Auditor of State
Betty Montgomery

Ohio Medicaid Program

Report on Medicaid Reimbursements Made to Bruce M. Rothschild, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

November 23, 2004

Tom Hayes, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Bruce M. Rothschild, M.D.
Provider Number: 0641596

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Bruce M. Rothschild, M.D., for the period April 1, 2000 through March 31, 2003. We identified $46,142.80 in findings that are repayable to the State of Ohio. We also identified questioned costs of $14,171.83 for multiple trigger point injection services that we believe were billed incorrectly. Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers, and 117.10 of the Ohio Revised Code. The specific procedures employed during this audit are described in the scope and methodology section of the report.

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make any final determinations regarding recovery of the findings and questioned costs identified herein. If you have any questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group at (614) 466-4858.

As a matter of courtesy, a copy of this report is being sent to Bruce M. Rothschild, M.D., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also available on the Auditor's web site (www.auditor.state.oh.us)

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ABBREVIATIONS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
MMIS	Medicaid Management Information System
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Bruce M. Rothschild, M.D. (hereafter called the Provider), Provider #0641596, doing business at 5500 Market Street #119, Youngstown, Ohio 44512. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with 117.10 of the Ohio Revised Code. As a result of this audit, we identified $46,142.80 in findings, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code. We also identified questioned costs of $14,171.83 for multiple trigger point injection services that we believe were billed incorrectly. We are recommending that ODJFS, as the Medicaid program administrator in Ohio, make the final determination as whether the findings and questioned costs are repayable.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet general principles regarding reimbursement for Medicaid covered services.[1] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Ohio Adm.Code 5101:3-1-29(A) states in pertinent part: "…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…."

In addition, Ohio Adm.Code 5101:3-1-29(B)(2) states: " 'Waste and abuse' are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program."

[1] *See Ohio Adm.Code 5101:3-1-01 (A) and (A)(6)*

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, if warranted, calculate the amount of any recoverable overpayments. The Provider is identified within the Medicaid program as an individual physician with a specialty in internal medicine.

Following a letter of notification, we held an entrance conference with the Provider on October 22, 2003 to discuss the audit scope. The scope of our audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of April 1, 2000 through March 31, 2003. The Provider was reimbursed $361,505.85 for 10,494 services rendered during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH 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 Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2]

Prior to beginning our field work, we performed computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for services to deceased patients or whether duplicate payments were made for the same recipient on the same date of service. Both tests were negative.

We also analyzed the Provider's claims history and identified the following area for further testing:

- Multiple trigger point injections for the same patient on the same date of service.

Trigger point injections are anesthetic medications for a sensitive or irritable spot in the body that can be a main or associated source of pain conditions. Trigger point injections accounted for $275,229.80, or 76 percent, of the total reimbursement to the Provider during our audit period.

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2 These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.

The injections accounted for 6,870 services, or 65 percent of the total services, billed by the Provider during this same period.

To facilitate an accurate and timely audit, we selected a stratified statistical sample of 84 trigger point injection recipient dates of service from the overall population of 540. This included 836 trigger point injections, from the total of 6,870 trigger point injections, billed during the audit period. A recipient date of services is defined as all services received by a particular recipient on a specific date.

Our work was performed between April 2003 and February 2004 .

RESULTS

We identified $46,142.80 in findings that resulted from the Provider's refusal to supply documentation to verify that services were performed as billed to Medicaid, and from unsupported and erroneous billing for radiology services. We also identified questioned costs of $14,171.83 for multiple trigger point injection services that we believe were billed incorrectly. We are recommending that ODJFS make the final determination as whether the findings and questioned costs are repayable.

The reasons for these findings and questioned costs are discussed below.

Records Not Made Available

Ohio Adm.Code 5101:3-1-17.2 states providers are required:

> ***
>
> (D) 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.
>
> (E) To furnish to the department, the secretary of the department of health and human services, or the Ohio medicaid fraud control unit or their designees any information maintained under paragraph (D) of this rule for audit and review purposes. Audits may use statistical sampling. Failure to supply requested records within thirty days shall result in withholding of medicaid or disability assistance medical payments and may result in termination from the medicaid and disability assistance medical programs.
>
> ***

The Provider supplied 21 of 24 patient medical records that we requested for review, but declined to supply the remaining three (3) records. Without the supporting documentation from these records, we were unable to verify that services billed to and reimbursed by Medicaid were

provided. Therefore, we identified $38,445.11 in findings, which represents the total reimbursement for the 972 services claimed for these three patients during our audit period.

Unsupported and Erroneous Billings for Radiology Services

Ohio Adm.Code 5101:3-4-25 (B) states in pertinent part:

> ***
>
> (1) The department recognizes a professional component and a technical component for each radiological procedure. When both components are performed by one provider, it is recognized as the total (radiological) procedure.
>
> (2) X-rays and documentation of all results of radiological procedures must be maintained on file for a period of six years. . . .
>
> ***
>
> (4) Professional Component
>
> ***
>
> (e) To bill for the professional component only use the appropriate CPT code modified by 26 . . .
>
> ***
>
> (5) Technical component
>
> (a) The department will reimburse a physician/provider for only the technical component if:
>
> (i) The physician personally performed the service . . .
>
> ***
>
> (6) Total procedure.
>
> (a) The department will reimburse a physician for the total procedure when the radiologist or treating physician performs the professional and technical components of a radiological procedure in a setting other than an inpatient hospital, an outpatient hospital, or an emergency room.
>
> ***

(c) To bill for the total procedure, use the appropriate CPT code unmodified (e.g., 70000).

***

Information on Radiology Equipment Not Made Available

During our audit period, the Provider billed a total of 215 radiological services where the procedure code indicated that both the technical and professional components were performed. In order for the Provider to perform the technical component, the Provider would need to have radiology equipment in his office.

Prior to the entrance conference, we asked the Provider to submit a list of all equipment in the office. We did not receive the listing from the Provider. During the entrance conference with the Provider, we were told only a microscope and centrifuge were kept at the facility.

Therefore, we identified $3,075.59 in findings for the technical component of the 215 radiology services, because we could not verify that the Provider had the equipment to perform the technical component of the radiological services.

More than One Unit of Service Billed for Radiology Services

The Provider billed one or the other of the following radiological codes 210 times during our audit period:

- 73130 - Radiologic examination, hand; minimum of three views[3]
- 73110 - Radiologic examination, wrist; complete, minimum of three views[4]

Each time the Provider billed one of these codes, he billed two (2) units of service for the same patient on the same date. As these codes include *a minimum* of three (3) views, then by definition, only one unit of service should have been billed. Therefore, we identified $4,622.10 findings, which represent the reimbursement for the second unit of each service billed.

QUESTIONED COSTS

Multiple Trigger Point Injection Services Billed Incorrectly

As noted earlier, Providers are required to bill for Medicaid services using HCPCS, which include descriptive CPT codes promulgated by the American Medical Association (AMA). Ohio Medicaid pays providers based on which code is billed.

[3] Per Code Manager 2003
[4] Ibid

Throughout our April 1, 2000 to March 31, 2003 audit period, the Provider billed Medicaid for trigger point injections using CPT code 20550, which until January 1, 2002 was defined as an "Injection, tendon sheath, ligament, trigger points or ganglion cyst". The Provider billed this code each time a trigger point injection was administered, which resulted in 3 to 18 trigger point injections being billed for the same patient on the same date of service during our audit period. (A date of service typically represents one office visit). On average (because of rate changes) Medicaid paid the Provider $40.06 each time CPT code 20550 was billed during our audit period. Thus, the Provider was paid $682.20 on the occasions when 18 trigger point injections were administered during one patient visit.

Beginning in 2002, the AMA created two CPT codes (20552 and 20553) for trigger point injections and modified its definition of CPT 20550 such that it no longer encompassed trigger point injections:

- 20552 Injection; single or multiple trigger point(s), one or two muscle group(s).
- 20553 Injection; single or multiple trigger point(s), three or more muscle group(s).
- 20550 Injection; tendon sheath, ligament, ganglion cyst

The Provider continued to bill CPT 20550 for each trigger point injection rendered during 2002 instead of CPT codes 20552 or 20553. The erroneous billings did not result in an overpayment, however, because the Medicaid maximum reimbursement for CPT 20550 was not more than the reimbursement for CPT 20552 and 20553.

In 2003, however, the AMA further modified the definition of CPT codes 20550, 20552 and 20553 to stipulate that these codes should only be billed once per session (office visit). The AMA explained[5]:

> In order to allay confusion and assist in the choice of the most accurate code describing the procedure(s) performed, the code series 20550-20553 has been revised to indicate that codes 20550-20553 are reported one time per session, regardless of the number of injections or muscles injected. These changes were accomplished by appending an '(s)' to the term 'Injection' and to the term 'muscle'.

Thus, in 2003, CPT codes 20552 and 20553 were defined as follows:

- 20552:--Injection(s); single or multiple trigger point(s), one or two muscle(s)
- 20553:--Injection(s); single or multiple trigger point(s), three or more muscle(s)

During 2003, the Provider continued to bill CPT code 20550 for each trigger point injection given to a patient during an office visit. Therefore, an overpayment occurred since only one service (CPT code 20553) occurred. The overpayment was calculated by allowing the Medicaid

[5] *CPT Changes 2003, page 55*

maximum reimbursement ($44.53) for one (1) unit of CPT code 20553 for each date of service with multiple injections billed.

We then subtracted this allowance from the total amount paid for each date of service for all patients with multiple injections billed from January 1, 2003 through March 31, 2003 (the end of our audit period).

Our calculation covered six (6) patients and 29 dates of service, and resulted in questioned costs to the Medicaid program of $14,171.83.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on May 28, 2004 in order to afford an opportunity to provide additional documentation, submit a corrective plan, and otherwise respond in writing. On June 11, 2004, we received a written response from the Provider's legal representative in which the representative agreed to consult with his client and make arrangements to review records not provided during our audit. However, no further information was received from the representative and subsequent attempts to contact him were unsuccessful. Therefore, we informed the legal representative on August 2, 2004 of our plans to finalize our report as drafted.

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BRUCE M. ROTHSCHILD, M.D.

MAHONING 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
NOVEMBER 23, 2004