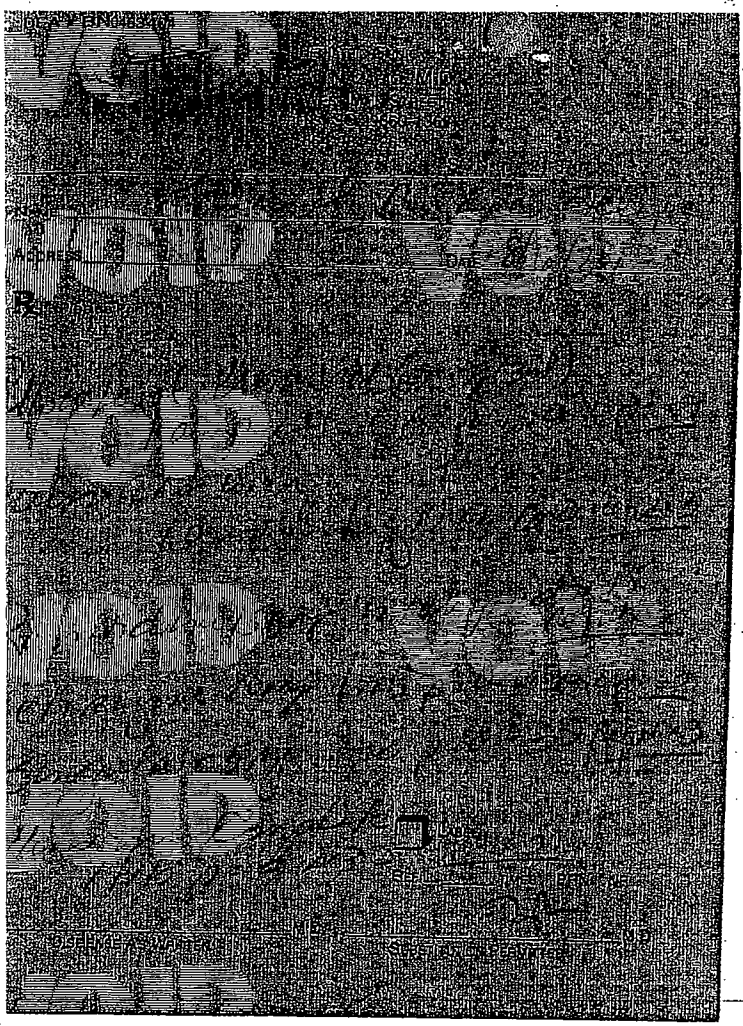
Diagnosis(es):

CBC/Lead/PE urine. allergy panels x2 TSH+ free T4 mono

Plan:
Prom on neb
Zyrtec 0.63mg + Pulm 0.5 neb q6h x2 days
TIPPS: YES NO
Anticipatory Guidance YES NO

Flu in 2wks. VZV + PPV 23

no candy. / due to recurrent Bronchitis albuterol x 1 year.



MULTISTIX 10 SG

8/6/10 Pascual Felipe 3:20 pm

LEUKOCYTES	NEGATIVE			TRACE	SMALL +	MODERATE ++	LARGE +++			
NITRITES	NEGATIVE				POSITIVE					
UROBILINOGEN	NORMAL				2	4	8			
PROTEIN	NEGATIVE	TRACE		30	100	300	2000 or More			
PH	5.0	6.0	6.5	7.0	7.5	8.0	8.5			
BLOOD	NEGATIVE	NON-HEMOLYZED TRACE	MODERATE	HEMOLYZED TRACE	SMALL +	MODERATE ++	LARGE +++			
SPECIFIC GRAVITY	1.000	1.005	1.010	1.015	1.020	1.025	1.030			
KETONES	NEGATIVE		TRACE 5	SMALL 15	MODERATE 40	80	LARGE 160			
BILIRUBIN	NEGATIVE				SMALL +	MODERATE ++	LARGE +++			
GLUCOSE	NEGATIVE		100	250	500	1000	2000 or M			

LAURENS HOME MEDICAL SERVICES
22 SIRRINE STREET
LAURENS, SC 29360-0000
(864)984-1010 Fax: (864)984-1011
(000)000-0000

Telephone No
Cell: 200-0920
Day:
Night:

Account No:
Name: Pascual Andres Felipe
Address 1:
Address 2: 304 D Bronco Dr
City, State Zip: Laurens SC 29360.

Scheduled Date of Service: 08/06/10
Actual Date of Service: 08/06/10
Invoice #:
PO Number #:
MEDICAID SC 1780225362

D.O.B. 11-06-03
Patient Technician:

Line	Qty Ordered	Equipment Code		Description	Rx #	Qty Shipped	Service
1	1 EA	E0570		NEBULIZER WITH COMPRESSOR	058558		DELIVER
SMCD	Service Type		SALE	Serial #: ML10030714S.			180.00
2	2 EA	A7003		ADMIN SET\SM VOL NONFILT PNEU NEBULIZER	058558		DELIVER
SMCD	Service Type		SALE	Lot #:			8.16
3	2 EA	A7004		SM VOL NONFILTERED PNEUMATIC NEBULIZER\\	058558		DELIVER
SMCD	Service Type		SALE	Lot #:			4.60
4	2 EA	A7015		AEROSOL MASK USED W/DME NEBULIZER	058558		DELIVER
SMCD	Service Type		SALE	Lot #:			8.16

licare or my insurance has not purchased or rented same or similar items stated above. JB (Initials)

terms of the agreement on the reverse side hereof are incorporated herein and are part hereof, and I acknowledge I have read the same and received a copy eof. Read the contract agreement on reverse side of this invoice.

HORIZATION TO ASSIGN BENEFITS TO PROVIDER & RELEASE OF MEDICAL INFORMATION:

est that payment of authorized Medicare and other benefits be made on my behalf to the above company for products and services that they have provided for me. I further authorize a copy of greement to be used in place of the original and authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents or , any information needed to determine these benefits or compliance with current healthcare standards.

ature of Patient X Jaime Bottazzo Date/Time
ned by caregiver or other, list relationship and reason for signing.)

rtionship if not patient: (Circle one) Address above unless stated: Spouse/Relative Caregiver Other

livery_____ Pick-Up_____ Height: 0 0 Weight: 0 Contact Made_____ Yes_____ No___

Fitted for:
Left / Right

Tax: 0.00
Due / Copay: 0.00
Total: 200.92

red by: DR. NILSA NAZARIO
Doctor: NILSA NAZARIO
Salesperson: CHRIS ROBERTS
Operator: CHRIS ROBERTS
10/22/2009 7:23PM

Explain maintenance and cleaning procedures
Basic home safety assessment performed
Warranty Information Provided
Has Received Rights and Responsibilities

Customer Evaluation Form
Information on Company products and services
Training on safe and proper use of equipment
Repair Policy Explained
Written Instructions Provided

CASH RECEIVED:_____
BY: P.G.

EIVED BY: Jaime Bottazzo

99215 36415 81002 --
94664 94640 92552

Nilsa F. Nazario, M.D., F.A.A.P.
Pediatric Clinic
915 West Main Street Laurens, S.C. 29360
Tel Fax (864) 984-4158 Tel (864) 984-4263

Date of service 08 06 10
Accompanying Adult: F
Patient's Name:
Tel.
Address:
Last OV: / /
DOB: 10/06/03 7yo
ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other:
Current Medications:
Chronic Illnesses:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations:
Blood Transfusions: Year , Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: 5k ; Grade Avg: Problems? Yes No
Adolescent females only: LMP month /Year
4 y/o or older: Bedwetting? NO YES (Day/ Night)
Snoring? No Yes (How long?)
Reason for this visit: Check, Because start school in next week

Physical Exam-Pertinent VS and Findings:
HR 76/min, RR 16 /min, Temp. 98.2 F (ax, oral, rectal), BP 90/50.
Wt. 70 3/4 lbs Ht. 46" , HC
Pertinent Findings:
Gen: A & O x 10 well nourished
Positive for:
Head and Neck tender ETM scarring.
Respiratory: bilateral rales + prolonged expiration at bases
Cardiovascular: RRR no MM
Gastrointestinal:
Genito-Urinary:
Musculoskeletal:
Nervous System:
Skin: Obs. large mosquito bites. marks on legs
Psychiatric:
Interventions: Vision: OU 20/30, OD, OS 20/30 Not color blind.
Hearing: Passed all tones @ 25dBHL
Urine:
Diagnosis(es):
Plan:
TIPPS: YES NO
Anticipatory Guidance YES NO

CBC/diff/PT/PTT
urine.
allergy panel x2
TSH+ free T4
ANA

Flu inj. Zith. vial + PPSV23
no candy.) due + recurrent Bronchitis

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

11-06-03

Name

Patient's Receipt

Service Given	Code	Paid
X Medical Exam		
X Blood Drawing		
___ Hematrocrit		
X Hearing Test		
X Vision Screening		
___ Tympanometry		
___ Blood Sugar (Accu-Check)		
X Resp Treatment x $10.00 each tx 1x 2P		
___ Urine Cath		
___ EKG, LLI		
___ Immunization Type ___		
___ Antibiotic Type ___		
X Urine		
___ Cognitive Assessment		
X Train or nebulizer/Inhaler		
___ Other ___		

Pranicin, Chlor-Trimeton, Tylenol, Motrin, Nystatin
Lectra (Pricetabulated) Amp/Pm

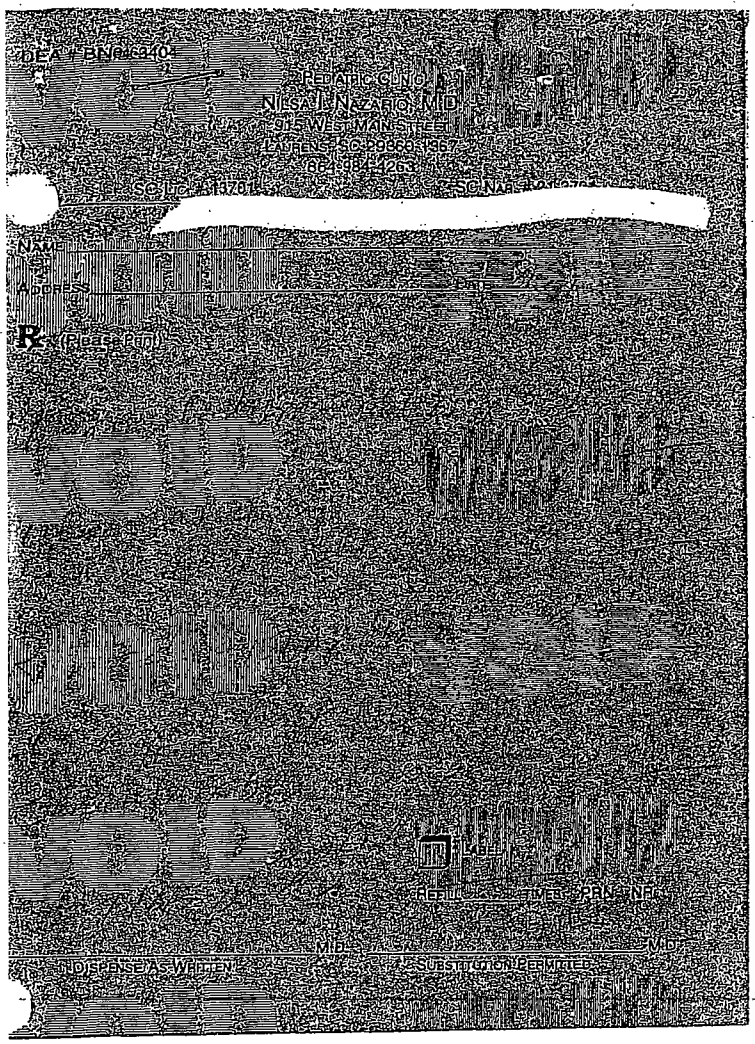
Date 08/06/2010 Method of Payment ___ Cash ___ VISA/MC

Follow-up 2wks PPV23 ___ Check ___ Medicaid

Diagnoses Sinusitis / Bronchitis Amount Paid ___

lamp Albuterol + Budesonide 3 Pulmicort Am/Pm

Cetirizine/Singulair


DEA # BN
PEDIATRIC CLINIC
NILSA L. NAZARIO, MD
911 WEST MAN ST
LUTHER, OK 73054-9668
(405) 277-4263
SS#: 447-01-
NAME
ADDRESS
Rx (Please Print)
REFILL
TIMES PRN
MD
DISPENSE AS WRITTEN
SUBSTITUTION PERMITTED
MD

8/6/10 3:20 pm

LEUKOCYTES	NEGATIVE ☑	TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐	
NITRITES	NEGATIVE ☑	POSITIVE ☐				
UROBILINOGEN	NORMAL ☑	2 ☐	4 ☐	8 ☐		
PROTEIN	NEGATIVE ☐	TRACE ☑	30 ☐	100 ☐	300 ☐	2000 or More ☐
PH	5.0 ☐	6.0 ☐	6.5 ☐	7.0 ☑	7.5 ☐	8.0 ☐	8.5 ☐
BLOOD	NON-HEMOLYZED NEGATIVE ☑	NON-HEMOLYZED TRACE ☐	NON-HEMOLYZED MODERATE ☐	HEMOLYZED TRACE ☐	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐
SPECIFIC GRAVITY	1.000 ☐	1.005 ☐	1.010 ☑	1.015 ☐	1.020 ☐	1.025 ☐	1.030 ☐
KETONES	NEGATIVE ☑	TRACE 5 ☐	SMALL 15 ☐	MODERATE 40 ☐	80 ☐	LARGE 160 ☐	
BILIRUBIN	NEGATIVE ☑	SMALL + ☐	MODERATE ++ ☐	LARGE +++ ☐		
GLUCOSE	NEGATIVE ☑	100 ☐	250 ☐	500 ☐	1000 ☐	2000 or Mc ☐

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SCREENING AGE GUIDELINES

AGE	2 wk	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20 yr
HISTORY Initial or Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEAD CIRCUMFERENCE	X	X	X	X	X	X	X	X	X											
BLOOD PRESSURE										X	X	X	X	X	X	X	X	X	X	X
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IMMUNIZATION ASSESSMENT*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT				X		X			X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAMINATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DENTAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEARING SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HCT OR HGB **				X																
HEALTH EDUCATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
URINALYSIS ***												X								
LEAD Assessment ****					X				X											

* Immunization schedule may vary according to recommendations from the American Academy of Pediatrics (AAP) and the Advisory Committee.

** Test should be performed between 6 - 9 months and at least once for menstruating females.

*** A urinalysis should be performed on all children at five years of age and a dipstick urinalysis should be performed for leukocytes for sexually active male and female adolescents.

**** Assessment of individual/family history of lead exposure/symptoms, environment, and personal risk factors should be obtained and documented at 9 months to 12 months and again at 24 months.

Chief Complaint: YES NO **Pt. Name:** **MRN:**

HISTORY

HPI (History of Present Illness)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms

		Brief 1-3 elements		Extended ≥4 elements or status of 2-3 chronic/ inactive conditions

ROS (Review of Systems)

☐ Constitutional (wt. Loss, etc) ☐ Ears, nose mouth, throat ☐ GI ☐ GU ☐ Integumentary (skin, breast) ☐ Endo ☐ Hem/lymp
☐ Eyes ☐ Card/vasc ☐ Musculo ☐ Neuro ☐ Allergy/Immunological
☐ Resp ☐ Psych ☐ "All others negative"

None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"

PFSH (past medical, family and social history)

☐ Past medical history
☐ Family history
☐ Social history

No PFSH required for 99231-33, 99307-10

Established/ Subsequent/ED		None	1 history area	2 or 3 history areas
New/Initial		None	1 or 2 history area(s)	3 history areas
To determine History level, draw a line down the column with the circle farthest to the left.		PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED / COMPRE-HENSIVE

EXAM

1997 General Multi-System Exam

Problem Focused 1-5 elements	Exp. Prob Focused ≥ 6 elements	Detailed ≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas	Comp ≥ 2 elements in 9 areas

1995 Body Areas

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Genitalia, groin, buttocks ☐ Back, including spine
☐ Neck ☐ Abdomen ☐ Each extremity

Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	8 or more body areas/ systems

1995 Organ Systems

☐ Constitutional (vitals, gen app, etc) ☐ Ears, nose, mouth, throat ☐ Resp ☐ GI ☐ Musculo ☐ Skin ☐ Psych ☐ Hem/lymph/ Immuno
☐ Eyes ☐ Cardiovascular ☐ GU ☐ Neuro

System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system
PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

MEDICAL DECISION MAKING

A Number of Diagnoses or Treament Options

Problems (to Examiner)	Number	Points	Results
Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	=
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			0

B Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2
TOTAL (TRANSFER TO MDM Summary section below)	0

C Risk of Complications and/or Morbidity or Mortality

MIN	One self-limited or minor problem, e.g. cold, insect bite tinea corporis	Laboratory tests requiring ~~venipuncture~~ ~~Chest x-rays~~ KOH prep EKG/EEG Urinalysis Ultrasound e.g. echo	Rest Gargle Elastic Bandages Superficial dressings
LOW	2 + self-limited or minor problems 1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Physiologic test not under stress e.g. pulmonary function tests. Non-cardio. Imaging studies with contrast e.g. barium enema. Superficial needle bxs. Clinical Lab test requiring arterial puncture. Skin biopsies.	Over-the-counter drugs Minor surgery with no identified risk factors. Physical therapy Occupational therapy IV fluids w/o additives
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis e.g. lump in breast Acute illness with systemic symptoms e.g. pyelonephritis pneumonitis, colitis Acute complicated injury e.g. head injury with brief loss of consciousness	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional bx Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open percutaneous or endoscopic) with no identified risk factors Prescription drug mgmt Therapeutic occ med IV fluids with additives Closed treament of fracture or dislocation without manipulation.
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment. Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurological status e.g. seizure, TIA	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open percutaneous or endoscopic) with identified risk factor Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or de-escalate care because of poor prognosis

MDM SUMMARY

	≤ 1	2	3	≥ 4
A Number of diagnoses or treatment options	Minimal	Limited	Multiple	Extensive
B Amount and Complexity of Data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

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OUTPATIENT, CONSULTS (Outpatient, Inpatient)

	New Office/Consults If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					Established Office If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	C
Complexity of MDM	SF	SF	L	M	H		SF	L	M	H
New Office Visit	99201	99202	99203	99204	99205					
Inpatient Consultation	99251	99252	99253	99254	99255	99211	99212	99213	99214	99215
Office or Outpt. Consultation	99241	99242	99243	99244	99245					

INPATIENT

	Initial Hospital/Observation If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Inpatient/ Observaton Care If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of MDM	SF or L	M	H	SF or L	M	H
Hospital Admission	99221	99222	99223	99231	99232	99233
Hospital Observation	99218	99219	99220	99224	99225	99226
Admit/Discharge same day	99234	99235	99236			

NURSING FACILITY

	Initial Nursing Facility If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			Subsequent Nursing Facility If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.			
History	D or C	C	C	PF interval	EPF interval	D int.	C int.
Examination	D or C	C	C	PF	EPF	D	C
Complexity of MDM	SF or L	M	H	SF	L	M	H
	99304	99305	99306	99307	99308	99309	99310

Emergency Dept

	New/Established If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.								
History	PF	EPF	EPF	D	C				
Examination	PF	EPF	EPF	D	C				
Complexity of MDM	SF	L	M	M	H				
	99281	99282	99283	99284	99285				

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

TIME

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If all answers are "Yes", then level may be selected based on time.

Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)?	❑ Yes:	❑ No:
Does documentation reveal that more than half of time was counseling/coordination of care?	❑ Yes:	❑ No:
Does documentation describe the content of counseling/coordination of care?	❑ Yes:	❑ No:

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

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Chief Complaint: YES NO Pt. Name: Andres-Felipe P MRN: 8/6/10

HISTORY

HPI (History of Present Illness)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms

	Brief 1-3 elements		Extended ≥4 elements or status of 2-3 chronic/ inactive conditions

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☐ Eyes ☐ Card/vasc ☐ Musculo ☐ Neuro ☐ Psych ☐ Resp ☐ "All others negative"

None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"

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New/Initial		None	1 or 2 history area(s)	3 history areas
To determine History level, draw a line down the column with the circle farthest to the left.	PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

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1997 General Multi-System Exam

Problem Focused 1-5 elements	Exp. Prob Focused ≥ 6 elements	Detailed ≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas	Comp ≥ 2 elements in 9 areas

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☐ Neck ☐ Abdomen ☐ Each extremity

Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	8 or more body areas/ systems

1995 Organ Systems

☐ Constitutional (vitals, gen app, etc) ☐ Eyes ☐ Ears, nose, mouth, throat ☐ Cardiovascular ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/ immuno

System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system
PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

MEDICAL DECISION MAKING

A Number of Diagnoses or Treament Options

Problems (Diagnosis or Management Options)	Number	Points	Totals
Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	=
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			0

B Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2
TOTAL (TRANSFER TO MDM Summary section below)	4

C Risk of Complications and/or Morbidity or Mortality

Level	Presenting Problem	Diagnostic Procedure Ordered	Management Options Selected
MIN	One self-limited or minor problem, e.g. cold, insect bite tinea corporis	Laboratory tests requiring venipuncture Chest x-rays / KOH prep EKG/EEG / Urinalysis Ultrasound e.g. echo	Rest Gargle Elastic Bandages Superficial dressings
LOW	2 + self-limited or minor problems 1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Physiologic test not under stress e.g. pulmonary function tests. Non-cardio. imaging studies with contrast e.g. barium enema. Superficial needle bxs. Clinical Lab test requiring arterial puncture. Skin biopsies.	Over-the-counter drugs Minor surgery with no identified risk factors. Physical therapy Occupational therapy IV fluids w/o additives
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis e.g. lump in breast Acute illness with systemic symptoms e.g. pyelonephritis pneumonitis, colitis Acute complicated injury e.g. head injury with brief loss of consciousness	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional bx Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open percutaneous or endoscopic) with no identified risk factors Prescription drug mgmt Therapeutic nuc med IV fluids with additives Closed treament of fracture or dislocation without manipulation
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment. Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurological status e.g. seizure, TIA	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open percutaneous or endoscopic) with identified risk factor Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or de-escalate care because of poor prognosis

MDM SUMMARY

	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
A Number of diagnoses or treatment options	Minimal	Limited	Multiple	Extensive
B Amount and Complexity of Data	≤ 1 Minimal or Low	Limited	Moderate	Extensive
C Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

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OUTPATIENT, CONSULTS (Outpatient; Inpatient)

New Office/Consults

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	PF	EPF	D	C	C
Examination	PF	EPF	D	C	C
Complexity of MDM	SF	SF	L	M	H
New Office Visit	99201	99202	99203	99204	99205
Inpatient Consultation	99251	99252	99253	99254	99255
Office or Outpt. Consultation	99241	99242	99243	99244	99245

Established Office

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

Minimal problem that may not require presence of physician	PF	EPF	D	C
	PF	EPF	D	C
	SF	L	M	H
	99211	99212	99213	99214	99215

INPATIENT

Initial Hospital/Observation

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	D or C	C	C
Examination	D or C	C	C
Complexity of MDM	SF or L	M	H
Hospital Admission	99221	99222	99223
Hospital Observation	99218	99219	99220
Admit/Discharge same day	99234	99235	99236

Subsequent Inpatient/ Observaton Care

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

PF interval	EPF interval	D interval
PF	EPF	D
SF or L	M	H
99231	99232	99233
99224	99225	99226

NURSING FACILITY

Initial Nursing Facility

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	D or C	C	C
Examination	D or C	C	C
Complexity of MDM	SF or L	M	H
	99304	99305	99306

Subsequent Nursing Facility

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

PF interval	EPF interval	D int.	C int.
PF	EPF	D	C
SF	L	M	H
99307	99308	99309	99310

Emergency Dept

New/Established

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	PF	EPF	EPF	D	C
Examination	PF	EPF	EPF	D	C
Complexity of MDM	SF	L	M	M	H
	99281	99282	99283	99284	99285

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)?	❑ Yes:	❑ No:
Does documentation reveal that more than half of time was counseling/coordination of care?	❑ Yes:	❑ No:
Does documentation describe the content of counseling/coordination of care?	❑ Yes:	❑ No:

If all answers are "Yes", then level may be selected based on time.

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

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10-Felipe, Pascual Andres-11/06/03DOB

DOS 06/24/10 Dx: OTM, Sinusitis, School Entrance exam
Q+, E+, I: vision, hearing, blood drawn, urine,Rx+
Hearing not billed
Filed 99215 but AGREE to change to 99214
AGREE to disallow $26.55

DISAGREE to disallow to 99213 for $51.89

DOS 08/06/10 Dx: Bronchitis, Sinusitis
Q+, E+, I: Xopenex (sample), 2 Pulmicort (not billable), 8 L indirect oxygen, avoidance of allergens, trained on nebulizer, urine, blood, vision, hearing
Filed 99215 NOT 93993, hearing test is not included
DISAGREE to disallow $27.58 for visit & $10 for hearing test

DOS 01/03/11 Dx: Sinusitis, Early Croup, Overweight
Q+, E+, I: Racemic Epinephrine and Pulmicort (not billable), urine
Thus 99215 NOT 99214
NOTE: I had agreed to 99214, but visit reviewed stays 99215
DISAGREE to disallow $26.55

##DOS 01/29/11 Dx: Overweight, nasal sore
Q+, E+, I: urine, flu shot, wt reduction diet/exercise
Thus 99214 NOT 99212
STRONGLY DISAGREE to disallow $45.55

DOS 08/04/11 Dx: Overweight, V20.2
Q+,E+, I: vision, hearing, blood drawn, urine
School Entrance exam, filed 99215
ONLY AGREE to disallow to 99214 for $26.55
STRONGLY DISAGREE to 99212 for $67.90

TOTAL AGREED TO DISALLOW $53.10

173 Watson St
Laurens SC 29360
and
156 Woodson St
Laurens SC 29360

NILSA I. NAZARIO, M.D.
Pediatric Clinic
915 W. Main Street • Laurens, SC
(864) 984-4263

2-2-09

Name Malaysia Cook

Patient's Receipt

Service Given	Code	Paid
b Medical Exam		
Blood Drawing		
Hematrocrit		
Hearing Test		
Vision Screening		
Tympanometry		
Blood Sugar (Accu-Check)		
p Resp Treatment x $10.00 each tx X 2p		
Urine Cath		
EKG, LLII		
Immunization Type		
b Antibiotic Type Rocephin 500mg (2units) IM Q day by MD. NDC 00505-0752-01		
Urine		
Cognitive Assessment		
X Train or nebulizer/Inhaler		
Other		

Date 2/5/10 Method of Payment ___ Cash ___ VISA/MC

Follow-up 1 week. ___ Check ___ Medicaid

Diagnoses OM / Mastoiditis

Amount Paid

Tonsils 3+

Bronchospasm

Nilsa F. Nazario, M.D., F.A.A.P.
Pediatric Clinic
913 West Main Street Laurens, S.C. 29360
Tel - Fax (864) 984-4158 Tel (864) 984-4263

Date of service: 2/5/10
Accompanying Adult: grandmother
Patient's Name: Malaysia Cook
Tel. 200-5136 / 981-7760
Address: 173 Watson St Laurens SC 29360
Last OV: 10/29/09
DOB: 2/2/09

ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: Ø
Current Medications:

Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: Ø
Blood Transfusions: Year_____, Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead
Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade:_____; Grade Avg:_____ Problems? Yes No
Adolescent females only: LMP month_____/Year_____
4 y/o or older: Bedwetting? NO____, YES_____ (Day/ Night)
Snoring? No____, Yes_____ (How long?_____)
Reason for this visit: congested, fever, trouble breathing at night
Stuffy nose, machine burned up in a house fire.

Physical Exam-Pertinent VS and Findings:
HR 116 /min, RR 28 /min, Temp. 97.5 F (ax, oral, rectal), BP ___T___
Wt. 20th 14oz Ht. 29", HC 17 1/8
Pertinent Findings:
Gen: A A NAD. cryful
Positive for:
___Head and Neck: erythematous TM's, erythematous rhinorrhea
___Respiratory: ↓ air movement
___Cardiovascular:
___Gastrointestinal:
___Genito-Urinary:
___Musculoskeletal:
___Nervous System:
___Skin: OK
___Psychiatric:
Interventions:
2:35pm Xopenex 1.25 + pulmicort 0.5mg x 2 + 10 L IN O2
4 after tx playful + smiling
Pain after tx

Diagnosis(es):

Plan: 3:15pm Rocephin 500mg IM @ thigh by MD
NDC 60505-0752-01
See copy Rx + Receipt
TIPPS: YES NO
Anticipatory Guidance YES NO

Flu in knee

Malaysia Cook 2/5/2010

AM

Ranitidine 1ml → Carafate 1tsp → Cephalexin 1tsp

→ Zithromax 1tsp (today) 1/2tsp for 4 days. → Orapred 1 tab → Tussin DM 1/2tsp

PM

Tussin DM 1/2tsp → Cephalexin 1tsp

Treatments 1/2amp Albuterol + Pulmicort 0.5mg
7-4-10

20z water + 20z Pedialyte cucumber. Boiled chicken carrots + potatoes.

DEA # BN0483404

Pediatric Clinic
Nilsa L. Nazario, M.D.
915 W. Main Street
Laurens, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC Nat'l # 213701

NAME

ADDRESS DATE

℞ (Please Print)

☐ Label

Refill Times (Print) M.D.

Dispense As Written M.D. Substitution Permitted M.D.

DEA # BN0483404

Pediatric Clinic
Nilsa L. Nazario, M.D.
915 W. Main Street
Laurens, SC 29360-1367
864-984-4263

SC Lic. # 13701 SC Nat'l # 213701

NAME

ADDRESS DATE

℞ (Please Print)

☐ Label

Refill Times (Print) M.D.

Dispense As Written M.D. Substitution Permitted M.D.

South Carolina Department of Health and Human Services
Detailed Claims Report

Medicaid ID: 5780979667 COOK, MALAYSIA T SSN: 668307460 DOB: 2/2/2009 County Elig: LAURENS
Household ID: 100130674 Gender: F Race: 2 Phone: 8649816434 Street: 100 WRIGHT ST City: LAURENS Zip: 29360

PROVIDER ID AND NAME	PAY PROV	FROM	TO	PLACE	TYPE	REV	DIAG	DIAG DESC	PROC CD	PROCEDURE	MOD	UNITS	CHARGES	PAID	REASON	MA AMT	EXPLANATION	PAYMENT #	CHECK #
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490		Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95					12/04/09 09927002388100
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490		Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11					12/04/09 09927002388100
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490		Bronchitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37					12/04/09 09927002388100
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607		Wheezing	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$51.89	Documentation reviewed supports 99213		02/19/10 10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607		Wheezing	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95					02/19/10 10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607		Wheezing	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11					02/19/10 10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.98					08/13/10 10218005748104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D1	$0.54	Incorrect code billed, doc. supports 99392		08/13/10 10218005748104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	90471	IMMUNIZATION ADM-VACCINE/TOXOI	0	1.00	$20.00	$13.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	90698	DTAP-HIB-IP VACCINE, INTRAMUSC	0	1.00	$0.00	$0.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$20.00	$13.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$0.00	$0.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202		Routin Child Health Exam	90716	IMMUNIZATION ACTIVE VARICELLA	0	1.00	$0.00	$0.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	08/20/10	08/20/10	20	11	4739		Chronic Sinusitis NOS	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00					08/13/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	10/08/10	10/08/10	20	11	4739		Chronic Sinusitis NOS	99213	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$50.00	$50.00					08/19/10 10218005798104
137015 NILSA I NAZARIO MD FAAP	137015	10/08/10	10/08/10	20	11	4739		Chronic Sinusitis NOS	94640	AIRWAY INHALATION TREATMENT	0	5.00	$50.00	$10.11					11/19/10 10319001288103
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486		Pneumonia, Organism NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$26.55	Documentation reviewed supports 99214		11/19/10 10319001288103
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486		Pneumonia, Organism NOS	94640	AIRWAY INHALATION TREATMENT	0	3.00	$30.00	$10.11					02/04/11 11030000358116
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486		Pneumonia, Organism NOS	J0696	INJEC CEFTRIAXONE SODIUM PER 2	0	2.00	$30.00	$2.14					02/04/11 11030000358116
137015 NILSA I NAZARIO MD FAAP	137015	01/06/11	01/06/11	20	11	46619		Acu Bronchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.54	Documentation reviewed supports 99213		02/04/11 11030000958116
137015 NILSA I NAZARIO MD FAAP	137015	02/18/11	02/18/11	20	11	46619		Acu Bronchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.54	Documentation reviewed supports 99213		03/11/11 11064004728102
137015 NILSA I NAZARIO MD FAAP	137015	04/14/11	04/14/11	20	11	462		Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213		04/01/11 11085009068105
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929		Dermatitis NOS	85013	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.89					05/20/11 11135004168118
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929		Dermatitis NOS	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61					05/20/11 11135004168118
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929		Dermatitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213		05/20/11 11135004168118
137015 NILSA I NAZARIO MD FAAP	137015	05/19/11	05/19/11	20	11	5289		Cellulitis/Abscess Mouth	90633	HEP A VACCINE PED/ADOL DOS I2	0	1.00	$0.00	$0.00					05/20/11 11135004168118
137015 NILSA I NAZARIO MD FAAP	137015	08/16/11	08/16/11	20	11	75		Infectious Mononucleosis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213		05/20/11 11135004168118
																			06/24/11 11169001998591
																			09/02/11 11240005658100

Claim Count:
29

Medicaid Total Paid:
$3,058.62

HMO Total Paid:
$141.41

Medicaid and HMO Total Paid:
$3,200.03

TOTAL DISALLOWED $204.41

South Carolina Department of Health and Human Services
Detailed Claims Report

Medicaid ID: 5780979687 COOK, MALAYSIA T SSN: 658307450 DOB: 2/2/2009 County Elig: LAURENS
Household ID: 100130674 Gender: F Race: 2 Phone: 8849816434 Street: 100 WRIGHT ST City: LAURENS Zip: 29360

137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490	Bronchitis NOS	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95					12/04/09	09327002388100
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490	Bronchitis NOS	94640	AIRWAY INHALATION TREATMENT	0	2.00	$20.00	$10.11					12/04/09	09327002388100
137015 NILSA I NAZARIO MD FAAP	137015	10/29/09	10/29/09	20	11	490	Bronchitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37					12/04/09	09327002388100
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607	Wheezing	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	(D6)	$26.55	Documentation reviewed supports 99213 (Allow 99214)	02/19/10	10044002578121	
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607	Wheezing	94664	DEMO/EVAL PATIENT USE OF INHAL	0	1.00	$20.00	$10.95					02/19/10	10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	02/05/10	02/05/10	20	11	78607	Wheezing	94640	AIRWAY INHALATION TREATMENT	0	1.00	$20.00	$10.11					02/19/10	10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	85018	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$30.00	$10.11					02/19/10	10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37					02/19/10	10044002578121
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90471	IMMUNIZATION,ADM-VACCINE/TOXOI	0	1.00	$20.00	$19.00					08/13/10	10218005748104000
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90698	DTAP-HIB-IP VACCINE, INTRAMUSC	0	1.00	$20.00	$19.00	D1	$0.34	Incorrect code billed, doc. supports 99392	08/13/10	10218005748104000	
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90472	IMMUNIZATION ADM COMBO-VACCINE	0	1.00	$0.00	$0.00					08/13/10	10218005798104000
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90707	IMMUNIZATION MMR LIVE	0	1.00	$20.00	$13.00					08/13/10	10218005798104000
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90716	IMMUNIZATION ACTIVE VARICELLA	0	1.00	$0.00	$0.00					08/13/10	10218005798104000
137015 NILSA I NAZARIO MD FAAP	137015	07/13/10	07/13/10	20	11	V202	Routin Child Health Exam	90669	PNEUMOCOCCAL CONJU VAC,POLYV,	0	1.00	$0.00	$0.00					08/13/10	10218005798104000
137015 NILSA I NAZARIO MD FAAP	137015	08/20/10	08/20/10	20	11	4739	Chronic Sinusitis NOS	99213	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$50.00	$50.00					08/13/10	10218005798104000
137015 NILSA I NAZARIO MD FAAP	137015	10/08/10	10/08/10	20	11	4739	Chronic Sinusitis NOS	94640	AIRWAY INHALATION TREATMENT	0	5.00	$50.00	$10.11					11/19/10	10319001798103000
137015 NILSA I NAZARIO MD FAAP	137015	10/08/10	10/08/10	20	11	4739	Chronic Sinusitis NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$26.55	Documentation reviewed supports 99214	11/19/10	10319001798103000	
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486	Pneumonia, Organism NOS	99215	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$120.00	$101.92	D6	$26.55	Documentation reviewed supports 99214	11/19/10	10319001798103000	
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486	Pneumonia, Organism NOS	94640	AIRWAY INHALATION TREATMENT	0	5.00	$50.00	$10.11					02/04/11	11030000350116000
137015 NILSA I NAZARIO MD FAAP	137015	01/03/11	01/03/11	20	11	486	Pneumonia, Organism NOS	90696	INJEC CEFTRIAXONE SODIUM PER 2	0	2.00	$30.00	$2.14					02/04/11	11030000350116000
137015 NILSA I NAZARIO MD FAAP	137015	01/06/11	01/06/11	20	11	46619	Acu Bronchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37					02/04/11	11030000350116000
137015 NILSA I NAZARIO MD FAAP	137015	02/18/11	02/18/11	20	11	46619	Acu Bronchits d/t Oth Org	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$75.37	D6	$25.34	Documentation reviewed supports 99213	03/11/11	11064004728102000	
137015 NILSA I NAZARIO MD FAAP	137015	04/14/11	04/14/11	20	11	462	Acute Pharyngitis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213	04/01/11	11085009068106000	
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929	Dermatitis NOS	85018	BLOOD COUNT, SPUN MICROHEMATOC	0	1.00	$10.00	$2.89					05/20/11	11135004158118000
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929	Dermatitis NOS	90460	IMMUN ADMIN <=AGE 18; ANY ROUT	0	1.00	$20.00	$12.61					05/20/11	11135004158118000
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929	Dermatitis NOS	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213	05/20/11	11135004158118000	
137015 NILSA I NAZARIO MD FAAP	137015	04/29/11	04/29/11	20	11	6929	Dermatitis NOS	90633	HEP A VACCINE PED/ADOL DOS (2	0	1.00	$0.00	$0.00					05/20/11	11135004158118000
137015 NILSA I NAZARIO MD FAAP	137015	05/19/11	05/19/11	20	11	5289	Cellulitis/Abscess Mouth	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$73.11	D6	$24.58	Documentation reviewed supports 99213	05/20/11	11135004158118000	
137015 NILSA I NAZARIO MD FAAP	137015	08/16/11	08/16/11	20	11	75	Infectious Mononucleosis	99214	E/M OFFICE/OP SERV EST PATIENT	0	1.00	$100.00	$70.99					06/24/11	11169001998591000
																		09/02/11	11240005658100000

REVISED TOTAL DISALLOWED $179.07

Claim Count:

Medicaid Total Paid:
1,056.52

IMD Total Paid:
NIL

Medicaid and IMD Total Paid:
1,056.52

DIR/MAK DOS:

Units

HISTORY

HPI (History of Present Illness)

☐ Location ☐ Severity ☑ Timing ☑ Modifying factors
☐ Quality ☐ Duration ☑ Context ☑ Associated signs and symptoms

	Brief 1-3 elements		**Extended** ≥4 elements or status of 2-3 chronic/ inactive conditions

ROS (Review of Systems)

☐ Constitutional (wt. Loss, etc) ☐ Ears, nose mouth, throat ☐ GI ☐ GU ☐ Integumentary (skin, breast) ☐ Endo ☐ Hem/lymp
☐ Eyes ☐ Card/vasc ☐ Musculo ☐ Neuro ☐ Allergy/Immunological
☐ Resp ☐ Psych ☐ "All others negative"

None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"

PFSH (past medical, family and social history)

☐ Past medical history
☐ Family history
☐ Social history

No PFSH required for 99231-33, 99307-10

Established/ Subsequent/ED		None	1 history area	2 or 3 history areas
New/Initial		None	1 or 2 history area(s)	3 history areas
To determine History level, draw a line down the column with the circle farthest to the left.		PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED / COMPRE-HENSIVE

EXAM

1997 General Multi-System Exam

Problem Focused 1-5 elements	Exp. Prob Focused ≥ 6 elements	Detailed ≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas	Comp ≥ 2 elements in 9 areas

1995 Body Areas

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Genitalia, groin, buttocks
☐ Neck ☐ Abdomen ☐ Back, including spine ☐ Each extremity

Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	8 or more body areas/ systems

1995 Organ Systems

☑ Constitutional (vitals, gen app, etc) ☐ Ears, nose, mouth, throat ☑ Resp ☐ Musculo ☐ Psych
☐ Eyes ☐ Cardiovascular ☐ GI ☐ Skin ☐ Hem/lymph/ Immuno
☐ GU ☐ Neuro

System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system
PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPRE-HENSIVE

MEDICAL DECISION MAKING

A Number of Diagnoses or Treament Options

Problem (Dx or Mgmt Option)	Number	Points	Results
Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	= 1
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			3

B Amount and/or Complexity of Data to be Reviewed

Data to be Reviewed	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	2
TOTAL (TRANSFER TO MDM Summary section below)	0

C Risk of Complications and/or Morbidity or Mortality

Risk Level	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MIN	One self-limited or minor problem, e.g. cold, insect bite tinea corporis	Laboratory tests requiring venipuncture	Rest
		Chest x-rays / KOH prep	Gargle
		EKG/EEG / Urinalysis	Elastic Bandages
		Ultrasound e.g. echo	Superficial dressings
LOW	2 + self-limited or minor problems	Physiologic test not under stress e.g. pulmonary function tests.	Over-the-counter drugs
	1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH	Non-cardio. Imaging studies with contrast e.g. barium enema.	Minor surgery with no identified risk factors.
			Physical therapy
			Occupational therapy
	Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Superficial needle bxs.	IV fluids w/o additives
		Clinical Lab test requiring arterial puncture.	Refer ENT
		Skin biopsies.	
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test	Minor surgery with identified risk factors
	Two or more stable chronic illnesses	Diagnostic endoscopies with no identified risk factors	Elective major surgery (open percutaneous or endoscopic) with no identified risk factors
	Undiagnosed new problem with uncertain prognosis e.g. lump in breast	Deep needle or incisional bx	Prescription drug mgmt
		Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath	Therapeutic nuclear
	Acute illness with systemic symptoms e.g. pyelonephritis • pneumonitis, colitis	Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	IV fluids with additives
			Closed treament of fracture or dislocation without manipulation Fill Work Recapitum Resp. TX
	Acute complicated injury e.g. head injury with brief loss of consciousness		
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment.	Cardiovascular imaging studies with contrast with identified risk factors	Elective major surgery (open percutaneous or endoscopic) with identified risk factor
		Cardiac electrophysiological tests	Emergency major surgery (open, percutaneous or endoscopic)
	Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure.	Diagnostic endoscopies with identified risk factors	Parenteral controlled substances
		Discography	Drug therapy requiring intensive monitoring for toxicity
			Decision not to resuscitate or de-escalate care because of poor prognosis
	An abrupt change in neurological status e.g. seizure, TIA		

MDM SUMMARY

	≤ 1 Minimal	2 Limited	3 Multiple	≥ 4 Extensive
A Number of diagnoses or treatment options			3	
B Amount and Complexity of Data	≤ 1 Minimal or Low	2 Limited	3 Moderate	≥ 4 Extensive
C Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

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Office/Consults

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	PF	EPF	D	C	C
Examination	PF	EPF	D	C	C
Complexity of MDM	SF	SF	L	M	H
New Office Visit	99201	99202	99203	99204	99205
Inpatient Consultation	99251	99252	99253	99254	99255
Office or Outpt. Consultation	99241	99242	99243	99244	99245

ished Office

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

Minimal problem that may not require presence of physician	PF	EPF	D	C
	PF	EPF	D	C
	SF	L	M	H
99211	99212	99213	99214	99215

INPATIENT

Initial Hospital/Observation

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	D or C	C	C
Examination	D or C	C	C
Complexity of MDM	SF or L	M	H
Hospital Admission	99221	99222	99223
Hospital Observation	99218	99219	99220
Admit/Discharge same day	99234	99235	99236

Subsequent Inpatient/ Observaton Care

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

PF interval	EPF interval	D interval
PF	EPF	D
SF or L	M	H
99231 99224	99232 99225	99233 99226

NURSING FACILITY

Initial Nursing Facility

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	D or C	C	C
Examination	D or C	C	C
Complexity of MDM	SF or L	M	H
	99304	99305	99306

Subsequent Nursing Facility

If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.

PF interval	EPF interval	D int.	C int.
PF	EPF	D	C
SF	L	M	H
99307	99308	99309	99310

Emergency Dept

New/Established

If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.

History	PF	EPF	EPF	D	C
Examination	PF	EPF	EPF	D	C
Complexity of MDM	SF	L	M	M	H
	99281	99282	99283	99284	99285

PF = Problem Focused
EPF = Expanded Problem Focused
D = Detailed
C = Comprehensive
SF = Straight Forward
L = Low
M = Moderate
H = High
Int. = Interval

TIME

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If all answers are "Yes", then level may be selected based on time.

Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)?	☐ Yes:	☐ No:
Does documentation reveal that more than half of time was counseling/coordination of care?	☐ Yes:	☐ No:
Does documentation describe the content of counseling/coordination of care?	☐ Yes:	☐ No:

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

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Case discussed on Hearing

brought by DHHS as example

to them of Checkup - EPSDT

where they use the form HCPro

for evaluation + Screening Age

guidelines (which I proved by having

done school history + neurologic exam

I had completed requirement of developmental

assessment. Yet this visit obviously

complexed with Bronchitis + Sinusitis

was billed 99215 correctly by me.

Here DHHS chose to demote it to a

brief 99213 per HCPro form.

(extremely brief, focused exam, 10 minutes or less)

case on file in court 1st page only recopied

+ age appropriate screening form + HCPro form

Ira F. Nazario, M.D., F.A.A.P.

Pediatric Clinic

915 West Main Street Laurens, S.C. 29360
Tel Fax (864) 984-4158 Tel (864) 984-4263

Date of service 08 09 10
Accompanying Adult: F
Patient's Name:
Tel.
Address:
Last OV: / /
1.06.03 7yo
ALLERGIES TO MEDS:
Penicillin, Erythromycin, Sulfa, Cephalosporins
Other: cf
Current Medications:
Chronic Illnessess:
Asthma, Allergies, ADHD, LD, MR, CP, Epilepsy, Diabetes Mellitus, HBP, Other
Operations: cf
Blood Transfusions: Year 4 Type: RBC'S, Plasma, Platelets, Whole Blood
Immunizations: UTD, Not UTD// Varicella Status: Illness, Vaccine, Neither
Frequent travel to Asia, Latin America Yes No
Lead Risk Factors: Old house, works with batteries or glass or pottery, lives near a lead Smelter plant or a battery recycling plant, has unknown type of anemia or developmental delay
School history: Grade: 5k ; Grade Avg: Problems? Yes No
Adolescent females only: LMP month /Year
4 y/o or older: Bedwetting? NO YES (Day/ Night)
Snoring? No Yes (How long?)
Reason for this visit: Check, Because start school in next week

Physical Exam-Pertinent VS and Findings:
HR 76/min, RR 16 /min, Temp. 98.2 F (ax, oral, rectal), BP 90/50.
Wt. 40-3/4 Ht. 46" , HC
Pertinent Findings:
Gen: A & O x 3 overweight
Positive for:
Head and Neck: under 2mm serous
Respiratory: bilateral rales + prolonged expiration at bases
Cardiovascular: RRR no m
Gastrointestinal:
Genito-Urinary:
Musculoskeletal:
Nervous System:
Skin: Ob. Large nevus to both thighs. marks on legs
Psychiatric:
Interventions: Vision: OU 20/30, OD, OS 20/30 not color blind.
Hearing: Passed all tones @ 25dBHL
Urine:
Diagnosis(es):
Plan: CBC/diff/pc urine. allergy panels x2 TS ft4 free T4 urine
train on nebs
Xopenex 0.63mg + Pulm 0.5 x2
TIPPS: YES NO
Anticipatory Guidance YES NO
flu in Oct. vac + PPV 23
no candy.) due + recurrent Bronchitis keep on nebulizer + allergy shots x 1 year.

Note No name or date yet attached to example brought to the hearing

SECTION 2 POLICIES AND PROCEDURES

PROGRAM SERVICES

SCREENING AGE GUIDELINES

AGE	2 wk	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20 yr
HISTORY Initial or Interval	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MEASUREMENTS Height and Weight	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEAD CIRCUMFERENCE	X	X	X	X	X	X	X	X	X											
BLOOD PRESSURE										X	X	X	X	X	X	X	X	X	X	X
NUTRITIONAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IMMUNIZATION ASSESSMENT*	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DEVELOPMENTAL ASSESSMENT				X		X			X	X	X	X	X	X	X	X	X	X	X	X
PHYSICAL EXAMINATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DENTAL ASSESSMENT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
VISION SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HEARING SCREENING	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
HCT OR HGB **				X																
HEALTH EDUCATION	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
URINALYSIS ***											X									
LEAD Assessment ****					X				X											

* Immunization schedule may vary according to recommendations from the American Academy of Pediatrics (AAP) and the Advisory Committee.

** Test should be performed between 6 - 9 months and at least once for menstruating females.

*** A urinalysis should be performed on all children at five years of age and a dipstick urinalysis should be performed for leukocytes for sexually active male and female adolescents.

**** Assessment of individual/family history of lead exposure/symptoms, environment, and personal risk factors should be obtained and documented at 9 months to 12 months and again at 24 months.

Work No review of pertinent yet attached to the case presented on the hearing

Chief Complaint: YES NO Pt. Name: MRN:

HISTORY

HPI (History of Present Illness)

☐ Location ☐ Severity ☐ Timing ☐ Modifying factors
☐ Quality ☐ Duration ☐ Context ☐ Associated signs and symptoms

	None	Brief (1-3 elements)		Extended (≥4 elements or status of 2-3 chronic/ inactive conditions)
	X		X	

ROS (Review of Systems)

☐ Constitutional (wt. Loss, etc) ☐ Ears, nose mouth, throat ☐ GI ☐ GU ☐ Integumentary (skin, breast) ☐ Endo ☐ Hem/lymp ☒ Allergy/Immunological
☐ Eyes ☐ Card/vasc ☐ Musculo ☐ Neuro ☐ Psych ☐ "All others negative"
☐ Resp

	None	Pertinent to problem 1 system	Extended 2-9 systems	Complete ≥10 systems or some systems with statements "all others negative"

PFSH (past medical, family and social history)

☐ Past medical history
☐ Family history
☐ Social history

No PFSH required for 99231-33, 99307-10

	None	1 history area	2 or 3 history areas
Established/ Subsequent/ED	X		
New/Initial	X		

To determine History level, draw a line down the column with the circle farthest to the left.

	PROBLEM FOCUSED	EXP. PROB. FOCUSED	DETAILED	COMPREHENSIVE

EXAM

1997 General Multi-System Exam

	Problem Focused (1-5 elements)	Exp. Prob Focused (≥ 6 elements)	Detailed (≥ 2 elements from 6 areas or ≥ 12 elements in 2 or more areas)	Comp (≥ 2 elements in 9 areas)

1995 Body Areas

☐ Head, including face ☐ Chest, including breasts and axillae ☐ Genitalia, groin, buttocks ☐ Back, including spine
☐ Neck ☐ Abdomen ☐ Each extremity

	Problem Focused 1 body area	Exp. Prob Focused 2-4 body areas	Detailed 5-7 body areas	
				8 or more body areas/ systems

1995 Organ Systems

☐ Constitutional (vitals, gen app, etc) ☐ Ears, nose, mouth, throat ☐ Resp ☐ GI ☐ GU ☐ Musculo ☐ Skin ☐ Neuro ☐ Psych ☐ Hem/lymph/ Immuno
☐ Eyes ☐ Cardiovascular

	System related to problem	2-4 systems	5-7 systems	Or complete exam of a single organ system

	PROBLEM FOCUSED	EXP .PROB. FOCUSED	DETAILED	COMPREHENSIVE
				X

MEDICAL DECISION MAKING

A Number of Diagnoses or Treatment Options

Self-limited or minor (stable, improved or worsening)	Max = 2	x 1	=
Est. problem (to examiner): stable, improved		x1	=
Est. Problem (to examiner): worsening		x2	
New problem (to examiner): no additional workup planned	Max = 1	x 3	=
New prob. (to examiner): add. Workup planned		x 4	=
TOTAL (TRANSFER TO MDM Summary section below)			0

B Amount and/or Complexity of Data to be Reviewed

Review and/or order of clinical lab tests	*	1
Review and/or order of tests in the radiology section of CPT		1
Review and or order of tests in the medicine section of CPT	*	1
Discussion of test results with performing physician		1
Decision to obtain old records and/or obtain history from someone other than patient		1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another healthcare provider.	*	2
Independent visualization of image, tracing or specimen itself (not simply review of report).	*	2
TOTAL (TRANSFER TO MDM Summary section below)		0

C Risk of Complications and/or Morbidity or Mortality

MIN	One self-limited or minor problem, e.g. cold, insect bite, tinea corporis	Laboratory tests requiring venipuncture Chest x-rays KOH prep EKG/EEG Urinalysis Ultrasound e.g. echo	Rest Gargle Elastic Bandages Superficial dressings
LOW	2 + self-limited or minor problems 1 stable chronic illness e.g. well controlled HTN, non-ins. dep. diabetes, cataract, BPH Acute uncomplicated illness or injury e.g. cystitis, allergic rhinitis, simple sprain	Physiologic test not under stress e.g. pulmonary function tests. Non-cardio. Imaging studies with contrast e.g. barium enema. Superficial needle bxs. Clinical Lab test requiring arterial puncture. Skin biopsies.	Over-the-counter drugs Minor surgery with no identified risk factors. Physical therapy Occupational therapy IV fluids w/o additives
MODERATE	1 + Chronic illnesses with mild exacerbation, progression or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis e.g. lump in breast Acute illness with systemic symptoms e.g. pyelonephritis * pneumonitis, colitis Acute complicated injury e.g. head injury with brief loss of consciousness	Physiologic test under stress e.g. cardiac stress test, fetal contraction stress test Diagnostic endoscopies with no identified risk factors Deep needle or incisional bx Cardiovascular imaging studies with contrast and no identified risk factors e.g. arteriogram, cardiac cath Obtain fluid from body cavity e.g. lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major surgery (open percutaneous or endoscopic) with no identified risk factors Prescription drug mgmt Therapeutic nuc med IV fluids with additives Closed treament of fracture or dislocation without manipulation
HIGH	1+ chronic illnesses with severe exacerbation progression or side effects of treatment. Acute or chronic illnesses or injury that may pose a threat to life or bodily function e.g. multiple trauma, acute MI pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure. An abrupt change in neurological status e.g. seizure, TIA	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery (open percutaneous or endoscopic) with identified risk factor Emergency major surgery (open, percutaneous or endoscopic) Parenteral controlled substances Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or de-escalate care because of poor prognosis

MDM SUMMARY

Number of diagnoses or treatment options	≤ 1 Minimal	2 Limited	3 Multiple *	≥ 4 Extensive	
Amount and Complexity of Data	≤ 1 Minimal or Low	2 Limited	3 Moderate *	≥ 4 Extensive	
Highest Risk of Complications and/or Morbidity or Mortality	Minimal	Low	Moderate	High	
Type of Decision Making	Straight forward	Low Complex	Moderate Complex	High Complex	

To determine Level - Draw a line down the column with 2 or 3 circles and circle the Decision Making Level OR draw a line down the column with the center circle and circle the Decision Making Level.

Problem Planned OR

not a D truly a 6 or. extended

A is a 4
B is a 6
C is moderate

line is thrown where 2 are circled thus High complex 99215 as billed

HCPro

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s discussed from page 1 of HCPro

Note No patient Name yet attached to case with DOB 11-06-03, introduced by DHHS as example.

OUTPATIENT, CONSULTS (Outpatient, Inpatient)

	New Office/Consults					Established Office				
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.					If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.				
History	PF	EPF	D	C	C	Minimal problem that may not require presence of physician	PF	EPF	D	C
Examination	PF	EPF	D	C	C		PF	EPF	D	* C
Complexity of MDM	SF	SF	L	M	H		SF	L	M	* H
New Office Visit	99201	99202	99203	99204	99205					
Inpatient Consultation	99251	99252	99253	99254	99255	99211	99212	99213	99214	* 99215
Office or Outpt. Consultation	99241	99242	99243	99244	99245					

Exam is Complex MDM is truly High Complex so marked by * done by me The case was correctly deemed 99212 when it was a 99215

INPATIENT

	Initial Hospital/Observation			Subsequent Inpatient/Observaton Care		
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.		
History	D or C	C	C	PF interval	EPF interval	D interval
Examination	D or C	C	C	PF	EPF	D
Complexity of MDM	SF or L	M	H	SF or L	M	H
Hospital Admission	99221	99222	99223	99231	99232	99233
Hospital Observation	99218	99219	99220	99224	99225	99226
Admit/Discharge same day	99234	99235	99236			

NURSING FACILITY

	Initial Nursing Facility			Subsequent Nursing Facility			
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.			If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.			
History	D or C	C	C	PF interval	EPF interval	D int.	C int.
Examination	D or C	C	C	PF	EPF	D	C
Complexity of MDM	SF or L	M	H	SF	L	M	H
	99304	99305	99306	99307	99308	99309	99310

Emergency Dept

	New/Established								
	If a column has 3 circles, draw a line down the column and circle the code OR find the column with the circle farthest to the left, draw a line down the column and circle the code.								
History	PF	EPF	EPF	D	C				
Examination	PF	EPF	EPF	D	C				
Complexity of MDM	SF	L	M	M	H				
	99281	99282	99283	99284	99285				

PF = Problem Focused; EPF = Expanded Problem Focused; D = Detailed; C = Comprehensive
SF = Straight Forward; L = Low; M = Moderate; H = High
Int. = Interval

TIME

If the provider documents total time and documents that counseling or coordinating care dominates (more than 50% the encounter, time may determine the level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction or discussion with another health care provider.

If all answers are "Yes", then level may be selected based on time.

Does documentation reveal total time (F2F in outpt. setting; Unit/Floor in inpt. setting)?	☐ Yes:	☐ No:
Does documentation reveal that more than half of time was counseling/coordination of care?	☐ Yes:	☐ No:
Does documentation describe the content of counseling/coordination of care?	☐ Yes:	☐ No:

Minimum face-to-face or unit/floor time:

Code/time					
99201 - 10	99211 - 5	99221 - 30	99231 - 15	99241 - 15	99251 - 20
99202 - 20	99212 - 10	99222 - 50	99232 - 25	99242 - 30	99252 - 40
99203 - 30	99213 - 15	99223 - 70	99233 - 35	99243 - 40	99253 - 55
99204 - 45	99214 - 25			99244 - 60	99254 - 80
99205 - 50	99215 - 40			99245 - 80	99255 - 110

HCPro

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There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 06/23/11- It appears that the Petitioner is requesting that this Hearing Officer make an initial determination to require the Respondent to pay for a 99214 examination when the Petitioner failed to bill for any type of examination. The Petitioner is required to submit claims free of errors to the Respondent within one (1) year from the date of service in order for those claims to be considered for payment; therefore, the Petitioner is not entitled to the payment for code 99214 as a part of this Final Administrative Decision pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05.*

DOS: 06/25/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 08/05/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This Hearing Officer cannot determine the reason for this visit based on the Petitioner's office notes; however, since the child was diagnosed with contact dermatitis on the face and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

10) P.A.F., Medicaid Recipient # 1780225362

DOS: 08/06/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. This child was seen for a check-up because he was starting school in the next week. There is no indication that extensive data was reviewed or that the data was of extensive complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was high; therefore, Complexity of Medical Decision Making for this billed visit was not of high complexity. Additionally, the Petitioner has presented no CPT-driven evidence to prove that this exam was not an EPSDT visit (99393), which would have included the hearing test.

STATE OF SOUTH CAROLINA
ADMINISTRATIVE LAW COURT

Laurens Pediatric Clinic,

Appellant/Petitioner,

vs.

SC Dpt of Health and Human Services

Respondent.

Docket No. 15-ALJ-08-0109-AP

CERTIFICATE OF SERVICE

I hereby certify that I am the Petitioner (Appellant/Petitioner/Respondent) in the above-captioned matter and that on the 18th day of May, 2015, in Laurens (city), South Carolina, I served a copy of the forgoing Brief (type of document) on the following person(s) by depositing the same in the United States Mail, postage paid, and addressed as follows:

Name Evan Gessner, Esquire
Address SCDHHS 1801 Main St
City/State/Zip Columbia, SC 29201
Attorney for Respondent

Name
Address
City/State/Zip

Name
Address
City/State/Zip

Name
Address
City/State/Zip

Laurens Pediatric Clinic
C/O NILSA I. VAZQUEZ MOFFATT
(Print Name)

Nilsa I. Vazquez Moffatt
(Signature)

PO Box 1367
(Street)

Laurens SC 29360-1367
(City, State, Zip Code)

FILED
MAY 18 2015
SC ADMIN. LAW COURT

February 22, 2015

To: Administrative Law Court
Edgar A. Brown
1205 Pendleton St, Suite 224
Columbia, SC 29201

From: Laurens Pediatric Clinic c/o
Nilsa I. Nazario, M.D., F.A.A.P.
PO Box 1367 // 915 West Main St
Laurens, SC 29360-1367
864 984-4263-0ffice;864 483-0234-cell
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To Admistrative Law Court (ALC):

I hereby request ALC an appeal on the administrative decision of Case#12-PA-024 (Program Assessment) in the appeal matter of Laurens Pediatric Clinic v. SCDHHS for overpayment in the amount of $11,199.49, based on CPT coding, of which I agree to only $1,601.19. The audit was held at my office in November 2011. They asked for 40 records but in 8 hours they could only scanned 29. The audit covered office visits on these patients from September 1, 2009 through August 31, 2011. The Division of Appeals and Hearings view the case on October 31, 2012. The judgement is dated January 25, 2015. Copy of the judgement is enclosed.

I am appealing for the following reasons (I - VIII):

I:
Both the auditor Cheryl Casey from Medicaid, and appeals judge Robert French
failed to acknowledge that my records have 2 of the 3 components of CPT coding, and patient encounters have clear documentation on physical exam and decision making. History is also available but although claimed not sufficient, it was clearly accepted in many instances. CPT coding needs 2 of the following 3 components:
1-comprehensive history; 2-comprehensive physical exam; 3-decision making of: low complexity for 99213 code; moderate complexity for 99214; and high complexity for 99215. It also estimates times for the services face to face encounters:

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15 minutes 99213, 25 minutes 99214; and 45 minutes for 99215.

My notes show history taking -10 minutes to do in average; complete vital signs and measures-10 minutes to complete in average; complete physical exam- 15 minutes to complete in the average; and decision making, including interventions, diagnosis (note receipt copy and prescription copies are part of the office note), and multiple medicines mostly written in one or two prescription pads and then explained to the parent, vary in time from 10 minutes up to several hours.

II:
The auditor also demoted coding in many instances of very ill patients with advanced care from a 99215 high complexity billed to a 99213(low complexity) or 99212 (only focused brief exam), which denote grossly inadequate auditing.

III:
The ruling states that I do not comment on many instances audited, but contrary to Medicaid that only presented as evidence 4 patient encounters, I advised the court I was prepared to address one by one each encounter of which I presented as evidence not only a detailed review of each visit but as well provided copy of each patient encounter office notes to the court, and they were accepted as evidence. The judge preferred not to go one by one due to the multiple office visits involved given the time.

IV:
The Medicaid auditor and appeals judge put all the weight on lack of comprehensive history, ignoring the full exam and decision making in these patient encounters, and the history available which was sufficient for many accepted encounters.

V:
The auditor complaint about lack of EPSDT coding, but in the rural setting I practice, at the time of the visit we have to address illness as well. I chose to bill as illness instead of EPSDT. EPSDT components were met.

VI:
Medicaid also claimed to the court under oath and taped, that they based the audit on an HCpro form, to which I objected as I never was told about it, nor had I seen it at the informal hearing on March 2012. Note the form is not described in CPT coding, nor is it a mandate for audits on the Provider Manual for Medicaid.
The judge towards the end of the hearing on October 31, 2012, asked Medicaid to provide copies of these forms to the court, which they did several weeks later. The precider Robert French forwarded them to me for an opinion. Many flaws were found in the way they were filled out and interpreted, and most troubling, they were not signed and dated by the person completing the form. This audit had a detailed claim report in February 2012, before the informal hearing in March 2012. After that hearing several changes were made by the auditor and a new revised claim report was done in May 2012. The HCpro forms submitted do not reflect these changes.

VII:
During the court under oath and taped the lawyer for Medicaid says "that is because you have never been audited by Medicaid before", to which I replied that I was many years back. Then following their questions, I detailed that it was a judgement for $1,500 overpayment, that a doctor on the Medicaid board, even commented that the children were very sick, I recalled one in particular that had multiple breathing treatments to rescue him from an Asthma attack. But, I didn't have the time to appeal and paid the amount. To my surprise the judge counted this past incident against me in this ruling.

VIII:
The judgement could be bias against me as the decision comes 5 days before Medicaid was to release the ACA enhanced payment owed to me for January through September 2014, which they were stalling since September 2014 from me, and was accepted to be paid after a phone call on January 15,2015 with Jon Tapley (in charge of coordinating ACA enhanced payments), who claimed that the computer problems were not fixed yet, for which I said "then you will be audited by IG" (Inspector general). That afternoon Deidra Singleton (Medicaid director's aid and Jon Tapley in conference call agreed to pay January through

September 2014. Jon Tapley sends an email the next day confirming that payment on the amount of $41,932.54 will be sent to HMO Molina on January 23, 2015. On January 21, 2015, two days before money was suppose to be released, I get another e mail from Jon Tapley claiming the information was not keyed in on time, and that now payment will be released to Molina HMO on January 30, 2015. The judgement on this case, against me, by the Division Of Appeals and Hearings is dated January 25,2015(a Sunday), and was received by certified mail on Friday, January 30, 2015. A bill for the amount of $11,199.49 was sent by Medicaid dated January 27,2015 and I received it on January 29,2015. This violates rules of appeals as at the time I got the bill, I had no knowledge of a judgement on the appeal case seen in 2012, and left message to April Wilson who forward the bill, Bruce Carter-Medicaid lawyer, and Robert French-Chief Officer of Appeals, that I understood billing me was wrong and they should erase that from my record. The fact that Medicaid forced a bill 2 days after a judgement and three days before an ACA enhance payment (rightfully earned and owed to me), is intimidating and goes against my right to appeal.
Ironically, the Affordable Care Act enhanced pay given to Medicaid providers that qualify,
is meant to match what Medicare providers get paid for services coded 99213, 99214, and 99215,thus acknowledging that all along Medicaid providers have been underpaid.

I am Board Certified in Pediatrics and have served Medicaid and uninsured patients at my office, on 915 W. Main St, Laurens,SC since December 15, 1992. I do not contract with private insurance. I am the only Pediatrician in Laurens City, but I am fluent in Spanish and I see also patients from Greenwood, Spartanburg and Greenville of Hispanic background.

I was targeted for audit on the basis of high pay. But I am confident that my records meet criteria for CPT codes billed based on services rendered, except for the amount of $1,601.19. I appeal the decision of overpayment owed to SCDHHS Medicaid for the amount of $11,199.49.

I respectfully submit this appeal to the Administrative Law Court for consideration, I am enclosing copy of the letter to Medicaid (SCDHHS)-Division Of Appeals and Hearings requesting copy of the transcript, at my cost. In compliance to rule 71, the administrative fee to appeal of $25 US

dollars is also enclosed.

Sincerely,

Nilsa I. Nazario, M.D., F.A.A.P.

cc SCDHHS-Medicaid c/o Bruce Carter Attorney At Law
Assistant General Counsel

THE STATE OF SOUTH CAROLINA
IN THE ADMINISTRATIVE LAW COURT

Appeal from the Division of Appeals and Hearings
South Carolina Department of Health and Human Services

Robert French, Hearing Officer

Docket Number: 15-ALJ-08-0109-AP

Laurens Pediatric Clinic,

Appellant,

v.

South Carolina Department of Health
and Human Services,

Respondent.

RECORD ON APPEAL

VOLUME 1

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(unclear) $1600 in the first review but in the second review $1339, I believe it was. And I'm ready to prove office visit, per office visit that that is the case.

FRENCH: Okay, thank you. All right. Mr. Carter?

CARTER: If I could, Your Honor, there are some documents that I'd like to go ahead and introduce so that we can refer to them as we're going forward.

FRENCH: Okay.

CARTER: Dr. Nazario, the first of these is our sections of the Medicaid, South Carolina Medicaid Physician's Provider Manual that are associated with the types of services and billing that was done by Dr. Nazario.

FRENCH: Dr. Nazario, would you like to look over these just to see what's in there?

NAZARIO: If there is something I can really disagree, I'll have to take a moment to review but I reviewed, you know, all my CPT codes.

FRENCH: Are you familiar with the Physician's Provider Manual?

NAZARIO: Yes.

FRENCH: From Health and Human Services?

NAZARIO: Yes, but I'm also very familiar with the CPT codes that's on the—I'm the sole practitioner, I'm the only coder there in my office.

FRENCH: All right. Go ahead, Mr. Carter.

CARTER: Okay.

FRENCH: With your witness and then I think that'll help Dr. Nazario understand what's here.

CARTER: If there's a couple—I have a couple more if...

FRENCH: Okay.

CARTER: ...I can go ahead and...

FRENCH: Sure.

CARTER: This is from the CPT 2011 guide, specifically on E and M EPSDT codes or just E and M.

VOICE: No, those are just E & M.

CARTER: E & M.

FRENCH: And...

CARTER: Evaluation and Management codes.

FRENCH: Okay.

CARTER: And this is a copy of the Provider Enrollment Agreement from Dr. Nazario. This page with the Provider Manual that I gave you?

FRENCH: The last page?

CARTER: Uh-huh. Yeah, I see it.

VOICE: Yeah, okay. That's just some sample of the tools.

CARTER: Okay, and was it, was it with this one? I just want to make sure because I have it sitting here and that means I may have not picked it up for one.

FRENCH: Have you got this last page?

CARTER: Never mind. I understand what we're—I was confused, I apologize. Okay. This is an example which, part of which comes from our Physician's Provider Manual, part of which is a tool that the Medicaid Integrity Institute at the National Advocacy Center recommended as a good tool for the scoring or actually documentation of reviews that were done for evaluation and management codes so. And these are a few of the, both the documentation submitted in the scoring that we did on the—in the course of our review. It's not the entire amount. It's just a representative sample.

FRENCH: Okay. All right. Go ahead.

CARTER: Okay. Ms. Casey, would you state for the record your name and your role here at the Department.

CASEY: I'm Cheryl Casey and I'm a Medical Nurse Reviewer II for Program Integrity and...

CARTER: Could you tell us a little bit about your background?

CASEY: I am—I have a Bachelor's of Science in Nursing, I'm a Registered Nurse, I'm a Registered Vascular Ultrasonographer retired and I'm a Certified Coder. I was a Pediatric Nurse for four years, one of those years I worked in neonatal intensive care and I have six years of coding experience with Evaluation and Management Services, five years with Medicare and I've been here for almost three years, here at Medicaid.

CARTER: So your time with Medicare was with a Medicare Contractor?

CASEY: Yes.

CARTER: Okay, was it a contractor in South Carolina?

CASEY: Yes, it was.

CARTER: And that would be Palmetto GBA?

CASEY: Correct.

CARTER: Can you tell us how you came to be involved in the review of Dr. Nazario?

CASEY: We have a Surveillance and Utilization Review Department within Program Integrity that run reports periodically of CPT codes and our providers and one of the reports that—one of the ranking reports that they ran showed Dr. Nazario as ranking 11th in the billing of the evaluation and management or office codes, 99214 and 99215. So that's how I...

CARTER: Why would we be running a report on those particular codes?

CASEY: Because those are high level evaluation and management codes and they take more time and effort to perform.

CARTER: Okay. And as a—what did you do as a result of the report?

CASEY: As a result of the report, I ran a detailed claims report for the time period of September 1, 2009 through August 31, 2011, and I selected twenty-nine recipients randomly from that sample and then I scheduled a time to go to Dr. Nazario's office to scan records on those twenty-nine recipients.

CARTER: Okay, and then what happened?

CASEY: I brought the documentation back to the office and using our Medicaid Policy and the CPT Manual and the 1995 guidelines provided by CMS, I scored each, each office visit using that, using the tool that I think they were provided.

CARTER: Okay.

FRENCH: Can I ask a question?

CASEY: Yes.

FRENCH: The '95 guidelines by CMS? What...

CASEY: The 1995 guidelines. Those were guidelines set up in 1995. It just—those were when the original guidelines were set up to evaluate evaluation and management services, how they are coded and how they're leveled. There

were certain, there were certain levels within the office visit that have to do with the complexity of the office visit. There's certain measures within the office visit that we look at, the history of the present illness or the history and the physical exam and the medical decision making and based on the complexity of each one of those, we score the, we score the office visit using the CPT codes provided in the manual.

FRENCH: So that's the most up to date...

CASEY: Correct.

FRENCH: ...that CMS has provided.

CASEY: Correct.

FRENCH: Oh okay. Okay.

CARTER: Let's go into that a little further. CPT is updated how often?

CASEY: Every year.

CARTER: Every year. And CPT, which is Common Procedural Terminology, that, that's published by whom or who puts that together?

CASEY: American Medical Association.

CARTER: Okay. And CMS has adopted the CPT as its standard coding system?

CASEY: Correct.

CARTER: Okay. And 1995 was the first year which these particular evaluation and management codes were incorporated into the CPT?

CASEY: Mmmm.

FRENCH: No.

FRENCH: Just one person. You can certainly say you don't know.

CASEY: I really am not sure whether that was (unclear).

CARTER: Okay. But 1995 was the first year CMS issued any instructions for the use of, the use and interpretation of these codes. Okay. Okay, so you had—you obtained the records from, from Dr. Nazario.

CASEY: Yes.

CARTER: And what did you do with the records? Walk me through a little bit about the process of what you—how you went about reviewing the records.

CASEY: When I get the record, I look at the record in comparison with the score sheet and I look at, I look for certain, certain things within a documentation such as the chief complaint, the history of the present illness, the review of systems, and the past family and medical history.

CARTER: Okay.

CASEY: And, and social history and then I look at the physical exam and then I look at the medical decision making, the diagnosis and the plan of care for treatment.

CARTER: Okay. The scoring sheet that you use, I'm sure you still have it. I'm going to refer to it so Dr. Nazario if you're familiar with it, fine but—yes, that's fine. Let me borrow it for just one second. There's two pages, one is from our Provider Manual, correct?

CASEY: Right, and that is for—that is what I used to score if it was, it was stated that it was a checkup what I did was I tried to go by Medicaid's policy and for their early, its EPSDT Policy requirements at that visit and I tried to see how many of the requirements that were met in the documentation.

CARTER: Okay.

CASEY: And if they were not met then I scored for evaluated, then I scored for an office visit.

CARTER: Okay, so you looked—so, so this particular exhibit is related to the EPSDT...

CASEY: Right, for them...

CARTER: ...screening for them to...

CASEY: ...to either, it's like a preventative or a checkup visit.

CARTER: Right, and I just totally forgot what the acronym stands for, Early...

CASEY: Early...

VOICE: Early...

CARTER: It's—Early...

VOICE: Early...

FRENCH: No ma'am, no ma'am. Not a tag team.

CASEY: Early, okay, it's for, I got it right here. It's for Early and Periodic Screening, Diagnosis and Treatment. That's what EPSDT stands for is Early and Periodic Screening and Diagnosis Treatment and we require those to be performed. We have a set schedule of when the child should receive those visits.

CARTER: And that's what this tool reflects is the...

CASEY: That's what the, that's what I used is our, is our guidelines for what the required services are at those visits.

CARTER: Okay, and so you reviewed the documentation from Dr. Nazario against that tool and for purposes of determining if it was an EPSDT...

CASEY: Correct.

CARTER: ...visit. Okay.

FRENCH: Okay, so and I'm probably getting ahead of you a little bit. So if it was, I assume there's a particular code for an EPSDT visit?

CASEY: Correct. But none of those codes were ever billed. Just, just evaluation or management codes were billed.

FRENCH: Is it...

CASEY: But if the documentation stated checkup, then I, I automatically, you know, would look to see if the requirements were made for an actual preventative visit.

FRENCH: EPSDT visit.

CASEY: Correct.

FRENCH: Okay.

CARTER: These are all pediatric patients?

CASEY: Correct.

CARTER: So this, the other tool which we have indicated came from the, from the Medicaid Integrity Institute as part of the training course from them, is that correct?

CASEY: Yes.

CARTER: And does it reflect the requirements for evaluation and management codes for office visits?

CASEY: Yes sir.

CARTER: Does it reflect the policies that we have in place in the Agency?

CASEY: Yes sir.

CARTER: And the '95 guidelines from CMS?

CASEY: Yes sir.

CARTER: So tell us how you use this tool and what you did in evaluating the documentation that was provided to you.

CASEY: I went through the documentation and looked to see if there was a chief complaint to look for the history of present illness, and what I did was I looked at what the child came in with to get, you know, the history of present illness and the review of systems. A lot of times it was really hard to get anything except for maybe allergy and sometimes I pulled from what was in the reason for the visit, I would try and pull some of that in for the review of systems. The past medical family and social, I would use whether the, whether the vaccinations were updated for the past and, you know, I would pull out of there what I could to get the history portion of that.

CARTER: Okay.

CASEY: In the exam I would check off and most times the review of systems would have a couple of things or the physical exam would have a couple of statements made on some of the systems but then have a line down and okay and I would allow for those on the, on the physical exam portion.

CARTER: Okay, would it be—why don't we take an example and walk through that.

FRENCH: Let's do this. Dr. Nazario, have you been able to look over these three pages that you've been given? These are the—well, one's from the manual, yeah, you've got this one. How about this first? Okay. Why don't you look over both of those? Are you familiar with them?

NAZARIO: I'm familiar with what she said.

FRENCH: Okay, well, what I'm going to do is ask you if you have any objections to these two documents being admitted to the record. So you need to look over these to make sure you know what they are. Okay, would you like to take some time?

NAZARIO: Well, the objection I would have is that as providers we're not furnished with this, you know, on a daily basis, you know or on a routine basis.

FRENCH: You're not familiar with this?

NAZARIO: Never seen it. You know, it must be in the manual but who reads a manual that is so big, you know, all of the pages, I cannot read all the pages so we concentrate on what are the CPT codes and what is it that we need to be (unclear), you know, so.

FRENCH: Okay. Well...

NAZARIO: So I mean...

FRENCH: ...is this...

NAZARIO: ...so the CPT code, my progress notes do meet CPT code requirements.

FRENCH: Okay, hold on just a second—this document from Medicaid Integrity...

CARTER: Institute.

FRENCH: ...that's not in the Physician...

CARTER: It's not in the Provider—in the Physician's Manual. It's a tool that the Agency uses simply to keep track of the findings that we make when we're reviewing the documentation.

FRENCH: Okay. Medicaid Integrity Institute.

NAZARIO: So therefore, that's my objection because if we are, you know, if they're gonna, you know, if we were to be aware that this is what they're going to be requiring, you know, in this detail and everything so then we could adjust our progress notes format, you know, to meet more criteria but I can assure you from CPT code itself, I meet criteria.

FRENCH: Okay, I understand your objection. Mr. Carter?

CARTER: What I would say, Your Honor, is that Ms. Casey testified that, that this document reflects both our policy and the 1995 Medicare Guidelines, that it is simply a, it acts no more than as a piece of paper for us to remind us of what we are reviewing and check off places where we have rece—where we can identify that that particular standard has been met, that these are from, these are essentially the CPT standards.

NAZARIO: But I have another objection. My objection is that we went to an informal hearing prior to this appeal, appellant court and from that informal meeting I brought all my documents as well and my records with two copies as well, and this paper was never shown to me or these codes with me. And so I object to these two papers because it's not something based on the data that they accepted as properly coded which I have samples of. You can compare all the rest of the notes and see that I meet criterias and my records...

FRENCH: Which criteria? The criteria here?

NAZARIO: For CPT's that I billed.

FRENCH: Okay, but, but not for this form here, right?

NAZARIO: This form, the criteria, well, then we have to discuss the criteria because the criteria is clear that you have to meet two of three requirements.

FRENCH: Okay.

NAZARIO: One being the comprehensive...

FRENCH: What I'm asking about, I'm asking about this document, nothing else. Okay.

NAZARIO: I have an, I have an objection because I have never seen it and it's not reflected for what they have accepted as well, and it has never been exposed to me before. And my notes is what we work with and my notes is what we had been evaluated and when I went to the informal hearing, that's all that we discussed was my notes.

FRENCH: All right.

NAZARIO: Not this. Not based on this or whatever.

FRENCH: Is there anything in the Physician's Provider Manual that, that would reflect that this is being used by Program Integrity?

CARTER: That that particular piece of paper is being used, no.

FRENCH: Yes sir.

CARTER: The particular piece of paper simply, these are the 1995 guidelines and all of the information that's contained in here is on that particular scoring sheet. It reflects the CPT-4 guidelines from the CPT-4 manual. It reflects that our policy manual says to the physician that you are to follow CPT-4 coding

guidelines and this is just simply a way for us to check off against the, the, the guidelines that exist that as the reviewer's reviewing they see that it has that history of the present illness is present and where they believe it falls in this particular range. It's just a recordkeeping is what it is.

FRENCH: Okay. And Dr. Nazario, you say you're familiar with the CPT coding?

NAZARIO: Yes.

FRENCH: Okay. All right. Well, I'm going to overrule the objection and you can certainly show me how your medical records meet the CPT coding guidelines, okay?

NAZARIO: And I can give you a comparison of those they accepted.

FRENCH: Okay.

NAZARIO: As well.

FRENCH: All right. So I'm going to call this, this is one page, it's front and back and that is from the Medicaid Integrity Institute and Mr. Carter you say this is really a guideline for...

CARTER: Correct. It's really a scoring sheet for us...

FRENCH: Okay.

CARTER: ...simply to record what our findings are against the CPT-4 guidelines.

FRENCH: Okay. And the third page is a page from the...

CARTER: Provider Manual.

FRENCH: Physician's Provider Manual. Okay. I'm going to call all three of those Respondent's Exhibit Number 1.

CARTER: Thank you, Your Honor.

FRENCH: Okay. All right.

CARTER: Mr. Hearing Officer, we're—I'd like to go through a couple of these examples that were provided or allow Ms. Casey to go through them so that we can—so she can walk through how her decisions were made and how they were translated to the scoring sheets.

FRENCH: Okay.

CARTER: You spent a lot of time talking earlier about, I don't have to document the amount of time that I spent. Then you spent the next hour talking about us trying to cut you down to a ten minute visit.

NAZARIO: But it's true. 99212's, if you are going to allow that in the time allotted again I say, my documentation is by common sense it spends a certain amount of time because there's no way you can run in fifteen minutes, full questions, full exam, a breathing treatment...

CARTER: Why do you do a full exam on every patient?

NAZARIO: Because in Pediatrics, it can change rapidly from one day to another, rapidly.

CARTER: So you assess the medical necessity of a full visit and a full exam and...

NAZARIO: A full exam every time.

CARTER: Every time?

NAZARIO: Every time.

CARTER: No exceptions?

NAZARIO: No exceptions.

CARTER: Medically necessary or not?

NAZARIO: It is medically necessary in a pediatric patient.

CARTER: Why is it medically necessary?

NAZARIO: Because they can change the course of the illness abruptly. It can spread. If it becomes septic then they could have abdominal pain. They could have now an ear infection spreading if they're not responding to the...

CARTER: So just walking in...

NAZARIO: ...if they're not responding to their medication.

CARTER: ...just walking in the door, you know all of that and decide that that pediatric patient needs a full examination.

NAZARIO: We do it on all the patients.

CARTER: Do you apply the medical necessity standards that the Agency sets?

NAZARIO: I do.

CARTER: You do?

NAZARIO: That's why I'm a pediatrician.

CARTER: So you make an assessment...

NAZARIO: Yeah.

CARTER: ...of the need?

NAZARIO: As you notice because I am thorough in my exams, I pick up on things that perhaps even the parent have not picked up on. Because I'm thorough in my exam.

CARTER: I admire that for you, Dr. Nazario...

NAZARIO: I k-p them out of the ER and hospitalization.

CARTER: ...but outcomes are not germane to whether or not you provided substantial documentation.

NAZARIO: I have documentation to prove that my documenta—that my visits are documented well and they meet criteria for the CPT codes.

CARTER: In your opinion.

NAZARIO: It is documented.

CARTER: In your opinion.

NAZARIO: It is documented.

CARTER: In your opinion.

NAZARIO: To the best of my knowledge.

CARTER: Do you have any external people that have told you it's all right.

NAZARIO: I've been a medical provider for twenty years.

CARTER: And you've not been reviewed before.

NAZARIO: I've been reviewed before, yes.

CARTER: By the Program Integrity folks?

NAZARIO: Uh-huh and it also came up to about $1500. It was about seventeen, eighteen cases and it was a...

CARTER: And it was documentation issues?

NAZARIO: I didn't appeal that time but I had cases where I had given, in one case it was severe respiratory distress. I remember and it was, I had to give like seven treatments to stabilize it and with oxygen and everything. Even the doctor that was there in the meeting said, oh, my gosh, this kid was really sick, you know, but and I had billed a 99215 and they still disallowed it to

a 99213, which is what I'm appealing this time because I think it's unfair that I do all the work, I keep them right and they are high complexity or moderate to high complexity like the CPT code calls for and I'm getting punished for this.

CARTER: You feel like we're punishing you?

NAZARIO: If you disallow things that are all the detail I put into the, into the work, all the care I put into doing it right...

CARTER: Would you put all that care and all that detail into your documentation?

NAZARIO: It is in there. To the best of my ability, it was in the documentation. Remember that's not one patient I see, you know, there's seventeen others waiting as well, you know, so you do the best you can, writing as much as you can within the timeframe, you know, that you have for writing...

CARTER: And without knowing what policies were.

NAZARIO: ...even though I've just been with a patient all the time.

CARTER: And even without knowing the policies and what you're supposed to be doing?

NAZARIO: The policies respond to law and the policies I know the law and I know the CPT codes.

CARTER: You know the law?

NAZARIO: Well, I know the, I know the CPT codes and that's law.

CARTER: No, the CPT codes are not law.

NAZARIO: Are law, are law, yes.

CARTER: It's not law.

NAZARIO: You have to follow the standards of the CPT codes, yes.

CARTER: The law doesn't talk about CPT-4 codes.

NAZARIO: No?

CARTER: The law sets up Medicaid programs.

NAZARIO: Well, I'm not a lawyer but I do my best as a pediatrician, Fellow of the Academy of Pediatrics Board Certified. I've re-certified three times.

CARTER: And nobody's questioning your credentials as a doctor. No one's questioning your treatment of your patients. We're questioning whether or not what you put on paper supports the level that you're billing.

NAZARIO: And that's why I'm appealing for the, for the court officer in charge to make an assessment and a judgment on the cases I disagree.

CARTER: If on one of your prescriptions you put a V-20.2, would that support billing a 99215 or would that be a well visit?

NAZARIO: Okay, you notice on the review...

CARTER: Pardon me?

NAZARIO: On the review, cases that were billed like that were by length of the visit. 99214's were more common than 99215's for V-20.2's only because of the length of the visit because I couldn't, in my understanding, I couldn't bill for the EPSDT code per se. Now two things, there are three instances where there was a credit even due to me, if I would have billed as an EPSDT code but then when I specified but I was not an EPSDT provider then on the review in May, that credit was disa—was erased and no further deductions were given. I can find the case for you if you give me a time and we go off record.

CARTER: No, I don't need to.

NAZARIO: Okay, then also but he has the evidence for review. It's in the detailed claim history of February and the detailed claim history of May, look for the credits which should have been billed as an EPSDT code that were V-20.2 and they were billed...

FRENCH: I don't care about the credits. All I'm looking at is what you disagree with as far as...

NAZARIO: Yes, and they're, they're, they're...

FRENCH: ...the disallowances...

NAZARIO: ...they're all stated here.

FRENCH: Okay.

NAZARIO: And the records are there for your review, uh-huh, yes.

CARTER: I have nothing further.

NAZARIO: I have no further things to say.

FRENCH: Anything else that you want to tell me after hearing Mr. Carter's questions?

NAZARIO: Yeah, I think I've specified the purpose for my visit here and I appreciate the court's time in reviewing this case and my appeal.

FRENCH: Okay. All right. So we've got, you're going to send me whatever you can find that doesn't allow you to bill for an EPSDT visit.

NAZARIO: It was my understanding, yes.

FRENCH: Sure, sure, if you can find something.

NAZARIO: Yes.

FRENCH: And Mr. Carter, you were going to—were you going to try to find some of the contractual information?

CARTER: We will give you, we will give you what we can find, what we can get from other contracts area regarding the agreements that the Agency has with Dr. Nazario.

FRENCH: Okay, and...

CARTER: And we will give you and Dr. Nazario the scoring sheet, the scoring sheets.

FRENCH: Yeah, all right. Okay, okay.

NAZARIO: Can I also get copies of those if they find those contracts and stuff, you know.

CARTER: Yes.

FRENCH: Oh sure.

FRENCH: Yeah, he'll —Mr. Carter will send you that.

NAZARIO: Okay, that'd be great, thank you.

FRENCH: How long should I hold the record open for you to look for that, Dr. Nazario and you, Mr. Carter?

NAZARIO: If you could give me till late December?

FRENCH: Late December?

NAZARIO: It's flu season. I have to give the flu shots. I'm so busy and I have to (unclear) records, eighty hours. I have to put eighty hours of (unclear) for records.

CARTER: We need a couple of weeks.

FRENCH: Any objection to late December for Dr. Nazario? I know it's a long time.

CARTER: No. I'd like to get this thing wrapped up but by the end of the year would be good, I guess.

FRENCH: Well, I can tell you...

NAZARIO: Hopefully before that.

FRENCH: From what I've got...

CARTER: I know you, I know you have a lot to do. I meant the records for this, I'm sorry.

FRENCH: I understand. Because a lot was left in my lap to look over.

CARTER: Yes sir, I understand.

FRENCH: Okay, how about the end of the year then?

NAZARIO: Oh sure, I—yeah, okay.

FRENCH: All right. So you look for that.

NAZARIO: Yes.

FRENCH: By the end of 2012, okay?

NAZARIO: Yes.

FRENCH: All right. So I'll hold the record open till the end of the year. Okay. All right. We've got an opportunity of any closing statements. Mr. Carter, would you like to make any closing statements?

CARTER: I believe that the Agency has indicated the reasons why it felt that the documentation submitted by Dr. Nazario didn't sufficiently describe the services that were being billed. I believe that we gave examples but we'll provide you with additional scoring sheets so that you—since you now have from Dr. Nazario the entire twenty-nine cases. We'll provide you those. We were hoping—we were trying to save the court's time in not going through each individual claim. We believe that, that the Agency's met it's burden here and that Dr. Nazario as the Petitioner has the burden of proving that the actions taken by the Agency were not appropriate and we don't feel that she's at this point met that burden, so we would urge you to complete your review and uphold the decisions made by the Program Integrity Department.

FRENCH: Okay, thanks. Dr. Nazario, closing statement?

NAZARIO: Yes. I appreciate the, the opportunity by the Appellant Court to hear my case and to be clear, as provided with the copy of the CPT codes I've used for coding which I complied with. And I thank you very much for your review in the cases I agree, disagree, and only agree to disallow partially which are detailed and given to you for evidence.

FRENCH: Okay, thank you. All right, we're off the record.

FINAL ADMINISTRATIVE DECISION IN THE APPEAL MATTER OF LAURENS PEDIATRIC CLINIC (PETITIONER) v. SCDHHS (RESPONDENT)

Appeals' Case # 12-PA-024 (Program Assessment)
Provider # 137015
Hearing date: October 31, 2012

JURISDICTION

Procedure in this case is governed under the authority granted by the South Carolina General Assembly to the South Carolina Department of Health and Human Services to administer various programs and grants (See e.g., S.C. Code Ann. 44-6-10, et seq.). This appeal has been conducted pursuant to the provisions of the Appeals and Hearings regulations of the South Carolina Department of Health and Human Services (Reg. 126-150, et seq.) and the South Carolina Administrative Procedures Act (S.C. Code Ann. 1-23-310, et seq.).

PROCEDURAL BACKGROUND

The Respondent, South Carolina Department of Health and Human Services (SCDHHS) is responsible for the administration of the South Carolina Medicaid Program. As such, its functions include providing criteria for the enrollment of providers and the drafting and publication of manuals and information to members and providers outlining the requirements for participation in Medicaid. The Respondent's Division of Program Integrity is entrusted to "safeguard against unnecessary, harmful, wasteful, and uncoordinated utilization of services by Medicaid eligible recipients and health care providers." S.C. Code Reg. §126-425.

The Respondent performed an audit of Medicaid services rendered by the Petitioner, Laurens Pediatric Clinic during the review period of September 1, 2009 through August 31, 2011. In the audit, the Respondent performed a comprehensive review of a sample of twenty-nine (29) Medicaid recipients' records and found the following errors: coding errors, duplicate billing, unbundling (provider services broken down to their individual components, resulting in a higher payment by Medicaid), medically unnecessary services, and insufficient documentation.

Following an informal conference with the Petitioner, the Respondent determined that the Petitioner had been overpaid $11,199.49 in Medicaid payments during the review period of September 1, 2009 through August 31, 2011 and this amount must be repaid to the Respondent. Via letter of June 14, 2012, the Petitioner's sole owner, Nilsa I. Nazario, M.D. timely appealed the Respondent's proposed recoupment of $11,199.49.

ISSUE

The issue is whether the Respondent properly disallowed $11,199.49 in Medicaid payments to the Petitioner due to improper documentation to support the filed claims on Medicaid recipients during the review period of September 1, 2009 through August 31, 2011.

STATEMENT OF APPEARANCES

A hearing was convened on October 31, 2012 at the SCDHHS, Jefferson Square Building in Columbia, South Carolina, with Robert French, Hearing Officer, presiding and sitting as sole fact finder. The Petitioner was represented by Nilsa I. Nazario, M.D., sole owner of Laurens Pediatric Clinic. Also present for the Petitioner was Gloria Holiday, CMA. The Respondent was represented by Bruce Carter, Esquire, SCDHHS Assistant General Counsel. Present for the Respondent were Cheryl Casey, Nurse Medical Reviewer in the SCDHHS Division of Program Integrity and Nancy Pittman, Supervisor in the SCDHHS Division of Program Integrity. Observing the hearing were Karen Fanning, Nurse Medical Reviewer in the SCDHHS Division of Program Integrity; Tresa Martin, Medical Reviewer in the SCDHHS Division of Program Integrity; Audrey Lutts, Nurse Medical Reviewer in the SCDHHS Division of Program Integrity; Bryan Jeffries, Contract Hearing Officer in the SCDHHS Division of Appeals and Hearings; and Luke Hughes, Contract Hearing Officer in the SCDHHS Division of Appeals and Hearings. Due to the extended nature of the hearing, some observers were not present for the entire hearing.

INFORMATION BEFORE THE HEARING OFFICER

I have the testimony of the following individuals:

a. For the Respondent:

Cheryl Casey: On direct examination, Cheryl Casey, Nurse Medical Reviewer with the SCDHHS Division of Program Integrity asserts that she is a certified coder. She became acquainted with codes that Dr. Nazario was submitting to the Medicaid agency and specifically the CPT codes 99214 and 99215. These are high level evaluation and management codes and these codes take more time and effort to perform. As a result of unusual reports, detailed claim reports were run for the time period of September 1, 2009 through August 31, 2011 and Ms. Casey states that she picked twenty-nine (29) Medicaid recipients randomly and these recipients' detailed claims reports were examined and then Ms. Casey went to Dr. Nazario's office and pulled the medical records that would be used to support these billed claims. These records were then compared to the scoring sheets, the Medicaid policy, the CPT Manual, and the 1995 guidelines provided by CMS,[1] and she scored each office visit. The CPT, *Current Procedural Terminology* is published by the American Medical Association. CMS has adopted the CPT as its standard coding document.

When the medical records were reviewed, Ms. Casey looked at such things as the Chief Complaint, History of the Present Illness, the Review of Systems, the past Family and Medical History and the Social History. Then, she would look at the Physical Exam and the Medical Decision Making, the Diagnosis and Plan of Care for treatment. The second page of Respondent's exhibit #1 is from Medicaid's policy manual and is related to an EPSDT visit, and if the requirements were not met from that page then Ms. Casey avers that she scored that particular visit as an office visit, rather than as a preventive or check-up. There is a set schedule for when an EPSDT visit should be made. There is a particular code for an EPSDT visit;

[1] Centers for Medicare and Medicaid Services

however, Dr. Nazario never billed for that code, just evaluation and management codes were billed. If the documentation indicated the visit was a check-up, then Ms. Casey avows that she would check to make sure that the records documented that an actual EPSDT visit was made.

The first page of Respondent's exhibit #1 came from the Medicaid Integrity Institute and it reflects the requirements for evaluation and management codes for office visits and it reflects the policies that SCDHHS has in place and the 1995 guidelines from CMS. Many times it was difficult to pull up information from the office notes and Ms. Casey states that many times she had to pull information from one part of the office note and apply it to another section that she was evaluating in order to find information on the scoring sheet. (See Respondent's exhibit #1, first page)

Ms. Casey references Respondent's exhibit #2 and the office visit of 08/06/10. For this office review, Dr. Nazario was given credit for the Review of Systems and Past Medical History. Ms. Casey asserts that she allowed Dr. Nazario an EPSDT visit for this child's 08/06/10 visit, that CPT code is 99393. She allowed for a blood draw, which is a CPT code of 36415, an 81002 for the urine, and 94664, which is demonstration of nebulizer or inhaler. Dr. Nazario did perform a nebulizer treatment on the child, which is a 94640. Dr. Nazario also billed a 92552, which is a hearing test and is included in an EPSDT visit; therefore, that code was bundled into the EPSDT visit that was paid and 92552 was not paid separately. Had Ms. Casey scored it as a 99215, which is an office visit, according to the score sheet, this visit would have been scored as a 99212 on the score sheet; therefore, Dr. Nazario got paid more money by Ms. Casey scoring it as an EPSDT visit rather than as a 99212. The Medical Decision Making, the Review of Systems and the documentation of the Plan of Care was lacking so the 99215 could not be paid.

Ms. Casey next references Respondent's exhibit #2 and the office visit of 01/25/10. On this visit, Dr. Nazario submitted a 99214, which is a detailed history, a detailed exam, and medical decision making of moderate complexity. Ms. Casey states that Dr. Nazario was given credit for Review of Systems. Ms. Casey only gave this visit an Expanded Problem Focused and 99214 requires a Detailed score under History. Ms. Casey gave this office visit credit for eight (8) body systems under the Physical Exam, which is a Comprehensive Physical Exam. Dr. Nazario did not order any tests or review any tests so this office visit was seen as Medical Decision Making of Low Complexity. This visit was allowed as a 99213, because it involved an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

Ms. Casey next references Respondent's exhibit #2 and the office visit of 4/20/10. There is nothing listed as the Reason for the visit so nothing could be marked for the History of the Present Illness. This visit was given credit for Review of Systems and Past Medical History. This visit was scored as Problem Focused because it was impossible to tell why the child was there. Under the Exam, this visit was scored as Comprehensive. Medical Decision Making was scored as Low Complexity. Based on this scoring, Ms. Casey found that this office visit should be coded as a 99213 rather than as a 99215 and the 94640 was allowed for the nebulizer treatment.

Ms. Casey states that an informal conference was held with Dr. Nazario and that was what led to the May 16, 2012 letter. The approximately $11,000 was based on what Dr. Nazario billed and what SCDHHS felt should have been billed.

On cross-examination, Ms. Casey asserts that the CPT codes 99381 through 99395 are the codes that encompass EPSDT visits. The policy states that screening components cannot be fragmented and billed separately. The screening provider cannot bill an office visit on the same day that a screening is billed (See Respondent's exhibit #3, page 2-57).

On redirect examination, Ms. Casey states that on the 08/06/10 visit (See Respondent's exhibit #2), she gave that visit a score under the Risk of Complications and/or Morbidity or Mortality (See Respondent's exhibit #2, ninth page) of Straight Forward because the child had a chronic illness with exacerbation. For a CPT code of 99215, the visit must meet or exceed two (2) of the three (3) key components: Comprehensive History, Comprehensive Examination, and Medical Decision Making of High Complexity. Ms. Casey states that for Comprehensive History, she found that to be Problem Focused rather than Comprehensive based on the History of Present Illness, the Review of Systems, and the Past Medical and Family History, so it did not meet the Comprehensive History component. For Comprehensive Examination, she found that to be Comprehensive. For Medical Decision Making, she found that to be Straight Forward. Therefore, this exam did not meet the requirements for a code of 99215.

Nancy Pittman: On direct examination, Nancy Pittman, Supervisor in the SCDHHS Division of Program Integrity asserts that the CPT is basically divided into five (5) different levels: it starts with 99201 through 99205 for the new patient visits and 99211 through 99215 for established patient visits. Within each of those ranges of visits are different levels with different components that are required to meet those levels for documentation and for billing for those levels of codes for office visits. Generally, there are three (3) components that are required for office management and billing: History, Physical Examination, and Medical Decision Making. There are components for each of these three major components. For example, under History there must be a Chief Complaint, a History of the Present Illness described, a Review of Systems, and a Past Family and Social History. All of these parts are considered in the History component of the CPT code. The Physical Examination component includes how many body systems or body areas the physician looks at. The Medical Decision Making component includes the number of tests that the physician might order, the old records that might be looked at, and there are risk factors that might be considered. For a particular code to be selected for an established patient, two (2) of the three (3) major components must be met or exceeded in the medical documentation.

On cross-examination, Ms. Pittman is directed to the 08/06/10 office visit in Respondent's exhibit #2 and states that the diagnosis given was sinusitis and bronchitis. Dr. Nazario billed this as a sick visit; however, what is documented in Dr. Nazario's office notes is primarily a well-child check or an EPSDT visit and this is the reason it was reassigned a preventive care code or a well visit code. There can be a sick component to the visit and that would be indicated by the diagnosis of that illness.

On redirect examination, Ms. Pittman states that the CPT does give guidance on how to code based on how much time is spent during the visit; however, unless the time is documented in the medical records, there is no way to tell how much time is spent. The amount of time spent is not used to determine what code should be used, unless fifty percent (50%) or more of the visit is used in counseling and coordination and that needs to be described or at least noted as a time. Dr. Nazario was paid $38,434.93 for the claims in question and SCDHHS is not asking for all of that money back.

b. For the Petitioner:

Dr. Nazario: On direct examination, Nilsa I. Nazario, M.D. asserts that she has provided examples of common procedure codes that were accepted by the Respondent for payment and she wishes to compare these codes to those that were not accepted by the Respondent (See Petitioner's exhibit #12, "Samples of 99204 Accepted", "Examples 99213 accepted", "Samples of 99214 accepted"). Dr. Nazario states that CPT codes 99391, 99392, and 99393 are the EPSDT codes. Dr. Nazario now refers to Petitioner's exhibit #12, "29 cases Reviewed" and read from her notes about what she disagreed with as far as how the Respondent determined if the CPT code given by Dr. Nazario was accurate.

On the first case, A.F., date of service (DOS) 04/16/10 (See Petitioner's exhibit #12, "29 Cases Reviewed") the diagnoses were Acute Gastroenteritis, Pharyngitis, Right Otitis Media (Rt. OTM), the patient had questions, he had an exam, he had interventions, hematocrit, 3 vaccines, diet instructions and he had a prescription. Dr. Nazario states that obviously at least twenty-five (25) minutes of moderate complexity, a full exam. He met criteria for 99214 not 99213; therefore, she disagrees with the Respondent.

On the next page, patient Y.G., DOS 11/14/10, the patient was very sick with tonsillitis, he had questions, exam, urine, flu shot. It was moderate complexity so it was billed 99214 and Medicaid only allowed 99212, which is a focused exam of ten (10) minutes, which means the patient came for just a sore throat and she only looked at his throat and gave him medicine. Her exams always include full vital signs and weight. Dr. Nazario avows the time of her examinations is not included in her office notes.

The next DOS is 01/03/11 which was a check-up. Dr. Nazario attests that during the period that the Respondent reviewed her billed claims, she was not an EPSDT provider per se.

On DOS 05/12/11, the patient came unstable with Croup and had questions, he had an exam, he had Racemic Epinephrine and two (2) Budesonides which is an anti-inflammatory drug by nebulizer, and ten (10) liters of indirect oxygen administered. The medicines are not billable. She states that obviously, this exam took over forty-five (45) minutes, it was a full exam and it had high complexity. Thus, it was a 99215 as billed and not a 99213, which means it would have had to be a fifteen (15) minute, low complexity exam; therefore, Dr. Nazario strongly disagrees with the Respondent's finding.

On case number 12, T.J., DOS 04/20/10, the patient had a diagnosis of Bronchitis. He had questions, an exam, Interventions were Xopenex, Pulmicort which is not billable, and ten

(10) liters of indirect oxygen. She states this is truly a 99215, high complexity because the child was unstable and not a 99213 which would make a short visit of fifteen (15) minutes of low complexity; therefore, Dr. Nazario strongly disagrees with the Respondent.

Dr. Nazario now refers to Petitioner's exhibit #12, "29 cases Reviewed" Case #20, I.R., and she refers to Petitioner's exhibit #9 which deals with the same patient. For the DOS 10/30/09, the child comes for fever and is found to have congestion of the chest with fine rales.[2] All the questions were done, all the vital signs were done, has multiple interventions done to include breathing treatments with oxygen, Xopenex with Pulmicort and is given medicine to control fever and a throat culture is done. The patient had an acute illness that involved respiratory distress and there was Medical Decision Making of high complexity and a full exam was done. Dr. Nazario states that because of her expertise, this patient did not have to go to the hospital.

Dr. Nazario next refers to Petitioner's exhibit #12, "29 cases Reviewed", Case #23, J.R., date of service 04/30/11 and Petitioner's exhibit #10 which deals with the same patient. This patient had all the questions, the comprehensive exam, the child was sick enough to stabilize with medicine for fever and he needed a full exam. He was given Pulmicort and Xopenex and he had eight (8) liters of oxygen and that cleared his airway. The CDC guidelines also apply in this case that allows a vaccination to be given if the child is sick and then stabilized. Dr. Nazario also checked the child's urine and hematocrit and she did multiple interventions in terms of the medicines. This case is not a 99213 which is a brief, low-complexity visit but is a 99215 because it is moderate to high complexity and it required multiple interventions and this child also did not end up in the emergency room.

Dr. Nazario next refers to Petitioner's exhibit #12, "29 cases Reviewed", Case #27, B.T.M., date of service 01/26/10 and Petitioner's exhibit #11. The diagnoses were Bronchiolitis, Otitis Media, and Mild Pharyngitis. There was an extensive review of medications and how to take them and there were breathing treatments administered. There were questions asked, there was a full exam, and there were interventions to include a double dose of Pulmicort which is not billable, because he had decreased air entry. Eight (8) liters of oxygen were administered and he was given a prescription also. Medicaid wants to change this visit to 99213 with makes it a fifteen (15) minute low complexity exam.

Dr. Nazario avers that prior to March 2011, Medicaid would not allow her to officially perform an EPSDT examination and because of this, many times she billed CPT codes for established patients rather than EPSDT codes; these established patient codes allowed less

[2] Extraneous sounds heard on auscultation of breath sounds; used by some to denote rhonchus and by others for crepitation. Rhonchus is an added sound with a musical pitch occurring during inspiration or expiration, heard on auscultation of the chest, and caused by air passing through bronchi that are narrowed by inflammation, spasm of smooth muscle, or presence of mucus in the lumen. Crepitation is crackling; the quality of a fine bubbling sound (rale) that resembles noise heard on rubbing hair between the fingers. See Stedman's Medical Dictionary for the Health Professions and Nursing (2012)

money to her than the EPSDT codes did. Additionally, Medicaid overlooks her translation costs. Dr. Nazario states that she is solely responsible for the coding done in her office.

On cross-examination, Dr. Nazario states that she performs a full examination on every patient at every visit because a full examination is medically necessary for all pediatric patients because their conditions can change so quickly.

FINDINGS OF FACT

The Petitioner, Laurens Pediatric Clinic is a corporation owned by a single Pediatrician, Dr. Nilsa Nazario. For ease of reading this Final Administrative Decision, the Petitioner and Dr. Nazario will be used interchangeably. Having observed the witnesses and exhibits presented at and after the hearing and closely passed upon their credibility, and considering the burden of persuasion by the parties, I make the following Findings of Fact by a preponderance of the evidence:

(1) This case is adjudicated under the authority of S.C. Code of Regulations, Reg. 126-150, et seq.

(2) Via Notice of Hearing of July 17, 2012, this Hearing Officer informed the parties of the hearing to be held on October 31, 2012. This Notice of Hearing directed that if either party as a part of their testimony intended to refer to a particular paragraph or section of a policy or procedure manual, directive, memorandum, etc., then it would be necessary for the parties to make copies in duplicate of these referenced sections.

(3) The South Carolina Department of Health and Human Services *Physicians Provider Manual*, Manual Updated 09/01/10, Section 2 Policies and Procedures, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Section discusses who may provide EPSDT services to Medicaid recipients and reads as follows:

Professional practitioners and other providers must be licensed and/or certified by the appropriate standard setting agency to provide services covered by South Carolina Medicaid. (Respondent's exhibit #3)

(4) As Dr. Nilsa Nazario has been found by the Respondent to be properly licensed and/or certified by the appropriate standard setting agency to provide services covered by South Carolina Medicaid, she was not prohibited from providing EPSDT services to Medicaid eligible recipients during the audit period in question, and I so find.

(5) Via the Medicaid Enrollment Agreement signed by Dr. Nilsa I. Nazario on February 16, 1990, Dr. Nazario agreed that she would keep adequate and correct fiscal and medical records to disclose the extent of services rendered and to assure that claims for funds are in accordance with all applicable laws, regulations and policies. Dr. Nazario also agreed that all services rendered and claims submitted shall be in compliance with all applicable federal and state laws and regulations and in accordance with the Health and Human Services Finance

Commission (now the South Carolina Department of Health and Human Services) policies, procedures, and Medicaid Provider Manuals. (Respondent's exhibit #4)

(6) The Respondent has provided this Hearing Officer with selected sections of the South Carolina Department of Health and Human Services *Physicians Provider Manual*, Manual Updated 09/01/10. While the audit period reviewed by the Respondent covered a period of time that also occurred before 09/01/10, neither party has asserted that the Physicians Provider Manual was different prior to 09/01/10; therefore, this Hearing Officer will presume that in the Physicians Provider Manual sections that have been provided, there were no substantive changes from the prior version. The Procedural and Diagnostic Coding section of the Physicians Provider Manual reads as follows:

> Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology, Fourth Edition* (CPT), published by the American Medical Association; and the diagnosis codes as defined in the *International Classification of Diseases, Ninth Edition (ICD-9)*, provided by the U.S. National Center for Health Statistics.
>
> In 1996, the Centers for Medicare and Medicaid Services (CMS) implemented the National Correct Coding Initiative (CCI) to control improper coding that leads to inappropriate increased payment for health care services. The South Carolina Medicaid program utilizes Medicare reimbursement principles. Therefore, the agency will use CCI edits to evaluate billing for CPT codes and Healthcare Common Procedure Coding System (HCPCS) codes by Medicaid providers in post-payment review of providers' records. (Respondent's exhibit #3)

(7) The Respondent asserts that the HCPro worksheets used to audit the Petitioner were introduced at the Medicaid Integrity Institute training at the National Advocacy Center. (Respondent's exhibit #8)

(8) The Petitioner asserts that she was unaware of the HCPro worksheets that were used to audit her records and these worksheets were not introduced at the informal conference with the Respondent. (Petitioner's exhibit #14 and Petitioner's testimony)

(9) The HCPro website[3] describes HCPro in this way: With more than 20 years of experience, HCPro, Inc. (www.hcpro.com), is a leading provider of integrated information, education, training, and consulting products and services in the vital areas of healthcare regulation and compliance.

(10) The HCPro worksheets used by the Respondent to audit the Petitioner's claims were simply tools utilized in the audit; however, the *Current Procedural Terminology, Fourth Edition* (CPT), published by the American Medical Association remained the guide and standard used to audit the Petitioner's records, and I so find.

(11) The Respondent has not proffered any CCI edits as guidelines for the audit period in question and has only proffered selected sections of the CPT as the guiding principles for the

[3] http://www.hcpro.com/about/hcpro.cfm

audit period in question and the Petitioner has not objected to these documents from the CPT; therefore, I find these documents to be those in effect during the audit period in question.

APPLICABLE LAW, POLICY AND AUTHORITATIVE TEXTS

The *Current Procedural Terminology, Fourth Edition* (CPT) is a proprietary text that is not available to this Hearing Officer; therefore, all direct CPT references come from those Respondent's exhibits proffered at the hearing. (See Respondent's exhibits #5 and #6) Additionally, the Petitioner has proffered excerpts from the *Current Procedural Coding Expert* which is a proprietary text from OPTUMInsight and which, while in a different format, appears similar to the CPT and will also be the source of CPT references. (See Petitioner's exhibit #12)

(1) The preponderance of the evidence means such evidence as, when considered and compared with that opposed to it, has more convincing force and produces in the mind the belief that what is sought to be proved is more likely true than not true. Sanders, Neese, and Nichols, South Carolina Trial Handbook, §9:5 Quantum of Evidence in Civil Cases (1994), (citing Frazier v. Frazier, 228 S.C. 149, 89 S.E.2d 225 (1955)).

(2) 42 CFR § 456.3 directs the South Carolina Medicaid agency (Respondent) in its oversight of Medicaid providers and reads as follows:

§ 456.3 Statewide surveillance and utilization control program.

The Medicaid agency must implement a statewide surveillance and utilization control program that—
(a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
(b) Assesses the quality of those services;
(c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
(d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

(3) 42 CFR § 456.5 further directs the Respondent with regard to the oversight of Medicaid providers and reads as follows:

§ 456.5 Evaluation criteria.

The agency must establish and use written criteria for evaluating the appropriateness and quality of Medicaid services. This section does not apply to services in hospitals and mental hospitals. For these facilities, see the following sections: §§ 456.122 and 456.132 of subpart C; and § 456.232 of subpart D.

(4) 42 CFR § 456.23 directs the Respondent with regard to post-payment reviews of Medicaid providers and reads as follows:

§ 456.23 Post-payment review process.

The agency must have a post-payment review process that—
(a) Allows State personnel to develop and review—
(1) Beneficiary utilization profiles;
(2) Provider service profiles; and
(3) Exceptions criteria; and
(b) Identifies exceptions so that the agency can correct misutilization practices of beneficiaries and providers.

(5) South Carolina Code of Regulations, Chapter 126, Article 4, Subarticle 1, 126-400E, defines provider abuse and reads as follows:

126-400. Definitions....

E. Abuse--provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

(6) South Carolina Code of Regulations, Chapter 126, Article 4, Subarticle 1, 126-401, describes the sanctions that may be applied to providers that abuse the Medicaid program and reads as follows:

126-401. Sanctions.

A. The Administrator of the Title XIX Single State Agency may invoke one (1) or more of the following administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program:
(1) Educational Intervention;
(2) Recoupment of Overpayment(s);
(3) Postpayment Review of Claims;
(4) Prepayment Review of Claims;
(5) Referral to Licensing/Certifying Boards or Agencies;
(6) Peer Review;
(7) Suspension;
(8) Termination.

B. The Administrator of the Title XIX Single State Agency may invoke one (1) or more of the following administrative sanctions against a Medicaid provider who has been determined to be guilty of fraud or convicted of a crime related to his or her participation in Medicare or Medicaid:
(1) Recoupment of Overpayment(s);
(2) Suspension;
(3) Termination.

(7) South Carolina Code of Regulations, Chapter 126, Article 4, Subarticle 1, 126-402, describes the factors to be considered when sanctioning a Medicaid provider and reads as follows:

126-402. Factors for Sanction.

The factors to be considered in determining sanctions shall include, but not be limited to, the following:
A. Seriousness of the offense(s);
B. Extent of violation(s);
C. History of prior violation(s);
D. Prior imposition of sanction(s);
E. Provider failure to obey program rules and policies as specified in the appropriate Provider Manual or other official notices.

(8) South Carolina Code of Regulations, Chapter 126, Article 4, Subarticle 1, 126-403, describes the grounds for sanctioning a Medicaid provider and reads as follows:

126-403. Grounds for Sanction.

The grounds for sanctioning providers shall include, but not be limited to, the following:

A. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.
B. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of the fee schedule or usual and customary charges.
C. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.
D. Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medicaid recipients and records of payment made therefore.
E. Continuing a course of conduct deemed abusive of the Medicaid Program after receiving written notice from the Single State Agency that said conduct must cease, provided that the written notice shall specify the practices deemed abusive.
F. Breach of the terms of the Medicaid provider agreement or failure to comply with the terms of provider certification on the Medicaid claim form.
G. Over-utilizing the Medicaid Program by including, furnishing, or otherwise causing a recipient to receive service(s) or merchandise not otherwise required by the recipient.
H. Rebating or accepting a fee or portion of a fee or charge for a Medical Patient referral.
I. Submission of a false or fraudulent application for provider status.
J. Conviction against a provider for a criminal offense related to his or her involvement in the Medicaid or Medicare Program.
K. Failure to meet standards required by State or Federal law for participation (i.e., failed to meet the licensing requirements constituting minimum qualification).
L. Exclusion from Medicare because of fraudulent or abusive practices (i.e., terminated or suspended from participation in the Medicare Program under 42 CFR Section 420, Part B.)

M. Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.
N. Failure to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments.

(9) The CPT has a section titled Evaluation and Management (E/M) Services Guidelines and the following sections are pertinent to this case:

> The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient).... The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes....
>
> The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See "Levels of E/M Services," page 3, for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on page 4.)....
>
> A chief complaint is a concise statement describing the symptom, problem, condition, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient's words....
>
> (Page 3) **Family History**
>
> A review of medical events in the patient's family that includes significant information about:
>
> - The health status or cause of death of parents, siblings, and children
> - Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review
> - Diseases of family members that may be hereditary or place the patient at risk
>
> **History of Present Illness**
>
> A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s)....
>
> The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the Levels of E/M Services. These components are:
>
> - History
> - Examination
> - Medical decision making

- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained," page 11.)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter....

The final component, time, is discussed in detail on page 8.[4]

Any specifically identifiable procedure (i.e., identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the level of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended.

The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date....

(Page 4) **Time**

The inclusion of time in the definition of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in *CPT 1992* is done to assist physicians in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances....

[4] The Respondent did not include page 8 of the CPT. The Petitioner also did not include page 8 of the CPT.

Studies to establish levels of E/M services employed surveys of practicing physicians to obtain data on the amount of time and work associated with typical E/M services. Since "work" is not easily quantifiable, the codes must rely on other objective, verifiable measures that correlate with physicians' estimates of their "work." It has been demonstrated that physicians' estimations of **intraservice** time (as explained on the next page), both within and across specialties, is a variable that is predictive of the "work" of E/M services. This same research has shown there is a strong relationship between intraservice time and total time for E/M services. Intraservice time, rather than total time, was chosen for inclusion with the codes because of its direct correlation with measurements of the total amount of time and work associated with typical E/M services.

Intraservice times are defined as **face-to-face** time for office and other outpatient visits and as **unit/floor** time for hospital and other inpatient visits....

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. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.

Physicians also spend time doing work before or after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact.

This **non-face-to-face** time for office services-also called pre- and postencounter time-is not included in the time component described in the E/M codes. However, the pre- and post-face-to-face work associated with an encounter was included in calculating the total work of typical services in physician surveys.

Thus, the face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit.

(10) The Evaluation and Management (E/M) Services Guidelines section of the CPT discusses Instructions for Selecting a Level of E/M Service and reads as follows:

Review the Level of E/M Service Descriptors and Examples in the Selected Category or Subcategory
The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (ie, history, examination, and medical decision making) should be considered the key components in selecting the level of E/M services. An exception to this rule is in the case of visits that consist predominantly of counseling or coordination of care (see numbered paragraph 3, page 8).

The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service.

Determine the Extent of History Obtained
The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of history that are defined as follows:

Problem focused: Chief complaint; brief history of present illness or problem.

Expanded problem focused: Chief complaint; brief history of present illness; problem pertinent system review.

Detailed: Chief complaint; extended history of present illness; problem pertinent system review extended to include a review of a limited number of additional systems; **pertinent** past, family, and/or social history **directly related to the patient's problems.**

Comprehensive: Chief complaint; extended history of present illness; review of systems that is directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; **complete** past, family, and social history. The comprehensive history obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

Determine the Extent of Examination Performed
The extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s). The levels of E/M services recognize four types of examination that are defined as follows:

Problem focused: A limited examination of the affected body area or organ system.

Expanded problem focused: A limited examination of the affected body area or organ system and other symptomatic or related organ system(s).

Detailed: An extended examination of the affected body area(s) and other symptomatic or related organ system(s).

Comprehensive: A general multisystem examination or a complete examination of a single organ system....

For the purposes of these CPT definitions, the following body areas are recognized:

- Head, including the face

- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

For the purposes of these CPT definitions, the following organ systems are recognized:

- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in Table 1 must be met or exceeded.

Comorbidities/underlying diseases, in and of themselves are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision making.

Table 1

Complexity of Medical Decision Making

Number of Diagnoses or Management Options	**Amount and/or Complexity of Data to be Reviewed**	**Risk of Complications and/or Morbidity or Mortality**	**Type of Decision Making**
minimal	minimal or none	minimal	**straightforward**
limited	limited	low	**low complexity**
multiple	moderate	moderate	**moderate complexity**
extensive	extensive	high	**high complexity**

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

1. For the following categories/subcategories, **all of the key components,** ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; inpatient hospital care; office consultations; initial patient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.

2. For the following categories/subcategories, **two of the three key components** (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3. When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then **time** may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

(11) The Evaluation and Management section of the CPT defines codes used to report evaluation and management services provided in the physician's office for established patients and reads as follows:

Established Patient

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.

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 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 and/or family.

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **An expanded problem focused history;**
- **An expanded problem focused examination;**
- **Medical decision making of low complexity.**

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 of low to moderate severity. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **A detailed history;**
- **A detailed examination;**
- **Medical decision making of moderate complexity.**

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 of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination;**
- **Medical decision making of high complexity.**

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 of moderate to high severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

(12) The Evaluation and Management section of the CPT defines codes used to report evaluation and management services provided in the physician's office for new patients and reads as follows:

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components:

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

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components:

- **A detailed history;**
- **A detailed examination;**
- **Medical decision making of low complexity.**

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 components:

- **A comprehensive history;**
- **A comprehensive examination**
- **Medical decision making of moderate complexity.**

(13) The *Current Procedural Coding Expert* defines codes used to report evaluation and management services provided in the physician's office for Preventive Medicine Visits, which include those considered by the Respondent to be EPSDT visits, and reads as follows:

99381-99397 Preventive Medicine Visits
Includes Care of a small problem or preexisting condition that requires no extra work
New patients or established patients (99381-99387 or 99391-99397)
Regular preventive care (e.g., well-child exams) for all age groups

Excludes *Counseling/risk factor reduction interventions not provided with a preventive medical examination (99401-99412)*
Diagnostic tests and other procedures

Code also immunization administration and product (90460-90461, 90471-90474, 90476-90749[90665])
Code also substantial problems that require additional work (99201-99215)

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age- and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

99382 early childhood (age 1 through 4 years)

99383 late childhood (age 5 through 11 years)
99384 adolescent (age 12 through 17 years)
99385 18-39 years

99386 40-64 years

99387 65 years and older

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)

99392 early childhood (age 1 through 4 years)

99393 late childhood (age 5 through 11 years)

99394 adolescent (age 12 through 17 years)

99395 18-39 years...

(14) The SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10* describes EPSDT services and reads as follows:

The South Carolina Medicaid Program, in accordance with federal requirements, must develop and maintain a program of Early and Periodic Diagnosis, Screening, and Treatment (EPSDT) for Medicaid eligible children. EPSDT is the preventive, well-child screening program in South Carolina. EPSDT provides comprehensive and preventive health services to Medicaid-eligible children from birth to age 21 through periodic medical screenings. The screening package includes the following:

- A comprehensive health and developmental history, including assessment of both physical and mental health development
- A comprehensive unclothed physical examination
- Identify the appropriate immunizations according to age and health history (does not include the administration)
- Health education, including anticipatory guidance
- Vision and hearing screening
- Dental screening

Immunization administration, topical fluoride varnish, laboratory tests, blood level assessments, age limited screenings, and elective tests are covered separately utilizing the appropriate CPT code and billed according to the periodicity schedule under "Reimbursement Policies" in this section. Each of these will also be outlined in this section.

(15) The SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10* describes EPSDT Reimbursement Policies and reads as follows:

EPSDT screening will be reimbursed at a uniform rate. Although screening services vary according to age and schedule, the reimbursement is intended to be an equitable average fee. Any other test or treatment service performed should be billed separately. The following guidelines should be used when billing:

- Screening components cannot be fragmented and billed separately. The screening provider cannot bill an office visit on the same day a screening is billed.
- South Carolina Medicaid policy does not allow providers to bill an EPSDT well-child screening on the same day as a sick visit.
- Use diagnosis code V20.2 when no medical problems are identified.
- If individual components of a screening are not performed, the reason must be appropriately documented. Reimbursement for the screening fee may be subject to recoupment if each age-appropriate component is not performed and documented.
- Medicaid providers enrolled with SCDHEC in the VAFAC program may bill an immunization administration fee.

The codes to be used when billing for screenings and immunizations are as follows:
99381 – Preventive visit, new, infant
99382 – Preventive visit, new, age 1 – 4
99383 – Preventive visit, new, age 5 – 11
99384 – Preventive visit, new, age 12 – 17
99385 – Preventive visit, new, age 18 – 39*
99391 – Preventive visit, established, infant
99392 – Preventive visit, established, age 1 – 4
99393 – Preventive visit, established, age 5 – 11
99394 – Preventive visit, established, age 12 – 17
99395 – Preventive visit, established, age 18 – 39*

(16) The SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment.

(17) The SCDHHS *Physicians, Laboratories, and Other Medical Professionals, Provider Manual, 02/01/05* states that with few specified exceptions in the South Carolina Medicaid program, the Respondent does not routinely cover brand name products for which there are "A" rated, therapeutically-equivalent generic products available. There are many drugs (or categories of drugs) that require clinical prior authorization. The South Carolina Medicaid Pharmacy Services' prior authorization program, administered by Magellan Medicaid Administration, is comprised of a clinical prior authorization process as well as a non-clinical prior authorization process. Prescribing physicians are able to use this system to attempt to obtain medications that are not normally available to patients eligible for Medicaid.

CONCLUSIONS OF LAW

The Petitioner outlined the twenty-nine (29) Medicaid recipients that were reviewed during the audit period in question and she stated those proposed recoupments with which she agreed and those with which she did not agree (see Petitioner's exhibit #12, 29 Cases Reviewed). The office

notes upon which the Respondent based its recoupment are found in Petitioner's exhibit #13. This Hearing Officer will structure his analysis based on the statements by the Petitioner in addition to relevant policy and regulations with regard to the Petitioner's individual recoupment arguments (Petitioner's exhibit #12, 29 Cases Reviewed) and the actual office notes (Petitioner's exhibit #13).

1) A.A.F., Medicaid Recipient # 8780864014

DOS: 04/16/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam but the Respondent has asserted via testimony that this was a Comprehensive exam. The Petitioner diagnosed three (3) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up and shots, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed one (1) condition in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 08/04/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

2) B.A.F., Medicaid Recipient # 0781077476

DOS: 10/11/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; therefore, this Hearing Officer cannot make an initial determination with regard to this CPT descriptor.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal or no data was reviewed or that the data was more than minimal or no complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was staightforward.

DOS: 01/15/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, I must assume that the Petitioner is referring to a CPT-driven "Detailed" exam. This visit was a follow-up visit after an emergency room visit. The Petitioner diagnosed three (3) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

3) Y.C.G., Medicaid Recipient # 7780561792

DOS: 08/12/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a well-child check-up, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. There is no indication as to the reason for this visit; however, the Petitioner was given a flu shot and was diagnosed with tonsillitis; therefore, it appears that this was a sick child visit for the tonsillitis. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since it appears that this child was seen for tonsillitis, at most this exam is a problem focused exam. The Petitioner diagnosed one (1) condition in this visit. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/03/11- This child was seen in order to obtain a second flu shot. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for only a flu shot and no particular diagnosis was given, at most this exam is a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 05/12/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner uses the term "full" exam which is not a CPT term; however, given the Petitioner's allegation that this was at least a 45 minute exam, it appears that the Petitioner is referring to a CPT-driven "Comprehensive" exam; however, since this child was seen for acute coughing, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this child. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 06/23/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the CPT descriptor for the type of exam done; however, given the Petitioner's allegation that this was at least a 25 minute exam, it appears that the Petitioner is referring to a CPT-driven "Detailed" exam; however, since this child was seen for a check-up prior to entering school, at most this exam is an Expanded problem focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

4) Y.C., Medicaid Recipient # 0781042174

DOS: 09/05/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; however, since it is alleged that this should be coded as 99204, it appears that the Petitioner feels that the exam was a comprehensive exam. The Petitioner was diagnosed with three (3) conditions. There is no evidence that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was greater than low; therefore, the complexity of medical decision making was low complexity.

DOS: 09/25/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since this child was seen for a recheck and shots, at most this exam is an Expanded problem

focused exam. The Petitioner diagnosed two (2) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 12/05/09- This child was seen in order to obtain needed shots. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam; however, since this child was seen only for shots and no particular diagnosis was given, at most this exam is a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 06/07/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. The Petitioner diagnosed three (3) conditions in this visit. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 07/26/10- This child was seen in order to obtain needed one year old shots. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam; however, since this child was seen only for shots and one (1) diagnosis was given, at most this exam is a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 11/08/10- This child was seen for an acute illness and a fifteen (15) month old check-up. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and that does appear reasonable. This child was seen only for pharyngitis and a routine child exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/03/11- This child was seen for a check-up and shots. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam. The child was diagnosed with sinusitis only and based on the limited exam for a check-up and shots, this was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/20/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that this visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness that does appear reasonable. The Petitioner diagnosed four (4) conditions in this child and respiratory treatments were administered and multiple medications prescribed. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 01/21/11- This child was seen as a recheck after the previous day's visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and since the previous day's visit showed the child to be acutely ill and requiring significant treatment, I find this to be valid. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 02/05/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam but since the child was seen just for a check-up and subsequently diagnosed with two (2) respiratory conditions, this was an expanded problem focused exam. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 02/12/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. The Petitioner diagnosed one (1) condition in this visit.

There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was staightforward.

5) M.C., Medicaid Recipient # 5780979687

DOS: 02/05/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute respiratory illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 07/13/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. The Petitioner did not diagnose a condition but only diagnosed this as a routine check-up. There is no indication that a detailed examination was made nor is there an indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity. The Petitioner was not precluded from billing for an EPSDT exam.

DOS: 10/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute respiratory illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute respiratory illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 04/14/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. The Petitioner did diagnose four (4) conditions in this child with significant respiratory and skin conditions; therefore, this does appear to be a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 05/19/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was a recheck from an insect bite. The Petitioner diagnosed two (2) skin conditions with an additional comment of enlarged tonsils so a detailed examination is appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

6) S.R.C., Medicaid Recipient # 1781132070

DOS: 04/22/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; however, since it is alleged that this should be coded as 99204, it appears that the Petitioner feels that the exam was a comprehensive exam. The Petitioner diagnosed three (3) conditions in this child with an acute respiratory problem and it was noted that the child has ear tubes, it is reasonable to assume that the Petitioner performed a comprehensive exam. There is no evidence that the Petitioner reviewed more than limited data or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was greater than low; therefore, the complexity of medical decision making was low complexity.

DOS: 05/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was due to an acute illness. The Petitioner diagnosed three (3) conditions so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 05/10/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however,

since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was a follow-up from the 05/01/10 office visit. The Petitioner diagnosed one (1) condition and the child was still in respiratory distress so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 06/04/10- This child was seen as a recheck after the 05/10/10 visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and since the previous visit showed the child to be acutely ill and requiring significant treatment, I find this to be valid. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 07/05/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This visit was due to this child needing routine, childhood shots. The Petitioner diagnosed one (1) respiratory condition in addition to providing the shots so it appears that this was only a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward. The Petitioner cannot be credited $13.00 for the administration of multiple shots because a clean claim has not been submitted to the Respondent within one year of the date of service pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05.*

DOS: 09/03/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This visit was due to this child's poor appetite. A physical examination was performed with no other studies done. The Petitioner diagnosed two (2) conditions so it appears that this was only a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 10/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner

feels that this is a detailed examination. This exam was done due to an acute illness and the Petitioner diagnosed four (4) conditions so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 10/23/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute respiratory illness, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 01/03/11- This child was seen for routine child development shots and for a second flu shot. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused." No diagnosis was given other than Routine infant or child health check; therefore, this exam was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/24/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was done due to an acute illness and the Petitioner diagnosed three (3) conditions so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 03/11/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was done due to an acute illness and the Petitioner diagnosed two (2) conditions so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 04/30/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was done due to an acute illness and the Petitioner diagnosed two (2) conditions so a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 05/10/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness with fever, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 06/18/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This exam was done to administer a childhood Hepatitis B vaccination but on examination it was noted that three abnormal conditions were present; therefore, a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 07/15/11- This child was seen for routine child development check-up. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused." Other than Routine infant or child health check, the only other diagnosis given was enlarged tonsils; therefore, this exam was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

7) M.D.B., Medicaid Recipient # 6781199253

DOS: 08/24/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; however, since

it is alleged that this should be coded as 99204, it appears that the Petitioner feels that the exam was a comprehensive exam. The Petitioner performed a limited exam that was related mainly to the problems that the parent discussed and many of the body systems were not examined; therefore, this was a problem focused exam. There is no evidence that the Petitioner reviewed more than minimal data or that the data was of more than minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was greater than minimal; therefore, the complexity of medical decision making was straightforward.

DOS: 08/26/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for a check-up but was diagnosed with two (2) conditions after examination of the following body areas: head, neck, and chest and the gastrointestinal system. Due to the limited exam, this was an expanded problem focused exam. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 10/29/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness and was given an extensive physical exam, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 11/15/10- This child was seen for a routine child development check-up. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam. The only diagnosis given was Routine infant or child health check; therefore, this exam was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and three (3) conditions were diagnosed; therefore, a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or

mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 01/22/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness and was given an extensive physical exam, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 02/11/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214 (or 99215), it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and two (2) conditions were diagnosed; therefore, a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 02/14/11- This child was seen for a recheck following the 02/11/11 office visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam. The only diagnosis given was Improved Bronchiolitis;[5] therefore, this exam was a problem focused exam. There is no indication that more than limited data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 03/05/11- The Petitioner billed this as 99214, Office or other outpatient visit; therefore, it appears that the Petitioner did not want this billed as an EPSDT visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a routine check-up and shots and the parents had no complaints; however, the child was diagnosed with Pharyngitis[6] and Routine infant or child health check. This was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence

[5] Acute viral illness common in children younger than 2 years old. See Stedman's Medical Dictionary for the Health Professions and Nursing (2012)

[6] Inflammation of the mucous membrane and underlying parts of the pharynx (throat). See id.

that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 04/25/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and three (3) conditions were diagnosed; therefore, a detailed exam appears appropriate. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 06/09/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness and was diagnosed with three (3) conditions, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

8) R.D.S., Medicaid Recipient # 5780783709

DOS: 09/25/09- This child was seen for a routine check-up and shots with a normal physical exam. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam. The only diagnosis given was Routine infant or child health check; therefore, this exam was a problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/22/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness and was diagnosed with one (1) respiratory condition, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 03/04/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 05/07/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a check-up and diagnosed with a heart murmur and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 07/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 09/10/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 11/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 01/03/11- This child was seen for a routine check-up and shots with a normal physical exam. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 02/12/11- This child was seen for a routine check-up. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 03/31/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 06/30/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

9) E.E., Medicaid Recipient # 0780804031

DOS: 09/10/09- This child was seen for an acute illness. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the

physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 09/19/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 10/12/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness and fever, that does seem reasonable. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 10/15/09- This child was seen for a recheck after the 10/12/09 office visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 10/22/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/05/09- This child was seen for a check-up and flu shot. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it

appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. The child was diagnosed with poor weight gain and Routine infant or child health check. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 11/16/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/23/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 12/14/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 01/05/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 02/09/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however,

since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 03/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 03/20/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/15/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/22/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 07/28/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a

CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 08/07/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a urine check, diagnosed with sinusitis and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 08/23/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 08/31/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 09/27/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 10/18/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner

feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 10/19/10- The Petitioner gave no reason for this visit; however, note it follows the previous day's visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. The child was diagnosed with improved otitis media and sinusitis. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 11/01/10- This child was seen for a check-up and was diagnosed with sinusitis and urinary stream problems and the child was referred to an Urologist. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 11/15/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a second flu shot and an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/30/10- The Petitioner gave the reason for this visit as ROS[7] ɵ[8] and the child was diagnosed with a Routine infant or child health check. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam

[7] Review of Systems. See Stedman's Medical Dictionary for the Health Professions and Nursing (2012)

[8] With no indication as to what this symbol means and being unable to find a reference source with this symbol, this Hearing Officer has interpreted it to mean "negative."

performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 12/10/10- The Petitioner gave the reason for this visit as a check-up and the child was diagnosed with resolved viral illness and sinusitis. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 12/20/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 01/04/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 01/27/11- The Petitioner gave the reason for this visit as a check-up and the child was diagnosed with a Routine infant or child health check. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than

minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/31/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute injury and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 02/03/11- The Petitioner gave the reason for this visit as a recheck of the injury related to the office visit of 01/31/11. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 02/21/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 03/21/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 04/11/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the

child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/25/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/28/11- The Petitioner did not give a reason for this visit; however, I note that it occurred soon after the 04/25/11 office visit. The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 05/31/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 06/06/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute injury and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 06/20/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This Hearing Officer cannot determine the reason for this visit based on the Petitioner's office notes; however, since the child was diagnosed with apparent exacerbations of conditions and based on the physical exam, this was a detailed exam.

There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 06/23/11- It appears that the Petitioner is requesting that this Hearing Officer make an initial determination to require the Respondent to pay for a 99214 examination when the Petitioner failed to bill for any type of examination. The Petitioner is required to submit claims free of errors to the Respondent within one (1) year from the date of service in order for those claims to be considered for payment; therefore, the Petitioner is not entitled to the payment for code 99214 as a part of this Final Administrative Decision pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05.*

DOS: 06/25/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 08/05/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This Hearing Officer cannot determine the reason for this visit based on the Petitioner's office notes; however, since the child was diagnosed with contact dermatitis on the face and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

10) P.A.F., Medicaid Recipient # 1780225362

DOS: 08/06/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and since the child was seen for an acute illness, that does seem reasonable. This child was seen for a check-up because he was starting school in the next week. There is no indication that extensive data was reviewed or that the data was of extensive complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was high; therefore, Complexity of Medical Decision Making for this billed visit was not of high complexity. Additionally, the Petitioner has presented no CPT-driven evidence to prove that this exam was not an EPSDT visit (99393), which would have included the hearing test.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and although the child was seen just for a check-up and shots, the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 01/29/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for needed shots and based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 08/04/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a check-up and was diagnosed with being overweight and a Routine infant or child health check. Based on the physical exam, this was a detailed exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

11) M.J.G., Medicaid Recipient # 0780073291

DOS: 07/31/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for a check-up and was diagnosed with tonsillitis, enlarged tonsils, white blood cells (WBC's) in urine and being overweight. Based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 12/11/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner

feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

12) T.N.J., Medicaid Recipient # 4781079479

DOS: 12/01/09- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and the child was seen for an acute illness and the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 01/07/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and as the child was seen for an acute illness, the exam given does appear to be comprehensive. There is no indication that extensive data was reviewed or that the data was of extensive complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was high; therefore, Complexity of Medical Decision Making for this billed visit is not of high complexity. The Petitioner was not precluded from performing an EPSDT examination.

DOS: 01/25/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 02/09/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam and the child was seen for an acute illness and the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 04/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/20/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. The Petitioner did not comment on the reason for the office visit but the child was diagnosed with an acute respiratory illness and the exam given does appear to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 10/28/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. This child was seen for needed shots and was diagnosed with allergies and an acute illness and based on the physical exam, this was a detailed exam. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity. The Petitioner was not precluded from performing an EPSDT examination.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for an acute illness and based on the exam given, it appears to be comprehensive. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 08/23/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. The Petitioner gave no reason for this visit but the child was diagnosed with only a Routine infant or child health check. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than minimal

data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

13) A.L., Medicaid Recipient # 8781109832

DOS: 02/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the extent of examination that was performed; however, since it is alleged that this should be coded as 99204, it appears that the Petitioner feels that the exam was a comprehensive exam. Based on the examination that was performed it does appear to be a comprehensive exam. There is no evidence that the Petitioner reviewed more than limited data or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was greater than low; therefore, the complexity of medical decision making was low complexity.

DOS: 02/08/10- It appears that the Petitioner is asserting that the 99391 (EPSDT) code should have been disallowed by the Respondent but was not. The Petitioner was not precluded from billing for an EPSDT examination and the Petitioner has given no valid CPT-driven argument for coding this visit as a 99213 visit rather than as a 99391 (EPSDT) visit.

DOS: 03/18/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 04/05/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for an acute illness and based on the exam given, it appears to be comprehensive. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 05/08/10- The Petitioner asserts that the Petitioner was precluding from billing for a 99391 (EPSDT) visit and for that reason this visit should be paid as a 99214 visit; however, the Petitioner has produced no evidence that it was not allowed to perform EPSDT exams. (SCDHHS *Physicians Provider Manual*, Manual Updated 09/01/10, Section 2 Policies and Procedures, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Section)

DOS: 07/10/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however,

since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was more than of limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 09/25/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for an acute illness and based on the exam given, it appears to be comprehensive. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 10/23/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that moderate data was reviewed or that the data was of moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was moderate; therefore, Complexity of Medical Decision Making for this billed visit was not of moderate complexity. Additionally, the Petitioner was not precluded from performing EPSDT exams pursuant to the SCDHH *Physicians Provider Manual*, Manual Updated 09/01/10, Section 2 Policies and Procedures, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Section.

DOS: 11/13/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. The Petitioner was seen for a check-up and was diagnosed with a cow milk protein allergy. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 02/12/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that moderate data was reviewed or that the data was of moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was moderate; therefore, Complexity of Medical Decision Making for this billed visit was not of moderate complexity.

DOS: 04/05/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that moderate data was reviewed or that the data was of moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was moderate; therefore, Complexity of Medical Decision Making for this billed visit was not of moderate complexity.

DOS: 05/14/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. This child was seen for needed shots and the child was diagnosed with a Routine infant or child health check, pharyngitis, and oral Moniliasis.[9] There is no indication that more than minimal data was reviewed or that the data was of more than minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 08/13/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for an acute illness and based on the exam given, it appears to be comprehensive. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was of low complexity.

DOS: 08/27/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. This child was seen for an acute illness. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

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[9] Moniliasis is a synonym for candidiasis. Candidiasis is an infection with, or disease caused by *Candida*, especially *C. albicans*. This disease usually results from debilitation (as in immunosuppression and especially AIDS), physiologic change, prolonged administration of antibiotics, and barrier breakage. Commonly affected areas include the skin, oral mucous membranes, respiratory tract, and vagina. See Stedman's Medical Dictionary for the Health Professions and Nursing (2012)

14) L.P.S., Medicaid Recipient # 4781222330

DOS: 10/28/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. The Petitioner did not indicate the reason for the office visit but the child was diagnosed with improving jaundice and bronchitis. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 10/30/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. This child was seen for an acute illness. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 11/06/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. The child was diagnosed with improved jaundice and bronchitis. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 11/15/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 12/21/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem

focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 01/03/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 01/08/11- The Petitioner billed for a 99214 visit and the Respondent asserts that the visit is actually a 99391(EPSDT) visit. The Petitioner disputes the change in CPT codes because the Petitioner alleges that she was not allowed to bill for an EPSDT visit. The Petitioner was not precluded from performing EPSDT exams pursuant to the SCDHHS *Physicians Provider Manual*, Manual Updated 09/01/10, Section 2 Policies and Procedures, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Section.

DOS: 08/06/11- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

15) G.M., Medicaid Recipient # 3780850545

DOS: 02/22/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 03/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner does not comment on the type of exam done; however, given the Petitioner's allegation that the visit should be coded as 99215, it appears that the Petitioner is referring to a CPT-driven "comprehensive" exam. This child was seen for an acute illness and based on the exam given, it appears to be comprehensive. There is no indication that extensive data was

reviewed or that the data was of extensive complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was high complexity; therefore, Complexity of Medical Decision Making for this billed visit was not of high complexity.

DOS: 04/08/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner did not comment on the type of exam performed; however, since it is alleged that this visit should be coded as 99213, it appears that the Petitioner is referring to a CPT-driven "expanded problem focused" exam and based on the physical exam, it was an expanded problem focused exam. There is no indication that more than minimal data was reviewed or that the data was more than of minimal complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than minimal; therefore, Complexity of Medical Decision Making for this billed visit was straightforward.

DOS: 04/12/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner billed this visit as 99214 and now states that it is truly a 99215, it appears that the Petitioner feels that this is at a minimum a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 05/03/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 06/17/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 07/01/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of

complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 07/15/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 09/11/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner alleges that this visit should be coded as 99214, it appears that the Petitioner feels that this is a detailed examination. Based on the exam that was given, it does appear to be a detailed examination. There is no indication that more than limited data was reviewed or that the data was of more than limited complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than low; therefore, Complexity of Medical Decision Making for this billed visit was low complexity.

DOS: 10/28/10- The Petitioner did not comment on the level of History descriptor for the levels of E/M services; therefore, this descriptor will not be evaluated by this Hearing Officer. The Petitioner also does not comment on the CPT descriptor for the type of exam done; however, since the Petitioner billed this visit as 99215, it appears that the Petitioner feels that this is a comprehensive examination. Based on the exam that was given, it does appear to be a comprehensive examination. There is no indication that more than moderate data was reviewed or that the data was of more than moderate complexity. There is no evidence that the child's risk of complications and/or morbidity or mortality was more than moderate; therefore, Complexity of Medical Decision Making for this billed visit was of moderate complexity.

DOS: 11/22/10- The Petitioner writes that she filed this claim as a 99215 visit but it is actually a 99214 visit. The Petitioner also writes that the Respondent incorrectly wishes to recoup the difference between a 99215 visit and an EPSDT (99393) visit. The Petitioner also disputes the Respondent's proposed recoupment of the money paid for the hearing test. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/22/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/05/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/11/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

16) M.M., Medicaid Recipient # 3780850547

DOS: 02/02/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/22/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/03/10- The Petitioner asserts that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, The SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 04/08/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/07/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 09/11/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/28/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. Additionally, the Petitioner was not precluded from performing an EPSDT exam.

DOS: 02/19/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/05/11- In the office notes for this visit, the Petitioner indicates that the reason for the visit was that the child had no complaints and the only diagnosis given was a Routine infant or child health check. The Petitioner has given no argument to support even a 99212 coding for this visit, i.e., that a problem focused history was obtained, that a problem focused examination was given or that medical decision making was even straightforward; therefore, the Respondent's finding that this visit should have been billed as a 99211 must be upheld.

DOS: 07/11/11- The Petitioner states that she incorrectly billed for a 99213 exam but the exam is truly an EPSDT visit. The Petitioner also alleges that the Respondent originally gave her credit for the EPSDT exam (99393) but later upon review did not allow this credit; however, with no evidence to support this allegation, this Hearing Officer has no way of determining what actually happened between the Petitioner and the Respondent. Based upon the Petitioner's

proffered Detailed Claims Report (See Petitioner's exhibit #13), it appears that the Respondent did recognize this as an EPSDT visit and deducted the amount paid for a hearing test as that is covered in an EPSDT exam.

17) V.M., Medicaid Recipient # 3780850543

DOS: 04/08/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/03/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/07/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/17/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/01/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 09/11/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/28/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/13/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/15/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/05/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/11/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

18) J.M.S., Medicaid Recipient # 8780695348

DOS: 03/02/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/08/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/08/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/29/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/30/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. The Petitioner originally billed the Respondent for a 99214 exam; however, the Respondent found that the exam done was a 99212 exam based on the office visit documents. The reason for the visit was for a check-up as the child was about to start school. The child was diagnosed with a Routine infant or child health check. The Petitioner now states that this could have been an EPSDT exam (99393) and apparently she is asking this Hearing Officer to direct the Respondent to pay her for that type of exam. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual*, 02/01/05 requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 06/25/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/13/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

19) B.M., Medicaid Recipient # 4781164085

DOS: 06/05/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/05/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 11/11/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/02/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. Additionally, the Petitioner was not precluded from performing EPSDT exams.

DOS: 12/20/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/15/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/22/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/26/11- The Petitioner asserts that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, The *SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 03/17/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/04/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/15/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/25/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. The Petitioner did not supply all of the components of an EPSDT exam pursuant to the *SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10*, such as, a developmental assessment, vision screening, and hearing screening. Therefore, the Petitioner could not appropriately bill for a 99392 (EPSDT) visit.

20) I.R., Medicaid Recipient # 5780909953 (These office notes are contained in Petitioner's Exhibit #9)

DOS: 10/30/09- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/11/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

21) J.R., Medicaid Recipient # 0781081084

DOS: 07/17/10- The reason for this visit was for a check-up and it was a new patient visit. The Petitioner performed all of the required components of an EPSDT exam pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10*; therefore, the Petitioner should have been paid for a 99383 EPSDT visit. The hearing test, a screening component, cannot be fragmented and billed separately. The Petitioner used diagnosis code V20.2 which is the code used when no medical problems are identified pursuant to the *SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10.* While the Petitioner also diagnosed this child with sinusitis, no evidence has been presented to document that the sinusitis was more than a small problem or preexisting condition that required extra work and this visit should be paid as a 99383 EPSDT visit pursuant to the *Current Procedural Coding Expert.* The Petitioner was not precluded from performing an EPSDT exam. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/19/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/08/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/07/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/11/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. The Respondent disallowed the payment for the hearing test because there was insufficient justification in the medical records for this test. There is no indication in the medical records that this child complained of decreased hearing and the Petitioner has produced no additional records to support sufficient justification for this test.

22) V.R., Medicaid Recipient # 0781081085

DOS: 06/14/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 09/23/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/08/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/07/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/11/11- The reason for this visit was for a check-up and it was an established patient visit. The Petitioner performed all of the required components of an EPSDT exam pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10*; therefore, the Petitioner should have been paid for a 99393 (EPSDT) visit. The Petitioner states that she agrees that this was a 99393 (EPSDT) visit; however, she still wants to get paid for the hearing test. The hearing test, a screening component, cannot be fragmented and billed separately. The Petitioner used diagnosis code V20.2 which is the code used when no medical problems are identified pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10.* While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/11/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

23) J.R., Medicaid Recipient # 1781132069 (These office notes are contained in Petitioner's Exhibit #10)

DOS: 05/01/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/05/10- The Petitioner states that the child was seen for a school check-up and the child was sick. The Petitioner performed all of the required components of an EPSDT exam pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10.* The child was diagnosed with sinusitis, allergies, and V20.2 which is the code used when no medical problems are identified pursuant to the *SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10.* The Petitioner again asserts that she was not able to provide

EPSDT services; however, she has presented no support for that assertion. The screening provider (Petitioner) cannot bill an office visit on the same day a screening (EPSDT visit) is billed pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10.* While the Petitioner alleges that the child was sick with sinusitis and allergies, there is no medical justification for performing the screening tests such as the vision exam and hearing test; therefore, this visit is properly coded as a 99393 EPSDT visit. The hearing test, a screening component, cannot be fragmented and billed separately. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/14/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/28/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/21/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/04/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/30/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/18/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/15/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

24) R.S., Medicaid Recipient # 5781235730

DOS: 12/02/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/06/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/10/10- The Petitioner asserts that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 01/04/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/06/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/08/11- The Petitioner asserts that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, The SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/13/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/20/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/27/11- While the Petitioner does agree to accept the recoupment in payment from an office visit (99214) to an EPSDT visit (99391), she again states that she was not allowed to perform EPSDT exams; however, she has offered no proof for this assertion.

DOS: 02/24/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/25/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/31/11- The Petitioner asserts that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial

claims processor and cannot act as the Respondent's agent in this matter. Additionally, the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 04/11/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/14/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/25/11- The Respondent paid the Petitioner for the billed 99213 office visit. Now, it appears that the Petitioner is asserting that this claim was originally billed incorrectly and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 05/19/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/23/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/31/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. The Petitioner did not supply all of the components of an EPSDT exam pursuant to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10*, such as, a developmental assessment, vision screening, and hearing screening. Therefore, the Petitioner could not appropriately bill for a 99391 (EPSDT) visit.

DOS: 06/27/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/07/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/05/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

25) D.T.P., Medicaid Recipient # 1781122218

DOS: 03/12/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/15/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/03/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/05/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/03/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/21/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. Additionally, the Petitioner has provided no evidence to support her assertion that she was not allowed to provide EPSDT exams (99391).

DOS: 07/29/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/12/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 09/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous. Additionally, the Petitioner has provided no evidence to support her assertion that she was not allowed to provide EPSDT exams (99391).

DOS: 11/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/03/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/13/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/24/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/17/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/18/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/12/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/26/11- Based on the Petitioner's argument (Petitioner's exhibit #12, 29 Cases Reviewed), it appears that the Respondent agreed to pay for a 99214 visit. The Petitioner did not perform the necessary components for an EPSDT exam (99392) as no vision or hearing screening was done and while proper immunizations were given, this appears to be predominantly a sick child visit and should be coded as 99214.

26) J.T.P., Medicaid Recipient # 3780580179

DOS: 10/30/09- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/16/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/05/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/24/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/14/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/15/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/19/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/29/10- The reason for this child's visit was a check-up. The Petitioner performed all of the age-appropriate EPSDT screenings, including vision and hearing screening. This visit is an EPSDT visit (99393). The hearing screening is a component of the EPSDT visit and cannot be fragmented and billed separately. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/14/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

27) B.T., Medicaid Recipient # 8781011497 (These office notes are contained in Petitioner's Exhibit #11)

DOS: 10/17/09- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/31/09- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/05/09- The Petitioner billed the Respondent for a 99213 exam for which the Respondent would have paid the Petitioner $50.00 according to the Detailed Claims Report. (See Petitioner's exhibit #11) The Petitioner now states that she incorrectly billed the Respondent and the correct billed code should be 99212 for which the Respondent would have paid the Petitioner $29.82.[10] Due to an alleged lack of documentation, the Respondent proposes to recoup the entire $50.00. The Petitioner writes, "auditor claims no documentation but refer to enclosed copy of original record". Petitioner's exhibit #11 contains a telephone message and Immunization Information on this child but no examination record or Patient's Receipt; therefore, there is no record which this Hearing Officer or the Respondent could examine in order to determine the accuracy of the billed claim (99212 or 99213).

DOS. 12/28/09- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

[10] See Respondent's exhibit #10 for the Medicaid Fee Schedule in place during the audited periods.

DOS: 01/26/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/05/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/18/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/01/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/20/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/01/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/13/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/31/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/07/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 11/13/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/11/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/18/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/05/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 03/05/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/02/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/04/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/18/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/30/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

28) T.T., Medicaid Recipient # 6781060263

DOS: 12/29/09- Based on the Detailed Claims Report in Petitioner's exhibit #13, the Petitioner filed a claim for 99214 and the Respondent determined that the documentation submitted only supported payment for 99213. According to the Petitioner's argument, 99214 was accepted by the Respondent. This Hearing Officer can find no testimony to support the Petitioner's allegation that the Respondent accepted 99214 as an accurate code nor can he find documentary evidence to support that allegation in the May 16, 2012 letter from the Respondent following the informal conference. (See Petitioner's exhibit #6) If the Respondent did not accept 99214 as the accurate code for billing, the Petitioner makes general statements of disagreement to this Hearing Officer but she has given no justification to this Hearing Officer that is supported in the CPT for her disagreement. While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/09/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 02/18/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 05/10/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/15/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 07/30/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 09/25/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/16/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 11/15/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 12/13/10- The Respondent paid the Petitioner for the billed 99214 office visit. Now, it appears that the Petitioner is asserting that this claim was originally billed incorrectly and she should have been paid for a 99215 visit and because of that the Petitioner is owed a refund. This Hearing Officer does not act as an initial claims processor and cannot act as the Respondent's agent in this matter. Additionally, the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05* requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment. The Respondent is not responsible for reimbursing the Petitioner for its own mistake.

DOS: 12/14/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/08/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 08/15/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

29) M.W., Medicaid Recipient # 8780974184

DOS: 10/29/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 10/30/10- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 01/03/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 04/04/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

DOS: 06/21/11- While the Petitioner makes general statements of disagreement, she has given no justification for her disagreement that is supported in the CPT and has presented no evidence that would show the Respondent's recoupments are improper or erroneous.

For those audited claims during the Respondent's review period of September 1, 2009 through August 31, 2011, the Petitioner's records contained the following errors: coding errors, duplicate billing, unbundling (provider services broken down to their individual components, resulting in a higher payment by Medicaid), medically unnecessary services, and insufficient documentation. The Respondent presented evidence to support its recoupments. The Petitioner failed to present sufficient evidence that the Respondent acted improperly, acted erroneously, acted arbitrarily or capriciously, or failed to use proper procedure when it requested recoupment of $11,199.49 in Medicaid overpayments made to the Petitioner. Therefore, the Respondent's proposed recoupment of $11,199.49 in Medicaid payments from the Petitioner is appropriate pursuant to S.C. Code Reg. § 126-401A, S.C. Code Reg. § 126-402, and 42 CFR § 456.23.

ANALYSIS/DISCUSSION

The Petitioner objects to the Respondent's use of the HCPro worksheets that were used to audit her records and she states that these worksheets were not introduced at the informal conference with the Respondent and that the audit should only use the *Current Procedural Terminology, Fourth Edition* (CPT) to determine if she billed the Respondent appropriately. While this Hearing Officer understands the Petitioner's frustration with the Respondent's first introduction of the HCPro worksheets at the hearing, it appears the forms were simply tools utilized in the review but the CPT remained the guide and standard used to audit the Petitioner's records. Additionally, this Hearing Officer did not utilize the HCPro worksheets in rendering this decision, so their admission in the record did not prejudice the Petitioner.

I made it very clear at the outset of the hearing that I am not a certified coder and in the area of claims processing and payments, both parties needed to prove to me in a very elementary manner how the recoupments were either correct or incorrect based on the CPT guidelines. However, throughout her testimony and throughout her proffered documentary evidence, the Petitioner makes general assertions about why her records indicate that office visits should be coded a certain way based on the CPT but at no time does she direct this Hearing Officer to specific CPT sections to support her assertions. The Petitioner continually asserts that based on common sense, it is clear that the services provided in the office visits would take a certain amount of time to perform and based on these times, she should be paid for a certain CPT coded visit.

The Respondent countered that argument with CPT supported evidence that states, "When counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time may be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties who have assumed responsibility for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). *The extent of counseling and/or coordination of care must be documented in the medical record* [emphasis added]." The Petitioner admits she does not indicate the time spent with the patient in her office

visit records and based on the CPT itself, I cannot find that "presumed" time spent during an office visit should in any way be solely determinative of the billed code.

The Petitioner continually directs this Hearing Officer to medications that she provided a patient but were not covered by the Respondent. I can only surmise that she is offering this information as a justification to support her billed codes; however, as stated before, I must have CPT-driven evidence to convince me that a billed code is correct or incorrect. The SCDHHS *Physicians, Laboratories, and Other Medical Professionals, Provider Manual, 02/01/05* does set forth a procedure for physicians to obtain approval for medications not normally covered by the Respondent.

The Petitioner states that she performs a "full" examination every time a patient is seen. I do not know what CPT-driven term the Petitioner is referring to when she refers to a "full" examination. The CPT describes four (4) types of examinations: problem focused, expanded problem focused, detailed, and comprehensive; therefore, it is obvious to me that the CPT does not assume that a Pediatrician will perform the same type of examination every time a patient is seen, and Dr. Nazario has not given me any type of CPT justification for performing the same type of exam for every office visit. In fact, in her testimony and proffered documents, she asserts that some exams are different based on the CPT-driven types of exams.

The Petitioner states that the Respondent also has overlooked her translation costs; however, she does not state that she has billed the Respondent for those translation costs, that the Respondent has denied payment for those translation costs, or that the CPT directs the Respondent to pay for those translation costs; therefore, I cannot see that this is a relevant issue in this matter.

The Petitioner states that during part of the audit period in question, she was not officially allowed by the Respondent to perform EPSDT exams; however, she has produced no proof to support this assertion and the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, Section 2, Manual Updated 09/01/10* does not support this assertion. The Petitioner states that in some instances she billed the Respondent for less than an EPSDT visit but what she performed was actually an EPSDT exam and she should now be paid for the difference in those coded visits. If I were to determine that the Petitioner should be now paid more for her previous mistakes, I would be forcing the Respondent to pay the Petitioner for a claim more than one (1) year after the DOS, contrary to the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual, 02/01/05*, which requires that claims free of errors must be submitted to the Respondent within one year from the date of service to be considered for payment.

The Respondent has provided the testimony of certified coders who have directed me to the appropriate CPT sections to support their findings. I find these witnesses to be qualified and credible as expert witnesses in coding. The Petitioner, while obviously a very qualified and caring Pediatrician, has not disclosed any coding training and based on her lack of use of CPT-driven terminology and arguments, I do not find Dr. Nazario to be qualified as a credible witness in coding.

The CPT states that there are three (3) components (history, examination, and medical decision making) that are considered the key components in selecting a level of service when billing and each of these components is described in the CPT. The Petitioner did not make any specific CPT-driven arguments with regard to the history component; therefore, I have not included that when determining whether a billed code was proper. The Petitioner does not indicate the level of examination performed (Problem focused, Expanded problem focused,

Detailed, or Comprehensive). In an attempt to be as fair as possible to the Petitioner, I have given her the benefit of the doubt that the type of exam conducted is equal to the type of exam that must be done, according to the CPT, to correlate with the code that was originally filed or that the Petitioner is now changing in her arguments. The CPT recognizes four (4) types of medical decision making: straightforward, low complexity, moderate complexity, and high complexity. Again, the Petitioner has provided no CPT-driven arguments to support a specific type of medical decision making in any of her testimonial evidence or documentary evidence; therefore, the evidence in the record supports the Respondent's determinations. Each given code in the CPT directs that the three (3) key components must rise to certain levels before that code may be used. Because the Petitioner has not supported her arguments by showing how the services she provided were entitled to certain CPT codes, I cannot find that the Respondent has incorrectly determined to recoup money from the Petitioner.

S.C. Code Reg. §126-401(B) states that the Respondent may invoke administrative sanctions, including recoupment of payments, against a Medicaid provider who has been determined to be guilty of fraud. The Respondent states emphatically that it does not suspect Dr. Nazario of fraud. S.C. Code Reg. §126-401(A) allows the Respondent to invoke administrative sanctions against a Medicaid provider who has been determined to have abused the Medicaid Program and one of those sanctions is recoupment of overpayments. Abuse is defined as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare." S.C. Code Reg. §126-400(E); See also, 42 CFR §455.2.

In this matter, the Petitioner bears the burden of proof and she must convince me that the Respondent has improperly determined to recoup money that she has already been paid and to do this, she must provide CPT-driven evidence that she did properly code the patient office visits examined in the audit. As stated earlier, while providing very general statements and in some instances incorrect statements, such as the EPSDT arguments and the office visit time-centered arguments, the Petitioner has provided no specific evidence that proves the Respondent has proposed to recoup payments based on anything other than sound CPT-driven factors; therefore, I must find that the Petitioner has abused the Medicaid Program by engaging in practices that are inconsistent with sound medical practices and result in an unnecessary cost to the Medicaid Program.

The next issue for me to determine is whether the administrative sanction imposed by the Respondent, recoupment of the overpayments, is appropriate pursuant to S.C. Code Reg. §126-402. The Respondent has asserted that the reason for the audit was because the Petitioner's Medicaid billing was significantly higher than her peers; therefore, I find this to be a serious offense pursuant to S.C. Code Reg. §126-402A. The Respondent found an extremely high number of improper coding issues in the twenty-nine (29) patient records that were examined; therefore, I find the extent of the violation to be significant and the recoupment of overpayments appropriate pursuant to S.C. Code Reg. §126-402B. The Petitioner did testify that she had been audited in the past and SCDHHS had recouped money; therefore, I find the recoupment of the overpayments to be appropriate pursuant to S.C. Code Reg. §126-402C. Finally, based on the Petitioner's overall unfamiliarity with the CPT and the SCDHHS *Physicians, Laboratories, and Other Medical Professionals Provider Manual,* I find the recoupment of the overpayments appropriate pursuant to S.C. Code Reg. §126-402E.

I do not find the Respondent's proposed recoupment of the money that was paid to the Petitioner to be arbitrary or capricious and I find this recoupment to be supported by South Carolina Medicaid policy, and State and Federal regulations. Since SCDHHS administers the Medicaid program through State and Federal funds, SCDHHS must, through its policy, also attempt to reduce waste, fraud and abuse in the use of Medicaid funds.

DECISION

Based on the Information Before the Hearing Officer; Findings of Fact; Applicable Law, Policy and Authoritative Texts; Conclusions of Law; and Analysis/Discussion; the Respondent's determination to disallow $11,199.49 in Medicaid payments to the Petitioner due to coding errors, duplicate billing, unbundling (provider services broken down to their individual components, resulting in a higher payment by Medicaid), medically unnecessary services, and insufficient documentation during the review period of September 1, 2009 through August 31, 2011, is **AFFIRMED**. The Respondent may recoup $11,199.49 from the Petitioner.

Robert French, Chief Hearing Officer
Division of Appeals and Hearings

Dated at Columbia,
South Carolina

January 25, 2015

Laurens Pediatric Clinic
Nilsa I. Nazario MD FAAP
PO BOX 1367
Laurens, South Carolina 29360
(864) 984-4263

June 14, 2012

Mr. Robert French
Division Of Appeals and Hearings
DHHS
PO Box 6206
Columbia, SC 29202-6206

Dear Mr. French:

I hereby request to appeal the audit held by DHHS, referred to on enclosed letters dated February 22, 2012 and May 16, 2012. A package containing detailed notations on each patient encounter plus additional information pertinent to the care given at this practice is being mailed today. This letter as requested is being faxed to you.

My case # is P5613 Provider # 137015

Discrepancies are significant and the internal review I did on each case merits no more than $1,601.19. DHHS wants to disallow $11,199.49.

I am a solo practitioner, one of three pediatricians in Laurens County, and the only one in Laurens City. I am the only one fully bilingual in English and Spanish, for which the practice has 20 to 30 percent Hispanics. I have seen in the period of this audit 2009-201, 617 patients at no charge, stabilize serious respiratory and infectious illness successfully saving the patients and Medicaid from ER and hospitalizations at a great expense to me as many medicines are not reimbursed or poorly reimbursed by Medicaid. This practice is over 90 percent Medicaid, and the rest uninsured as I do not accept private insurance.

My practice is a walk in clinic and patients have access to my cell phone 24 hours a day, at no cost to the patient or Medicaid. All telephone consults and patient management by phone are not being billed. I have served well the community of Laurens, mainly poor and uneducated for 20 years. I disagree and find unfair to be disallowed payment on the grounds of having done health maintenance, on a sick visit where patient although sick is still stable enough to receive vaccines or full exam prior to school entrance, including vision, hearing, blood and urine, and /or developmental screens. The population I attend to lacks resources to come just for well check visits, separate from sick visits. It is also noted how I get disallowance for having done hearing tests, all justified except one where office note documents patient became uncooperative. I self criticize my notes based on code billed and agree in total to disallow no more than the amount above mentioned.

Policies may need review and positive change in order to not strangle financially and discourage providers like myself who continue to serve at great personal sacrifice. Audits should be based on performance and results, and satisfactory control of illness, thus saving hospitalization and ER care costs to Medicaid.

I thus request an appeal, and thank you ahead for your interest in the case.

Sincerely,
Nilsa I Nazario MD FAAP

DUPLICATE

Nilsa I. Nazario, MD, FAAP

06/14/2012 10:52AM

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

May 16, 2012

CERTIFIED MAIL
Nilsa I Nazario, M.D. FAAP
915 West Main Street
P O Box 1367
Laurens, S.C. 29360-1367

DUPLICATE

PROVIDER #: 137015
CASE #: P5813

Dear Dr. Nazario,

We appreciate the opportunity to have met with you and Ms. Holiday at the informal conference held on April 11, 2012, to discuss the findings of your post-payment review and the related SC Medicaid physician policies. The informal conference is important in the review process because it allows us to explain our findings to you, answer questions you might have, listen to any concerns, and it provides an opportunity for education. As we explained during the conference, your post-payment review was a comparison of paid claims with the documentation in the medical record, using Medicaid physician service policy and CPT guidelines. We have evaluated the comments, information and documentation you presented at the informal conference. An updated copy of the Detail Claims Report reflecting any changes made as a result is enclosed. In some instances multiple errors applied to the same claim line. When additional documentation was accepted for one payment error, another payment error may have been cited for the discrepancy.

The following determinations have been made:

Finding #1: Coding Errors:

A. In three hundred and fifty-nine (359) instances claim lines were billed for a more comprehensive or complex level of evaluation and management service (99201-99215) than was documented in the medical records. (See payment error key D6). In twenty-five (25) instances claim lines were billed with an incorrect procedure code. (See payment error key D1) Evaluation and management codes were billed when the more appropriate code to bill was an EPSDT visit code (99381-99384).

Discussion: All the additional documentation you submitted was reviewed and the appropriate code matching the CPT description with your documentation was assigned. In some instances, the additional documentation you provided supported the level of code that you billed. However, the majority of the additional documentation did not augment the medical records to justify the level of code you billed. The Medicaid medical records must fully disclose the medical necessity for treatment and the extent of services provided to Medicaid beneficiaries. Medicaid recognizes the terminology in the Current Procedural Terminology Book (CPT) for the levels of services as established criteria for billing outpatient services.

The disallowance for this finding decreased from $11,850.04 to $10,646.53.

Compliance and Performance Review
Division of Program Integrity
P.O. Box 100210 • Columbia, South Carolina 29202-3210
(803) 898-2540 • Fax (803) 255-8224

Finding #2: No Documentation: The medical record and/or key components of the medical record were missing.

In five (5) instances claim lines were billed for services when the medical record was missing documentation for specific dates. (See payment error key B2)

Discussion: The additional documentation you submitted was reviewed. Three of the claim lines were allowed and two were given other payment error codes (Refer to payment error keys C1 and D6). Because more than one error applied to those two lines, the disallowance for the line was counted under the new payment error finding.

The disallowance for this finding decreased from $225.03 to $0.00.

DUPLICATE

Finding #3: Duplicate Billing:

Two (2) claim lines were billed for the same or similar procedure on the same date of service. (See payment error key F1)

Discussion: The additional documentation you submitted was reviewed. One of the claim lines was assigned another payment error code (D6) due to an incorrect date of service that was billed and the documentation reviewed did not support the code that was billed for that date. One line remains denied as only one evaluation and management code is allowed on the same date of service unless special circumstances are documented.

The disallowance for this finding decreased from $177.29 to $75.37.

Finding #4: Unbundling:

There were ten (10) instances when claim lines were billed for a hearing test, code 92552 for the same date of service as an EPSDT visit. (See payment error key H1).

Discussion: The hearing test is a required part of the preventive visit and bundles into the EPSDT visit; therefore, only a preventive care code should be billed.

The disallowance for this finding increased from $136.19 to $151.72 due to changes from Finding #5.

Finding #5: Medically Unnecessary Services:

There were four (4) instances when claim lines were billed for hearing tests, code 92552 and one instance for an EKG, code 93000 when there was no report or documentation to justify the test or the frequency. (See payment error key A1)

Discussion: The additional documentation you submitted supported the EKG. The disallowance for the hearing tests remain because there was no justification in the medical record for performing the tests. Two additional instances were added to this payment error as a result of the additional documentation. Developmental testing, code 96110 as described in Finding #6 was added.

The disallowance for this finding decreased from $76.65 to $60.34.

Finding #6: Insufficient Documentation:

There were four instances where claim lines were billed when the documentation did not support that the service was rendered. There were two (2) instances when developmental testing, CPT code 96110 was billed with an evaluation and management code for a sick visit. There was one claim line billed for a urine test, code 81002 when there was no documentation of urinalysis results. Code 92552 for a hearing test remains disallowed for lack of documentation to support the test performance. (See payment error key C1).

Discussion: The additional documentation you submitted did not support the medical necessity for the developmental tests being performed at the time of the sick visit that was billed. Therefore they were assigned a different payment error. (A1) The additional documentation for code 81002 for the urine test was allowed. The medical note provided at the informal conference to support missing documentation (Payment error key B2) for an evaluation and management service was added to this payment error. The documentation provided did not establish that the service billed was rendered as it did not meet CPT requirements for an evaluation and management code.

The disallowance for this finding increased from $33.85 to $85.53.

The revised total disallowance for the improper and miss-billed claims identified in the review has decreased from $12,499.05 to $11,199.49.

If you believe that SCDHHS is in error of its findings, you have the right to an evidentiary hearing with the Division of Appeals and Hearings in accordance with South Carolina Code of Laws R. 126-150. Within thirty (30) calendar days of the receipt of this letter, your written request, a copy of the letter dated February 22, 2012, the findings being appealed and a copy of this letter should be sent to the Director, Division of Appeals and Hearings, Department of Health and Human Services, Post Office Box 8206, Columbia, South Carolina 29202-8206. Questions related to your appeal may be directed to Robert French at (803) 898-2600 or (800)-763-9087.

You may be invoiced for the overpayment within 30 days. Upon receipt of the invoice, you may contact the Department of Accounting Operations to make payment arrangements. The contact information for the Department of Accounting Operations will be on the invoice.

If you have questions or wish to discuss the information you may contact Ms. Casey at (803) 898-3927.

DUPLICATE

Sincerely,

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

Enclosures

NOTE: The State authority for this review and recovery of improper payments can be found at Reg. 126.40 et seq. Code of Regulations of South Carolina 1976 as amended; the federal authority may be found at 42 CFR §§433.30 et seq.; See also 42 CFR §431.107; 42 CFR Part 455; and 42 CFR Part 456.

DUPLICATE

South Carolina Department of Health & Human Services

Anthony E. Keck • Director
Nikki R. Haley • Governor

February 22, 2012

CERTIFIED MAIL
Nilsa I Nazario, M.D. FAAP
915 West Main Street
P O Box 1367
Laurens, S.C. 29360-1367

APPEALS & HEARINGS
RECEIVED
JUN 14 2012
SCDHHS

PROVIDER #: 137016
CASE #: P5613

Dear Dr. Nazario,

The Division of Program Integrity has completed the preliminary post payment review of your Medicaid records. Through the activities of the Division of Program Integrity, the South Carolina Department of Health and Human Services (SCDHHS) ensures the integrity of the Medicaid program and seeks to reduce waste, fraud and abuse in the use of Medicaid funds. The purposes of program oversight are to safeguard against unnecessary or inappropriate use of Medicaid services, identify and recover excessive or inaccurate payments to providers, and ensure compliance with the applicable Medicaid laws, regulations and policies. Program integrity policies and operating procedures as well as citations to appropriate State and Federal Regulations can be found in Section 1 of each provider manual.

Ms. Cheryl Casey, RN scanned a sample of patient records at your office on November 21, 2011. Additional records that were not obtained during the onsite visit were requested and received by Program Integrity via fax. The comprehensive review covered a sample of twenty nine (29) beneficiary records with 1045 line items for services rendered from 09/01/09 through 08/31/11, with a total amount paid of $36,434.93. In some instances multiple discrepancies were noted for the same claim; however, the disallowance for each claim was only counted once. The discrepancies in this sample resulted in an error rate of 33%.

Please examine the preliminary findings and contact Ms. Casey at (803) 898-3927 within ten (10) calendar days of receipt of this letter if you have any questions or if you wish to discuss any of the information.

Findings and Recommendations:

Finding #1: Coding Errors: Various codes were billed that were incorrect when compared to the documentation in the medical record.

A. In three hundred and fifty-six (356) instances claim lines were billed for a more comprehensive or complex level of service than was documented in the medical records. The documentation did not substantiate the level of service billed. (See payment error key D6).

Amount of claim lines with potential overpayments: $11,703.44.

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Compliance and Performance Review
Division of Program Integrity
P.O. Box 100210 • Columbia, South Carolina 29202-3210
(803) 898-2840 • Fax (803) 255-8324

06/14/2012 10:52AM

DUPLICATE

There were two hundred twenty-six (226) instances where evaluation and management services were billed with CPT code 99214. The documentation reviewed for these dates of service did not support the level of service billed. Two of the three components did not meet or exceed the requirements of a detailed history, a detailed examination, or medical decision making of moderate complexity. The appropriate level of service was assigned based on the documentation in the medical record. (Refer to *Current Procedural Terminology, Standard Edition* (CPT) 2009, page 10; 2010, page 10; and 2011, page 11)

There were sixty-nine (69) instances where claim lines were billed for evaluation and management services using CPT code 99215. The documentation reviewed for these dates of service did not support the level of service billed. Two of the three components did not meet or exceed the requirements of a comprehensive history, a comprehensive examination, or medical decision making of high complexity. The appropriate level of service was assigned based on the documentation in the medical record. (Refer to *Current Procedural Terminology, Standard Edition* (CPT) 2009, page 10; 2010, page 10; and 2011, page 11)

In fifty-one (51) instances claim lines were billed for evaluation and management services with CPT code 99213. The documentation reviewed for these dates of service did not support the level of service billed. Two of the three components did not meet or exceed the requirements of an expanded problem focused history, an expanded problem focused examination, or medical decision making of low complexity. The appropriate level of service was assigned based on the documentation in the medical record. (Refer to *Current Procedural Terminology, Standard Edition* (CPT) 2009, page 10; 2010, page 10; and 2011, page 11)

There were ten (10) claim lines billed for evaluation and management services for a new patient using CPT code 99204. The documentation reviewed for these dates of service did not support the level of service billed. The three components did not meet or exceed the requirements of a comprehensive history, a comprehensive examination and medical decision making of moderate complexity. The appropriate level of service was assigned based on the documentation in the medical record. (Refer to *Current Procedural Terminology, Standard Edition* (CPT) 2009, page 9, 2010, page 9 and 2011, page 11)

3. There were twenty-five (25) instances where claim lines were billed with an incorrect procedure code. (See payment error key D1)

Amount of claim lines with potential overpayments: $146.60.

There were twenty-four (24) instances when codes 99213, 99214 or 99215 were billed for established patient evaluation and management services when an Early and Periodic Diagnosis, Screening, and Treatment (EPSDT) visit should have been billed. The age appropriate EPSDT codes were assigned based on the documentation in the medical record. There was one instance when a new patient evaluation and management service was billed using CPT code 99204 when an EPSDT visit was supported by the documentation. The appropriate code was assigned based on the documentation in the medical record. (Refer to the Physician's Medicaid Manual, 2005 edition, updated 12/01/06, Section 2, pages 41-57)

Policy cited: Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology (CPT), Fourth Edition*, published by the American Medical Association. Medicaid requires providers to follow the guidelines given by CPT unless otherwise stated in our

program policy. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, update 12/01/08, section 2, page 11).

Recommendation #1: Document and bill appropriately according to the requirements set in the *Current Procedural Terminology (CPT), Fourth Edition* for evaluation and management codes. Bill the appropriate preventive care codes for an EPSDT visit when you have performed and documented all of the required components for a well-child examination. Review claims prior to submission and only bill Medicaid for the level of visit supported by the documentation in the patient's record.

Finding #2: No Documentation: The medical record and/or key components of the medical record were missing.

In five (5) instances claim lines were billed for services when the medical record was missing documentation for specific dates. Evaluation and management codes 99213-99215 were billed for three dates of service when the clinical service notes for these dates of service were absent from the medical records. Services that are not documented are not eligible for reimbursement. (See payment error key B2)

The billing for an immunization, code 90471 had no supporting documentation in the medical records. Code 94640 for inhalation treatment for airway obstruction had no documentation to support that this service was rendered for the date of service billed.

Amount of claim lines with potential overpayments: $225.03.

Policy cited: Medicaid states that the documentation must be present in the beneficiaries' medical record prior to the physician filing the claim for reimbursement. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 12/01/08 update, section 1, pages 13-14).

Recommendation #2: Document at the time a service is provided and review the documentation prior to claims submission. Only bill Medicaid for the appropriate level of visit and ancillary services if they are rendered, that are supported by the documentation in the patient's record.

Finding #3: Duplicate Billing:

Two (2) claim lines were billed for the same or similar procedure on the same date of service. (See payment error key F1) On two separate occasions you billed evaluation and management services, codes 99214 and 99215, on the same date of service as another E/M service.

Amount of claim lines with potential overpayments: $177.29.

Policy cited: Medicaid recognizes the medical terminology as defined in the *Current Procedural Terminology (CPT), Fourth Edition*, published by the American Medical Association. Medicaid requires providers to follow the guidelines given by CPT unless otherwise stated in our program policy. (Refer to *Current Procedural Terminology, Standard Edition* (CPT) 2009, pages 3-4; 2010, pages 3-4; and 2011, pages 3-4)

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Recommendation #3: Document and bill appropriately according to the requirements set in the *Current Procedural Terminology (CPT), Fourth Edition* for evaluation and management codes. Only bill Medicaid once for the service rendered.

Finding #4: Unbundling:

There were nine (9) instances of unbundling charges and billing codes that should be included in all inclusive codes. Claim lines were billed for a hearing test, code 92552 for the same date of service as an EPSDT visit. (See payment error key H1). The hearing test is a required part of the preventive visit and bundles into the EPSDT visit; therefore, only a preventive care code should be billed.

Amount of claim lines with potential overpayments: $136.19.

Policy cited: Medicaid policy guidelines state that the hearing test is part of the EPSDT visit and cannot be fragmented and billed separately. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 12/01/08 update, Section 2, pages 41-57).

Recommendation #4: Review the Physicians' Medicaid Provider Manual available through the DHHS website prior to submitting claims to ensure that the services rendered are separately compensable. Only bill to Medicaid codes that are separately reimbursable and not included in another code billed for the same date of service.

Finding #5: Medically Unnecessary Services: The need for the treatment or services was not documented in the medical record as required by SCDHHS program policies.

There was insufficient justification in the medical record for the procedure or test you ordered or rendered. There were four (4) hearing tests, code 92552 and one ECG, code 93000 billed when there was no report or documentation to justify the test or the frequency. (See payment error key A1)

Amount of claim lines with potential overpayments: $76.65.

Policy cited: Medicaid states that the documentation must be present in the beneficiaries' medical record prior to the physician filing the claim for reimbursement. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 12/01/08 update, section 1, pages 13-14).

Recommendation #5: Document services in the medical record with the explanation for the test/procedure at the time they are rendered. Document any unusual circumstances for increased frequency of testing.

Finding #6: Insufficient Documentation: Documentation in the medical record was not sufficient to support the service.

The service notes do not substantiate that four services billed were rendered. There were two (2) instances when developmental testing, CPT code 96110 was billed. There was no test or test result documented in the clinical note. There was one claim line billed for a hearing test, code 92552 and one for a urine test, code 81002 also without documentation to support that the services were rendered. (See payment error key C1).

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Amount of claim lines with potential overpayments: $33.85.

Policy cited: Medicaid states that the documentation must be present in the beneficiaries' medical record prior to the physician filing the claim for reimbursement. (Refer to the Physician's Medicaid Provider Manual, 2005 edition, 12/01/08 update, section 1, pages 13-14).

Recommendation #6: Document services in the medical record at the time they are rendered. Review claims prior to submission and only bill Medicaid for services that are documented in the patient's medical record.

General Issues:

General Issue #1: No Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) visits were billed. Most of the visits were coded as high level evaluation and management services. When the documentation supported a well-child visit some required components of the EPSDT visit were missing. In almost all EPSDT visits the developmental assessment was missing. The documentation for the vision and hearing screenings was general. Also, the assessment of nutritional status was inadequate because there was no true evaluation as to age appropriate diet, eating habits, etc. In most cases any anticipatory guidance was missing or limited. All required elements must be present in order to bill an EPSDT visit.

General Issue #2: The diagnosis on many of the claim lines did not reflect the reason for the visit, test and/or procedure. Your diagnosis should specifically reflect your assessment and the patient's condition for the date of service the recipient is seen and for which the services are billed.

The potential disallowance for the claims reviewed from the sample of patient records is $12,499.05.

The Program Integrity area will continue to monitor your paid claims, and we encourage you to give immediate attention and correction to the billing of the cited codes and issues.

Enclosed you will find the Detailed Claims Report, the Discrepancy Key, and the policies upon which our findings are based. If we have not heard from you within 10 calendar days of receipt of this letter, we will conclude that you agree with the findings and the case will proceed toward closure. At your option, we may set up an informal conference to discuss the findings.

If you have questions or wish to discuss the information you may contact Ms. Casey at (803) 898-3927.

Sincerely,

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

Enclosures

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NOTE: The State authority for this review and recovery of improper payments can be found at Reg. 126.40 et seq. Code of Regulations of South Carolina 1976 as amended; the federal authority may be found at 42 CFR §§433.30 et seq.; See also 42 CFR §431.107; 42 CFR Part 455; and 42 CFR Part 456.

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