STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Euclid Clinic Foundation

A Compliance Review prepared by the:

Fraud, Waste and Abuse
Prevention Division

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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University Mednet
Linda Rowsey
Vice President of Operations
23001 Euclid Avenue
Euclid, Ohio 44117

Re: Medicaid Review of Provider Number #0297290

Dear Ms. Rowsey:

We have completed our review of selected medical services rendered to Medicaid recipients by Euclid Clinic Foundation for the period January 1, 1999 through December 31, 2001. We identified findings in the amount of $12,218.60, which I understand has already been repaid to the Ohio Department of Job and Family Services. Thank you for your prompt response to our audit results.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio Hospital Association. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

October 15, 2002

TABLE OF CONTENTS

ABBREVIATIONS

CPT	Physician's Current Procedural Terminology
E&M	Evaluation and Management Services
FWAP	Fraud, Waste and Abuse Prevention (Division of)
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
PA	Physician Assistant

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SUMMARY OF RESULTS

The Auditor of State performed a review of Euclid Clinic Foundation, Provider #0297290, doing business at 18599 Lakeshore Drive, Cleveland, Ohio 44119. We identified findings amounting to $12.218.60. The findings are recoverable as they resulted from Medicaid claims submitted by the Provider for services that did not meet reimbursement rules under the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code (OAC).

BACKGROUND

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federally and state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients. The Ohio Department of Job and Family Services (ODJFS) administers Ohio's Medicaid program, and issues the rules and regulations that providers must follow in the Ohio Medicaid Provider Handbook. The fundamental concept of the Medicaid program is medical necessity of services: those which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice[1].

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172 (E), providers are required to: "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B.6, [OAC Section 5101:3-1-198 (E)], overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In addition, Section 5101:3-1-29(C) of the OAC states: "In all instances of fraud and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

"Abuse" is defined in Section 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program."

[1] OAC Section 5101:3-1-01(A) and (A)(1)

PURPOSE, SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and to calculate the amount of any finding resulting from non-compliance.

In particular, we focused on whether the Provider properly modified their billings to ODJFS to indicate that particular services were performed by physician assistants (PA). A provider is eligible to bill for services provided by registered PA's, as long as the reimbursement requirements outlined in the OMPH are followed.

We explained the purpose of our review to Mary Eink, Director of Central Billing, and Linda Rowsey, Vice President of Operations and the Compliance Officer. They explained that PA services are rendered at four separate University MedNet locations and billed under the provider number for Euclid Clinic Foundation.

The scope of our review was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period January 1, 1999 though December 31, 2001. The Provider was reimbursed $1,976,824.19 for 69,436 services rendered during the audit period.

We used the Medicaid Provider Handbook and the OAC as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using the five (5) digit Current Procedural Terminology (CPT)[3] coding system or ODJFS local level codes[4].

In analyzing the Provider's claims history, we focused on claims for evaluation and management (E&M) services (e.g. office visits), which accounted for $1,020,126.15 and 27,458 services reimbursed to the provider during our audit period. We selected E&M services for review because they accounted for a significant portion of the Provider's reimbursements (51.6%).

The Central Billing Director told us the Provider utilizes PA's to render services to patients. Because the Provider's claims did not properly modify the billing code to specify who rendered these services, we could not use MMIS data to identify services rendered by PA's. As a result, the Provider agreed to furnish data from their information system identifying those services performed by PA's during the audit period. We then matched the Provider's data with claim information in MMIS to determine the amount reimbursed to the Provider for services performed by PA's.

[3]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[4] Local level codes are published in the Ohio Medicaid Providers Handbook.

Additionally, we analyzed the paid claims in MMIS for duplicate payments to the provider. We defined duplicate claims as two or more claims with the same date of service, patient, procedure code, procedure code modifier and reimbursement amount.

Our work was performed between February 2002 and August 2002 and was done in accordance with government auditing standards.

FINDINGS

We identified findings of $12,218.60 in two categories: physician assistant services and duplicate services. The circumstances leading to the findings are discussed below.

Erroneous Billings for Physician Assistant Services

According to Ohio Revised Code (ORC) 4730.01, "Physician assistant" means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

Euclid Clinic Foundation has one standard utilization plan on file with the Ohio State Medical Board and submits affidavits of supervision, along with payment, and notice of new PA's as they are brought on staff. We reviewed the utilization plan, the affidavits of supervision and the listing of PA's who rendered services to Medicaid patients during our audit period.

Physician Assistant Billed for New Patient Services

The OMPH Chapter 3336, Physician Services, Section 1125(C)(5),states that a physician, physician group practice, or clinic may not be reimbursed for *initial* office visits provided by a physician assistant.

Our match between Euclid Clinic Foundation's data and he MMIS data, found 97 new patient E&M visits with a reimbursement of $3,775.16, which were rendered by PA's. Therefore, an overpayment of $3,775.16 occurred.

Associated with new patient E&M patient visits, the Provider also billed and was reimbursed $377.73 for 24 services relating to labs, injections, etc. However, the OMPH Chapter 3336, Physician Services, Section 1003.2(B)(2) states:

> Services provided under direct supervision are covered only if the following conditions are met:
> The service must be furnished in connection with a covered physician service which was billed to the department.

Because the 24 services were not furnished in connection with a covered physician service, we also identified the $377.73 as a finding.

Total findings for the new patient evaluation and services issue area were $4,152.89.

Physician Assistant Services Billed for Establish Patients without Required Modifier

OMPH Chapter 3336, Physician Services, Section 1125(A) states in part:

> A physician may be reimbursed for the following procedures provided by a physician assistant under his/her employment if the services are set forth in his/her application of registration and approved by the Medical Board. An established physician visit. . . .
>
> When the procedures listed in paragraph (A) (above) are performed by a physician assistant, reimbursement will be the provider's billed charges or 85 percent of the Medicaid maximum, whichever is less. For reimbursement, the physician must bill to the department using the five-digit CPT code followed by the modifier AU.

Our review of the match between the Euclid Clinic Foundation's and MMIS' data showed 906 established patient evaluation and management services performed by PA's which were not modified with "AU" when billed. After giving the Provider credit for 85% of the reimbursement rate, we identified the remaining 15%, or $4,749.35, as a finding.

Duplicate Payments

Pursuant to OAC 5101:3-1-198 (E) Payment errors and overpayments:

> Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery . . .

Our review found 84 services, such as E&M visits, laboratory tests, injections, and echocardiographs, were duplicate billings and resulted in an overpayment of $3,316.36.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on September 19, 2002, to afford an opportunity to provide additional documentation or otherwise respond in writing. In a response dated September 26, 2002, the Provider summarized corrective actions already taken in response to our audit and enclosed a check to repay the audit findings.

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EUCLID CLINIC FOUNDATION

CUYAHOGA COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
OCTOBER 15, 2002