Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Doctors Park Family Medicine

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

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Auditor of State
Betty Montgomery

August 28, 2003

Doctors Park Family Medicine, Inc.
Jeffrey Haggenjos, D.O.
401 Lincoln Park
New Lexington OH 43764

Re: Medicaid Audit of Doctors Park Family Medicine, Inc.
Provider Number 0986965

Dear Dr. Haggenjos:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period October 1, 1999 through September 30, 2002. We identified findings in the amount of $22,371.32, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A provider remittance form is located at the back of this report for remitting payment. The attached report details the basis for the findings.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

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 Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director, Fraud and Investigative Audit Group at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
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ABBREVIATIONS

AOS	Auditor of State
CMS	Centers for Medicare and Medicaid Services
CPT	Physician's Current Procedural Terminology
E&M	Evaluation and Management Services
HCCA	Health Care and Contract Audit Section
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
ORC	Ohio Revised Code
PA	Physician Assistant

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SUMMARY OF RESULTS

The Auditor of State performed a audit of Doctors Park Family Medicine, Inc. Provider #0986965, doing business at 401 Lincoln Park, New Lexington, Ohio 43764. Our audit was performed at the request of the Ohio Department of Job and Family Services in accordance with 117.10 of the Ohio Revised Code (ORC). As a result of this audit, we identified findings amounting to $22,371.32, based on reimbursements that did not meet the rules of 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 (OMPH). 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 audits to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

Pursuant to Ohio Administrative Code Section 5101:3-1-17.2(D), 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 audit initiated within the six year period is completed."

In addition, OAC Section 5101:3-1-29(A) states: "In all instances of fraud, waste, 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."

OAC Section 5101:3-1-29(B)(2) defines "Waste and abuse" as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an over utilization of Medicaid covered services and results in an unnecessary cost to the Medicaid program.

PURPOSE, SCOPE AND METHODOLOGY

The purpose of this audit 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.

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

We notified the Provider by letter that they had been selected for a compliance audit and an Entrance Conference was held on January 8, 2003 at the Providers' place of business.

The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 1999 through September 30, 2002. The Provider was reimbursed $317,119.61 for 14,578 services rendered on 9,509 recipient dates of services during the audit period. A recipient date of services is defined as all services received by a particular recipient on a specific date.

We used the Medicaid Provider Handbook, OAC and ORC 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)[2] coding system or ODJFS local level codes[3].

To facilitate an accurate and timely audit of the Provider's medical services, we analyzed a statistically random sample of 187 recipient dates of services, containing a total of 377 services. In addition, we looked at 100 percent of HealthChek screenings where a recipient, over the age of two, had more than one HealthChek screening in a calendar year. The HealthChek group consisted of 10 recipients with a total of 22 services. These 22 HealthChek services were segregated from the services from which the statistically random sample was drawn to avoid double counting of the results.

We initially focused on claims for Evaluations and Management (E&M) services because they accounted for a significant portion of the Provider's reimbursement $227,446.65 (71.7%) and services 7,607 (52.2%.) An Evaluation and Management service is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient.

We also examined HealthChek visits where a recipient over the age of two received more than one HealthChek visit within the same calendar year. A "HealthChek" visit is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT) which is a federally-mandated program of comprehensive preventative health services available to Medicaid-eligible persons from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. The scope of the services provided to an individual depends on the age of the patient, gender, family medical history, ethnic background, and abnormalities encountered during a "HealthChek" (EPSDT) service.

Pursuant to OMPH Chapter 3336, Physician Services, Section 1105.2(B)(2), states that one screening service per calendar year may be provided from the individual's second birthday through the day before the individual's 21st birthday. If any of the screening services are given in the calendar year in which the child reaches his/her second birthday, another screening service may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year.

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

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

In the course of auditing claims for E&M services, we also identified several issues involving services provided by physician assistants. A provider is eligible to bill for services provided by registered physician assistants (PA's) as long as the reimbursement requirements outlined in the OMPH are followed.

We also analyzed paid claims in MMIS for duplicate payments to the Provider. We defined duplicate claims as one or more claims with the same date of service, patient, procedure code, procedure code modifier and reimbursement amount. We did not find any duplicate payments during our analysis of the Provider's MMIS data.

Our work was performed between November 2002 and February 2003 and was done in accordance with government auditing standards.

FINDINGS

We identified findings of $22,371.32 in four categories: Unsupported level of service billings, insufficient documentation, physician assistant services and HealthChek screenings. The circumstances leading to the findings are discussed below.

Unsupported Level of (E&M) Service Billings

An Evaluation and Management services is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient. Pursuant to the Medicaid Provider Handbook, Section 1101.2, providers must select and bill the appropriate visit (E&M services level) code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M service.

The descriptors of the levels of E&M services recognize seven components:

- History
- Examination
- Medical Decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The key components[4] in selecting a level of E&M service to bill are history, examination and medical decision making – the more complex the services involving these components, the higher the level of service billed and the more a provider is reimbursed. E&M outpatient or

[4] Other contributory factors are counseling, coordination of care, and nature of the presenting problem. The final component, time, is not considered a key or contributory component.

office services for new patients are billed using CPT codes 99201 through 99205; while services for established patients are billed using CPT 99211 through 99215.

Section 5101:3-4-06(B) of the Administrative Code states the Providers must select and bill the appropriate visit (E&M service level) code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M service.

In our sample of 377 services, 26 services were for critical care codes (CPT 99291 and 99292). These codes are used to report the direct delivery by a physician of medical care for a critically ill or critically injured patient. The time spent with the individual patient, should be recorded in the patient's record. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

According to the American Medical Association (AMA), CPT 99291 is the evaluation and management of the critically ill or critically injured patient; first 30-74 minutes and CPT 99292 is each additional block(s) of time, up to 30 minutes each beyond the first 74 minutes.

We found that the level of service billed in 18 of 26 critical services audited was not supported by the level of service documented in the patient's medical record or supported by the required components as established by the CPT. The time the physician spent with the individual patients was not recorded in the patient's records, and therefore, we down-coded the 18 services to CPT 99232. CPT 99232 is the per day hospital care charge for the evaluation and management of a patient.

Insufficient Documentation

Section 5101:3-1-27(A) of the Administrative Code states:

> " … all Medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to Medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services, the secretary of the federal department of health and human services, or the state Medicaid fraud unit upon request."

We found that 1 of the 377 services audited, did not have sufficient documentation to support the medical service billed to ODJFS. Patient records audited for this service did not indicate that a history and exam or a medical decision had occurred. Without this type of information, the Provider was not eligible to bill any level of service. The provider billed for an examination; however, the patient's medical record did not contain the necessary information to show an examination occurred. We therefore disallowed the payment for the service.

Physician Assistant Services

According to ORC 4730.01(A), "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.

The Provider had one standard physician assistant utilization plan on file with the Ohio State Medical Board and submitted notice when bringing new PA's on staff. We audited the utilization plan and the listing of PA's rendering services to Medicaid patients during our audit period to determine if physician assistant services had been billed in accordance with Medicaid rules.

Physician Assistant Services Billed for Established 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 procedure 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 the department using the five-digit CPT code followed by the modifier AU.

Our audit of the 377 services showed that 29 services had been provided by a physician assistant and billed without using the appropriate AU modifier. Since these services had been paid at the Medicaid maximum for a physician, we reduced the amount paid for each service by 15% to correct the reimbursement to that due for services provided by a PA versus a physician.

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. According to OAC 5101:3-4-03(B)(4) a patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.

Our audit of the 377 sample services rendered showed 16 services had been provided to new patients by physician assistants. We therefore disallowed the payments for these services.

Physician Assistant Saw Established Patients with New Conditions

OMPH Chapter 3336, Physician Services, Section 1125(B)(1)(a), states that services/procedures provided by a physician assistant under the supervision and direction of his/her supervision physician are covered if the services are listed as standard functions for a physician assistant approved by the state medical board as described in 4731-4-01 of the Ohio Administrative Code.

According to OAC 5101:3-4-03(B)(5), an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition. In addition, OAC 5101:3-4-03(B)(7) states that in each situation described in (B)(5) of this rule, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed management with the physician assistant. Furthermore, a physician assistant is prohibited from making a diagnosis of a disease or ailment or prescribing any treatment or regimen not previously set forth by the supervising physician according to OAC 4731-4-04(A) and (B).

Our audit of the 377 randomly selected services rendered showed four services performed by the physician assistant for established patients with new conditions where there was no documentation in the patient's medical record that the supervising physician evaluated or discussed the management of the condition with the physician assistant. We therefore disallowed the payment for these four services.

Multiple HealthChek (EPSDT) Screenings in a Calendar Year

A "HealthChek" visit is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT) which is a federally-mandated program of comprehensive preventative health services available to Medicaid-eligible persons from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. The scope of the services provided to an individual depends on the age of the patient, gender, family medical history, ethnic background, and abnormalities encountered during an "HealthChek" (EPSDT) service.

Section OAC 5101:3-14-04(B)(3) states:

> "One screening service per calendar year may be provided from the individual's second birthday through the day before the individual's twenty-first birthday. If any of the screenings described in paragraph (B)(1) of this rule are given in the calendar year in which the child reaches his/her second birthday, another screening may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year."

From the MMIS claims history data we identified 10 recipients over the age of two, with a total of 22 HealthChek screening services, where more than one service was billed within the same calendar year. We audited the patient records and found that 11 of the 22 HealthChek screening were multiple services provided in the same calendar year to the same recipient. These 11 services were down-coded to the appropriate E&M visit level of service provided to the patient. The down coding of the 11 HealthChek services resulted in $191.71 of additional findings.

Summary of Findings

In summary, we took exception with 68 of the 377 services included in our sample of 187 recipient dates of service and 11 of the 22 HealthChek services that were examined separately in their entirety. Table 1 shows the basis for exception and the number of services related to each exception in our sample.

Table 1: Summary of Exceptions from Sample Audit of Provider Records for the Period October 1, 1999 – September 30, 2002

Basis for Exception	Number of Services with Exceptions
Unsupported Level of E&M Service Billings	18
Insufficient Documentation	1
Physician Assistant Services	
Physician Assistant Billed Established Patients w/o the Required Modifier	29
Physician Assistant Billed for New Patient Services	16
Physician Assistant Saw Established Patients with New Conditions	4
Total Services with Exceptions	68

We calculated the amount of overpayment by projecting the correct payment amount for the sample 187 recipient dates of services across the total population of 14,587 recipient dates of service paid to the Provider and subtracted the estimated correct population payment amount from the actual amount paid to the Provider. The projected correct population payment amount was $294,940.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $279,241.00 to $310,638.00 (+/- 5.32 percent). This resulted in a projected finding of $22,179.61.

Table 2 details the basis for exception with 11 services included in our HealthChek screening audit.

Table 2: Summary of Exceptions from HealthChek Audit of Provider Records For the Period September 1, 1999 – October 30, 2002

Basis for Exception	Number of Services with Exceptions
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	11
Total HealthChek Services with Exception	11

Provider's Response to our Findings

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on June 19, 2003. The Provider sent us a written response on June 26, 2003, along with additional documentation to support some of the claims for services we took exception with. As a result of additional information supplied by the Provider, we reduced our findings from $22,477.32 to $22,371.32. These findings are repayable to the Ohio Department of Job and Family Services.

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APPENDIX I

Summary of Record Analysis of Doctors Park Family Medicine For the period October 1, 1999 to September 30, 2002

Description	Audit Period October 1, 1999 – September 30, 2002
Type of Examination	Statistical Random Sample of 187 Recipient Dates of Services
Number of Population Recipient Date of Services	9,509
Number of Population Services Provided	14,578
Number of Recipient Date of Services Sampled	187
Number of Services Sampled	377
Amount Paid for Services Sampled	$12,706.31
Total Medicaid Amount Paid During Audit Period	$317,119.61
Lower Limit Correct Population Payment Amount at 95% Confidence Level	$279,241.00
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	$37,878.61
Upper Limit Correct Population Payment Amount at 95% Confidence Level	$310,638.00
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	$6,481.61
Point Estimate of Correct Population Payment Amount	$294,940.00
Precision of Estimate Correct Population Payment Amount at the 95% Confidence Level	$15,698.00(5.32%)
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	$22,179.61

Source: AOS analysis of MMIS information and the Provider's medical records.

Summary of Audit Finding for Doctors Park Family Medicine For the Audit Period October 1, 1999 to September 30, 2002

Description of Audit Finding	Dollar Amount of Finding
Unsupported Level (E&M) of Service Billings Insufficient Documentation, Physician Assistant Services	$22,179.61
Preventative HealthChek Services	$191.71
Total Audit Findings	$22,371.32

Source: AOS analysis of MMIS information and the Provider's medical records.

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PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Doctors Park Family Medicine, Inc. Dr. Jeffrey Haggenjos 401 Lincoln Park New Lexington OH 43764
Provider Number:	0986965
Audit Period:	October 1, 1999 through September 30, 2002
AOS Finding Amount:	$22,371.32
Date Payment Mailed:	
Check Number:	

IMPORTANT:

To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Thomas Tedeschi at (614) 728-7398.

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Auditor of State
Betty Montgomery

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

DOCTORS PARK FAMILY MEDICINE, INC.

PERRY 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
AUGUST 28, 2003