Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Pleasant Valley Hospital Physicians

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

April 15, 2004

William A. Barker, Jr., Asst. Executive Director
Pleasant Valley Hospital Physicians
2520 Valley Dr.
Point Pleasant, WV 25550

Re: Audit of Pleasant Valley Hospital Physicians
Provider Number: 0104854

Dear Mr. Barker:

We have completed our audit of selected medical services rendered to Medicaid recipients by Pleasant Valley Hospital Physicians for the period October 1, 1999 through September 30, 2002. We identified $57,397.41 in findings, which must be repaid to the Ohio Department of Job and Family Services. 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 Rev.Code 131.02, if repayment is not made to the Ohio Department of Job and Family Services within 45 days of the date 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 State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management (services)
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Providers Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Pleasant Valley Hospital Physicians (hereafter referred to as the Provider), Provider #0104854, doing business at 2520 Valley Dr. in Point Pleasant, WV 25550. Our audit was performed at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified findings amounting to $57,397.41, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

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 5101:3-1-17.2(D) states that 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 within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in 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..."

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 to calculate the amount of any finding resulting from non-compliance. Within the Medicaid program, the Provider is listed as a physician group practice providing general practice services.

Following a letter of notification, we held an entrance conference with the Provider on July 24, 2003 to discuss the audit objectives. 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 to September 30, 2002. The Provider was reimbursed $848,688.41 for 23,401 services rendered on 16,736 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

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]

While analyzing the Provider data prior to beginning our fieldwork and prior to drawing a statistically random sample, we extracted the following types of claims for further exception testing at the Provider's place of business:

- Claims for more than one HealthChek visit within the same calendar year for recipient's between the age of two and twenty.
- Preventive medicine counseling services billed in conjunction with a HealthChek visit.
- Non-covered services of a preventive nature billed for patients over the age of twenty-one.
- Newborn services billed for individuals who are not newborn.
- Family planning visits billed in conjunction with an Evaluation & Management (E&M) office visit.
- Duplicative office visit billings involving the same recipient and date of service, but with different E&M codes.

[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.*

- Duplicative office visit billings involving the same recipient, dates of service, and E&M procedure code.
- New patient E&M codes billed for established patients who had received professional services within the previous three-year period of time.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a statistically random sample of 174 recipient dates of services, containing a total of 296 services. To avoid double counting, this sample was drawn from the sub-population of service claims excluding those already included in the exception tests identified above. Our objective was to determine whether documentation in patient files supported the services billed.

Our work was performed between December 2002 and August 2003 in accordance with government auditing standards.

FINDINGS

We identified findings of $57,397.41 from our exception tests and the projected results of our statistical sample. The circumstances leading to the findings are discussed below:

Results of Exception Tests

The following presents the results of our eight exception tests.

Exceptions with HealthChek (EPSDT) Services

Ohio Adm.Code 5101:3-14-01 states:

> (A) "HealthChek" is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT) which is a federally-mandated program of comprehensive preventive 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.
>
> (B) 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) services.
>
> ***

Multiple HealthChek (EPSDT) Screenings in a Calendar Year

Ohio Adm.Code 5101:3-14-04(B)(3) states[3]:

> 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

[3] *This rule was in effect during our audit period. Effective July 1, 2003, ODJFS revised its requirements for the frequency of HealthChek screening services to coincide with those followed by the American Academy of Pediatrics.*

> calendar year in which the child reaches his or 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.

We identified three recipients over the age of two, with six HealthChek screening services, where more than one service was billed within the same calendar year. Patient records showed that three of the six HealthChek screenings were multiple services provided in the same calendar year to the same recipient. After recoding these three services to the appropriate E&M visit level of service provided to the patients, we made a finding for $57.55, which represents the difference in reimbursement between the HealthChek and E&M services.

Preventive Counseling Billed In Conjunction with HealthChek Screenings

Ohio Adm.Code 5101:3-14-03(K) states in pertinent part:

> (1) Health education and counseling, including anticipatory guidance to parents and individuals as well as risk factor reduction interventions, is a required component of the "HealthChek" (EPSDT) screening service…
>
> ***
>
> (3) When the health education and counseling component of the "HealthChek" (EPSDT) screening services last approximately thirty minutes or more, additional reimbursement is available.
>
> > (a) Providers should bill the appropriate preventive medicine, individual counseling code from the "Physicians' Current Procedural Terminology."
> >
> > ***

We identified 164 occurrences where the Provider billed for a HealthChek screening service and a Preventative Counseling service lasting 30 minutes or more (billed as CPT 99402 - Preventive Counseling, Individual, approximately 30 minutes). We requested documentation from the Provider to verify that screening services lasted 30 minutes or more – a requirement for billing CPT 99402. The Provider was unable to provide the necessary documentation to support the additional billed services. Therefore, we accepted the billing for a HealthChek service, but took exception with all 164 services billed as CPT 99402, which resulted in findings of $5,437.40.

Billing Non-Covered Services

Ohio Adm.Code 5101:3-4-28 states in pertinent part:

> The following physician services are noncovered:
>
> ***
>
> (C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups with the following exceptions:
>
> > (1) All HealthChek (EPSDT) services;

> ***
>
> (10) Required physicals for employment or for participation in job training programs, when the employer (or other available funds) does not provide a physical free of charge. Documentation to support that the physical was performed for employment must be in the patient's medical records.
>
> ***

We identified 14 services where the Provider billed for routine physical examinations for recipients who were age 21 or older. Because Ohio Adm.Code 5101:3-14-04(B)(3) limits reimbursement for HealthChek services to patients under 21 years of age (see previous section), we requested documentation to verify that these physicals were performed for employment or for participation in a job training program. However, the Provider was unable to provide the necessary documentation. Therefore, we took exception with all 14 services resulting in $471.14 in findings.

Erroneous Billing for Newborn Services

Appendix DD of Ohio Adm.Code 5101:3-1-60 lists services reimbursable by Ohio Medicaid. Two reimbursable services for newborn infants are:

- Code 99435 (Hospital newborn discharge day). The American Medical Association further defines 99435 as the "history and examination of the normal newborn infant, including the preparation of medical records (this code should only be used for newborns assessed and discharged from the hospital or birthing room on the same date.)"
- Code 99436 (Attendance at delivery and initial stab) The American Medical Association further defines 99436 as "attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn."

We identified claims for six services that did not meet the above requirements because the services were billed for adult females, not newborn infants. In four instances, the payments appeared to duplicate payments made for the same service to an infant. The other two instances did not appear to be duplicate payments, but we could not identify an infant for whom the service applied. Because the services in question are intended for infants, we took exception with all six services, resulting in a finding of $414.88.

Although we are not identifying additional monetary findings associated with the Provider's documentation of delivery services, we noted other instances where the Provider did not fully document services billed to Medicaid. For example, we noted that the services provided by the attending physician were not documented in patient records. In these cases, we were able to verify that a birth occurred and an attending physician was present by referring to patient record notes made by the anesthesiologist and nursing staff. Therefore, we did not take exception with the claims for reimbursement of delivery services. However, we are recommending that the Provider systematically review physician delivery records for conformance with Ohio Adm.Code 5101:3-1-17.2(D), which requires that providers maintain all records necessary and in such form so as to fully disclose the extent of services provided.

Comprehensive Procedure Codes Incorrectly Billed Together

Ohio Adm.Code 5101:3-4-07(D)(1) states:

> A "family planning visit" is any visit performed for the purpose of providing a family planning service. The visit may be performed either by a physician and/or a health professional or social services professional qualified under the Revised Code. The visit may or may not include a physical examination.

Ohio Adm.Code 5101:3-4-07(D)(2) defines the two ODJFS local level family planning codes as follows:

> X1450 Minimal family planning visit is a visit not necessarily requiring the presence of a physician. Services include, but are not limited to, obtaining weight, blood pressure, overseeing laboratory orders, and filling, refilling, or renewing a prescription for contraceptive pharmaceuticals or supplies upon the orders of a physician when a physical examination is not required.
>
> X1453 Gynecological examination performed by a physician is a visit in which a physical examination including, at a minimum, a review of the medical history, pelvic examination, height, weight, and blood pressure, is performed in conjunction with family planning services. The visit also includes, when appropriate, all or a combination of the following services: breast examination, collection of a pap smear, collection of vaginal smears or cultures, evaluation and interpretation of laboratory procedures, checking an IUD, contraceptive counseling, generic counseling, and the prescription of contraceptive pharmaceuticals and supplies.

We identified six services for family planning office visits billed in conjunction with an E&M office visit, of which one service was billed as procedure code X1450 and five services were billed as procedure code X1453. We are taking exception with the reimbursement for all six family planning visit services because the medical records did not indicate that services beyond an office visit were performed. This resulted in findings of $241.02.

Multiple E&M Codes Billed Together

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified six services that were duplicative of another service type paid for the same patient on the same date of service, and which involved two different E&M codes. For five of the services the Provider billed a new patient office visit (CPT code 99203) in conjunction with an established patient office visit (CPT code 99213) for the same patient on the same day. The other service involved the Provider billing for two new patient office visits (CPT code 99204 and CPT code 99205) for the same recipient on the same day.

We requested documentation from the Provider to validate the multiple E&M codes billed for the same service; however, the Provider was unable to provide the necessary documentation. Therefore, we took exception with three of the six services amounting to $170.33 in findings.

New Patient E&M Codes Billed for Established Patients

Ohio Adm.Code 5101:3-4-06(B) states in pertinent part:

> 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…
>
> ***

The American Medical Association's Evaluation and Management (E&M) Service Guidelines state that:

> Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

We found eight services where the Provider billed new patient CPT codes for established patients who had received professional services within the past three years. We took exception with these eight services and reduced the services and the payment amounts to the appropriate established patient CPT codes. The reduction of these eight services resulted in findings amounting to $114.26.

Duplicate Billings

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified 11 duplicate billings involving the same patient, the same procedure code, and the same date of service. Because the medical records supported that only one service was rendered, we took exception with the 11 duplicative billings, which amounted to $257.73 in findings.

Summary of Exception Testing

For the 566 services that were segregated from the sampled population for complete examination, we took exception with 215 services. Table 1 summarizes the exceptions by reason.

**Table 1: Summary of Exceptions Found by Reason
For Paid Services 100 Percent Reviewed by Exception Tests
For the Period October 1, 1999 – September 30, 2002**

Basis for Exception	Number of Services with Exceptions	Amount of Overpayment
Preventive Counseling Billed In Conjunction with HealthChek Screenings	**164**	**$5,437.40**
Billing Non-Covered Services	**14**	**$471.14**
Duplicate Billings	**11**	**$257.73**
New Patient E&M Codes Billed for Established Patients	**8**	**$114.26**
Erroneous Billing For Newborn Services	**6**	**$414.88**
Comprehensive Procedure Codes Incorrectly Billed Together	**6**	**$241.02**
Multiple E&M Codes Billed Together	**3**	**$170.33**
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	**3**	**$57.55**
Total Services with Exceptions	**215**	**$7,164.31**

Source: AOS analysis of the Provider's MMIS claims history.

Results of Sample Analysis

Our analysis of the Provider's supporting documentation for the 296 services in the stratified random sample of 174 recipient dates of service identified exceptions in the following areas:

- Evaluation and Management services where the level of service billed was not supported by the documentation in the patient's medical record.
- Delivery codes billed with inclusive postpartum care where no evidence was found to show that the required postpartum care was provided.
- Anesthesia services billed where the level of service charged was not supported by documentation in the medical records.
- Other services in our sample where no documentation or no patient medical record was found to support that the services were performed.
- Duplicate delivery codes billed when twins were delivered by the same physician during the same procedure.

Unsupported Level of E&M Service

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. Ohio Adm.Code 5101:3-4-06(B) states in pertinent part:

> Providers must select and bill the appropriate visit (E&M service level) code in accordance with the code definitions and the CPT instructions for selecting a level of E&M service. . .
>
> ***

The American Medical Association uses the following seven components to determine a level of E&M service:

- 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. For example, E&M outpatient or office services for established patients are billed using CPT 99211 through 99215.

Of the 296 services in our sample, we found five services billed at the 99213 level that were not supportable because the patient's medical records did not contain the required level of service components for that CPT code billed. For the five services, the documentation supported the next lowest level of services (e.g., 99212 instead of 99213). The following are examples of service levels we took exception with:

- The patient was in for an office recheck. The medical record showed that patient vitals were taken (temperature, pulse rate, blood pressure), and showed that prescriptions were written. We re-coded the service from 99213 to 99212 because the patient record lacked evidence of two of three key components for 99213: an expanded problem focused history, an expanded problem focused exam, or a low complexity of decision making.
- The patient complained of a rash on buttock. The medical record showed that the patient's temperature was taken, and a focused exam of the effected area was performed. We re-coded the service from the 99213 level to the 99212 level because the patient record lacked evidence of two of three key components for 99213: an expanded problem focused history, an expanded problem focused exam, and a low complexity of decision making.

Unsupported Level of Postpartum Care

Pursuant to Ohio Adm.Code 5101:3-4-08(E)(2):

> Postpartum Care includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.

In addition, Ohio Adm.Code 5101:3-4-08(E)(5) states:

> For the reimbursement of CPT codes 59410, 59430, 59515, 59614, or 59622, the provider must render an evaluation and management service four to six weeks post-delivery.

[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.*

We identified nine services where the Provider did not render a postpartum service four to six weeks after delivery. Therefore, we took exception with these nine services and reduced them to CPT codes 59409, 59514, and 59620, which are codes for various delivery services that do not include a postpartum service.

Unsupported Level of Anesthesia Service

Ohio Adm.Code 5101:3-4-21 states in pertinent part:

> (A) The department will reimburse a physician for general, regional, or supplementation of local anesthesia services… provided during a surgical or diagnostic procedure. Anesthesia services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluid and/or blood products incident to the anesthesia or surgery, and the basic monitoring procedures…
>
> (B)(4) "Anesthesia time" is the actual number of anesthesia minutes as reported on the claim. Anesthesia time is defined in paragraph (D)(3) of this rule…
>
> (D)(3) Anesthesia time begins when the anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthetist is no longer in personal attendance, that is, when the patient may be safely placed under post anesthesia supervision…

Of the 296 services in our sample, we found five services that did not meet the requirements stated in Ohio Administrative Code rules cited above. Documentation for these five services did not support that time had been correctly billed. The following are examples of services we took exception with:

- The patient anesthesia record stated a start time of 11:30 and a stop time of 13:00, for a total anesthesia time of 90 minutes; however, the Provider billed for 150 minutes of anesthesia time. Because the patient record only supported the billing of 90 minutes, we reduced the amount of anesthesia time to the actual amount noted in the patient medical record.
- The patient anesthesia record shows a start time of 01:05 with no stop time. The anesthesiologist monitored the patient for 55 minutes, however, the Provider billed for 775 minutes of anesthesia time. Because the patient record only supported the monitoring of the patient anesthesia for 55 minutes, we reduced the amount of anesthesia time to the actual amount noted in the patient medical record.

When calculating our findings, we reduced the allowable payment for these five services to a level supported by documentation in the patient medical record.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

> … 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 services provided to medicaid consumers, and to document significant business transactions…

Of the 296 services in our sample, we found that 11 billed services where the patient medical records did not contain the required documentation to support billing to ODJFS. The following are the exceptions noted:

- For eight of the services, the patient medical records did not state the services in question were provided, although other services were shown on the service dates.
- For one of the services, the service date was stamped in the patient medical records but the patient record was otherwise blank for that date.
- For two of the services, no patient medical records were provided.

Because the Provider did not maintain the required documents, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these 11 services.

Duplicate Billing

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

Additionally, Ohio Adm.Code 5101:3-4-08(E)(5) states in pertinent part:

> Additional reimbursement will not be recognized for the complexity of the delivery, for multiple births...

Of the 296 services in our sample, we found two services where the Provider billed duplicate procedure codes. The Provider billed CPT 59514 - for a Cesarean section when postpartum care is provided by another provider; and 59515 - for a Cesarean section when postpartum care is provided by the same provider. The same physician performed the actual procedure on the patient which resulted in multiple births. We took exception with the second billing of the same type CPT code. Since the patients' medical records did not support evidence that postpartum care was provided by the delivering physician, we took exception with the billing of CPT 59515 and allowed the billing for CPT 59414.

Projected Findings from the Sample

Overall, we identified 32 exceptions in our sample of 296 services. Table 2 summarizes the basis for our exceptions.

Table 2: 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
Missing Documentation	11
Unsupported Level of Postpartum Care	9
Unsupported Level of Anesthesia Service	5
Unsupported Level of E&M Service	5
Duplicate Billing	2
Total Services with Exceptions	32

Source: AOS analysis of a sample of 174 recipient dates of service not included in previous tests.

As noted above, we took exception with 32 of 296 sampled recipient services (28 of 174 recipient dates of service) from a stratified sample of the Provider's population of paid services exclusive of those services selected for exception tests. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $773,601.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $725,855.00 to $819,353.77 (+/- 6.17 percent). We then calculated audit findings repayable to ODJFS by subtracting the calculated correct population amount ($773,601.00) from the amount paid to the Provider for this population ($823,834.10), which resulted in a finding of $50,233.10. See Appendix I for additional details regarding our findings calculations.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on January 12, 2004. The Provider sent us a written response on February 13, 2004, along with additional documentation to support some of the claims for services we had taken exception with. We also discussed our audit results with the Provider during a March 2, 2004 teleconference. As a result of additional supporting information supplied by the Provider, we reduced our findings from $114,768.08 to $57,397.41. These findings are repayable to the Ohio Department of Job and Family Services.

The Provider also committed to correcting the deficiencies identified by our audit. In a March 8, 2004 letter, the Provider stated:

> As discussed in the exit conference regarding the audit of our physician practices, please note the action plan to be implemented from these findings. We feel this action plan along with some additional education to the physicians and office staff and safeguarding of medical records, we will eliminate any potential exceptions in the future.

The Provider submitted the following list of process changes taken, or planned to be taken, in response to our audit.

Physician Practice Services
Ohio Medicaid Audit Findings
Action Plan Re: Audit Findings

Action	Process	Implementation	Date (if required)
1) Missing medical records	Implement a central retrieval and master list of medical records, location, dates of service and provider.	1. When divesting physician offices, maintain original medical records. 2. Develop master medical record list.	1. Ongoing 2. April 30, 2004
2) Missing documentation in the medical records	Reinstate the audit team to review documentation.	Review approximately 50 records monthly for appropriate documentation to support the physician coding.	May 1, 2003
3) Levels of service E&M coding	Reinstate the audit team to review documentation.	Review approximately 50 records monthly for appropriate documentation to support the physician coding.	May 1, 2003
4) Erroneous billing of newborn services	Process changed approximately $1^{1/2}$ years ago. OB department registers newborns.	Re-educate and reinforce to OB to enter all 000-00-0000 for newborns SSN so claim will reject in our system and we can obtain newborns Medicaid #.	March 31, 2003
5) Duplicate billings	Run monthly report for duplicate billings.	Work with CBO to implement process and educate physician office staff.	June 2003
6) New patient E&M's billed for established patients	Work with physician offices on procedures for billing new vs. established.	Re-educate the physicians and office staff on procedures.	Staff Meeting May 2003
7) Unsupported level of service PP care	No action/process necessary-no longer provide OB professional services.		
8) Unsupported level of service time in attendance	Developed a policy to address time in attendance and appropriateness of coding/billing anesthesia time.	Already implemented anesthesia services provided effective March 1, 2004 are contracted service no longer billable under this group.	

Source: Pleasant Valley Hospital Physicians, received by AOS on March 10, 2004.

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APPENDIX I

Summary of Sample Analysis for Pleasant Valley Hospital Physicians
Audit Period: October 1, 1999 – September 30, 2002

Description	Audit Period October 1, 1999 – September 30, 2002
Type of Examination	**Statistical Random Sample of 174 Recipient Dates of Service**
Number of Population Recipient Dates of Services[5]	**16,535**
Number of Population Services Provided	**22,835**
Number of Recipient Dates of Service Sampled	**174**
Number of Services Sampled	**296**
Amount Paid for Services Sampled	**$41,329.36**
Total Medicaid Amount Paid for Sub-population During Audit Period	**$823,834.10**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$725,855.00**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$97,979.10**
Upper Limit Correct Population Payment Amount at 95% Confidence Level	**$819,353.77**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	**$4,480.33**
Point Estimate of Correct Population Payment Amount	**$773,601.00**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$50,233.10**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$47,746.00 (+/- 6.17%)**

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

[5] *Adjusted population excluding services selected for exception analysis*

APPENDIX II

Summary of Audit Findings for Pleasant Valley Hospital Physicians
Audit Period: October 1, 1999 to September 30, 2002

Description of Audit Finding	Dollar Amount of Finding
Medicaid Services Sample Excluding Exceptions	**$50,233.10**
Preventive Counseling Billed In Conjunction with HealthChek Screenings	**$5,437.40**
Billing Non-Covered Services	**$471.14**
Erroneous Billing for Newborn Services	**$414.88**
Duplicate Billings	**$257.73**
Comprehensive Procedure Codes Incorrectly Billed Together	**$241.02**
Multiple E&M Codes Billed Together	**$170.33**
New Patient E&M Codes Billed for Established Patients	**$114.26**
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	**$57.55**
Total Audit Findings	**$57,397.41**

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

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
Accounts Receivable
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider: Pleasant Valley Hospital Physicians
2520 Valley Dr.
Point Pleasant, WV 25550

Provider Number: 0104854

Audit Period: October 1, 1999 through September 30, 2002

AOS Finding Amount: $57,397.41

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 (614) 728-7398: ATTN: Health Care and Contract Audit Section.

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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

PLEASANT VALLEY HOSPITAL PHYSICIANS

WEST VIRGINIA

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
APRIL 15, 2004