Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Robert L. Sliwinski, D.O.

A Compliance Audit by the:

Fraud and Investigative Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

May 06, 2004

Robert L. Sliwinski, D.O.
27 Walnut St.
P.O. Box 165
Ashville, OH 43103

Re: Audit of Robert L. Sliwinski, D.O.
Provider Number: 8157757

Dear Dr. Sliwinski:

We have completed our audit of selected medical services rendered to Medicaid recipients by you for the period July 1, 2000 through June 30, 2003. We identified $12,214.16 in findings that 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 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 State 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
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Physician's Current Procedural Terminology
E&M	Evaluation and Management Services
D.O.	Doctor of Osteopathic Medicine
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Ohio Auditor of State performed an audit of Robert L. Sliwinski, D.O., (hereafter called the Provider), Provider # 8157757, doing business at 27 Walnut St.; P.O. Box 165; Ashville, OH 43103. Our audit performed at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with 117.10 of the Ohio Rev.Code. As a result of this audit, we identified findings amounting to $12,214.16, based on reimbursements that did not meet the rules in 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 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' 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 an individual doctor of osteopathic medicine.

We notified the Provider by letter that he had been selected for a compliance audit and held an entrance conference at the Provider's place of business on August 28, 2003. The scope of the 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 July 1, 2000 through June 30, 2003. The Provider was reimbursed $501,938.76 for 18,309 services rendered on 11,379 recipient dates of services 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, service rendered, and the amount paid. Services are billed using the Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2]

To facilitate an accurate and timely audit, we used a combination of computerized exception analyses and statistically random samples of the Provider's paid medical services. Six groups of potentially inappropriate service codes or service code combinations were identified by our computer analysis for 100 percent review. These six groups included:

- Multiple preventative health visits billed for recipients between the age of 2 and 20 in the same calendar year.
- Services potentially duplicate billed and paid. Duplicates, for purposes of this test, were defined as more than one bill for the same recipient, same date of service, same procedure, same procedure modifier and same payment amount occurring on different claims.
- Potential erroneous payments for services due to values greater than one in the units of service field for evaluation and management (E&M) office visits.

[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.*

- Bills for services to deceased recipients for dates of service after the date of death.
- New patient E&M codes billed for established patients who had received professional services from the Provider within the previous three-year period of time.
- New patient E&M codes billed in conjunction with preventative E&M office visits.

In addition to the exception analyses, a statistically random sample of 124 recipient dates of service (comprising 317 services) was drawn from the subpopulation of services not already chosen for review (comprising 11,364 recipient dates of service and 18,250 services).

The test for claims for services rendered after the date of death of recipients was negative, but the other five analyses all identified potentially overpaid services. These potentially overpaid services were selected for verification during our field audit of the Provider's medical records.

Our work was performed between July 2003 and September 2003 in accordance with government auditing standards.

FINDINGS

Our computer exception reports and our sample of 124 recipient dates of service identified exceptions in several areas and resulted in $12,214.16 in findings that are repayable to ODJFS. In addition, we are recommending that the Provider, as president of a medical association that includes another provider who has an individual Medicaid provider number; obtain a "group" Medicaid provider number. The circumstances detailing our results are discussed below.

Results of Exception Testing

Our 100 percent review of cases identified by our computer exception testing identified findings of $1,159.16 in the following areas:

- $632.63 for preventative healthcheck services billed more than once per calendar year,
- $ 38.72 for duplicate claims for service,
- $ 97.43 for erroneously billed units of service and,
- $390.38 for exceptions with new patient evaluation and management (E&M) service claims.

Preventative HealthChek Services Billed More than Once per Calendar Year

Ohio Rev. Code 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.

Our computer analysis identified 20 occasions where the Provider billed for more than one HealthCheck service in the same calendar year for a recipient between the ages of 2 and 20. Our examination of patient medical records determined that the Provider was only entitled to bill for one service. We therefore reduced the additional HealthChek services to the appropriate level

evaluation and management office visit code and made a finding for the difference in payment amount. This resulted in a finding of $632.63.

Duplicate Claims for Services

Pursuant to Ohio Adm.Code 5101:3-1-19.8(F), state:

> Overpayments are recoverable by the department at the time of discovery.

Our computer analysis identified three instances of potential duplicate billing of services where the Provider billed more than once for the same procedure code for the same patients on the same day. Our examination of patient medical records determined that on two of the occasions only one service was documented. Therefore, we disallowed the second billed service. This resulted in a finding of $38.72.

Erroneously Billed Units of Service

Pursuant to Ohio Adm.Code 5101:3-1-19.8(F), state:

> Overpayments are recoverable by the department at the time of discovery.

Our computer analysis identified one claim where the Provider had billed and been paid for 11 evaluation and management office visits on the same day for the same patient. A review of the patient's medical records determined that only one office visit took place on that date, and that a billing error in the "units of service" field of the Provider's claim for reimbursement may have caused the overpayment. Therefore, we reduced the units of service to one unit and took exception with the difference, totaling $97.43.

Exceptions for New Patient Evaluation & Management (E&M) Service Claims

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

The American Medical Association, which promulgates CPT code definitions, states:

> Solely for the purpose 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.

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

One of our computer exception tests identified 24 services for five patients for whom the Provider had billed new patient E&M services after providing them professional services within the previous three years. After reviewing patient medical records and excluding claims that we took exception with for other reasons, we down coded four new patient E&M service claims to established patient visits and disallowed one E&M service claim because the patient record did not support that the service had been provided.

Another computer exception test identified eight services involving four patients where a new patient E&M office visit (CPT codes 99201 through 99205) was billed on the same day as a children's new patient E&M preventative visit (CPT codes 99381 through 99385). Our review of patient records did not support that two separate services were provided. Consequently, in accordance with Ohio Adm.Code 5101:3-1-19.8(F), we considered one of the billings as a duplicate. We accepted the more comprehensive of the two codes and disallowed the second less costly service.

The results of these two tests resulted in a finding of $390.38.

Results of Statistical Sample

We also identified projected findings of $11,055.00 for erroneously billed services in our sample of 124 recipient dates of service. These findings fell into four categories:

- unsupported levels of evaluation & management services,
- evaluation & management services billed in conjunction with family planning services,
- missing documentation and,
- non-covered services.

The rationale for our sample findings and the methodology used in projecting the sample results to the subpopulation of the Provider's paid services not examined as part of our exception analyses is presented below.

Unsupported Levels of E&M Services

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

> 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.

Ohio Adm.Code 5101:3-4-06(A)(2) states:

> A "physician visit" or an "evaluation and management (E & M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient.

The American Medical Association descriptors for levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

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

The key components[3] 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 services for new patients are billed using CPT codes 99201 through 99205; while E&M services for established patients are billed using CPT 99211 through 99215.

From our sample of 127 E&M services, 16 lacked adequate documentation in the patient medical records to support that the required components had been performed for the service billed and one hospital service that was not performed by the Provider. The 16 E&M office visits that we took exception with included services billed at the CPT code 99204, 99215, 99214, 99213 levels; and a hospital E&M visit 99223. When calculating our findings, we reduced the allowable payment for the 17 services to the level supported by documentation in the patient record.

The following are examples of services we took exception with:

- The Provider saw the patient for a swollen and sore throat, earache, backache, and sore chest. In addition, the chart included vitals (temperature, blood pressure, weight) and a limited review of systems. We reduced the service from 99214 to 99213 because the patient record lacked evidence of two of three key components for 99214: a detailed history and a detailed exam.

- The Provider saw the patient for a pre-operative visit. The patient record showed that patient vitals (blood pressure, temperature, and weight) had been taken, but lacked a review of systems. The Provider ordered a chest x-ray. We reduced the service from the 99215 to the 99213 level because the patient record lacked evidence of two of three key components for 99215: a comprehensive history and a comprehensive examination.

[3] 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.

- The patient received a well child exam. The patient record showed the patient's vitals (temperature, blood pressure, height, and weight); a review of systems; and hemoglobin and hematocrit. In addition, we located an immunization record. We re-coded the service from a 99204 (new patient E&M code) to a 99383 (new patient preventative HealthChek) because the record clearly stated that the visit was for a well child exam.

E&M Codes Billed in Conjunction with Family Planning Codes

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 service 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 X1453, a local level code to be used for a family planning visit as a:

> …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 IUD, contraceptive counseling, genetic counseling, and the prescription of contraceptive pharmaceuticals and supplies.

We found 17 of the 124 recipient dates of services in our statistical sample where the Provider billed for both an evaluation and management code (CPT 99201 – 99499) and a family planning code (X1453), when one or the other should have been billed.

Following are two examples:

- *New patient code 99203 billed in conjunction with X1453*: the patient came in for birth control and a pregnancy test. The patient record showed that the patient was new and vitals were taken (temperature, pulse, blood pressure, and weight). The record also indicated the patient's last menstrual period lasted for five days. The Provider diagnosed the patient with an irregular menstrual and performed a pelvic exam. The patient was given counseling about safe sex and family planning. In addition, the patient received a 150mg shot of depo provera and is due for another dose three months from that date. We determined that only the *99203* should have been billed.

- *Established patient 99214 billed in conjunction with X1453*: the patient came in for a depo provera injection. The patient record showed that the patient's vital signs were

> taken (temperature, pulse, blood pressure, height, and weight), a gynecological exam was performed and a depo provera shot of 150mg was administered and family planning counseling was given. The patient was scheduled to return in three months. We determined that only *X1453* should have been billed.

For these 17 recipient dates of service, we disallowed the service not supported by the patient medical record. This resulted in 11 family planning service codes and six (6) E&M services being disallowed.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(C) states:

> Records, documentation, and information must be available regarding any services for which payment has been or will be claimed to determine that payment had been or will be made in accordance with applicable federal and state requirements. For the purposes of this rule, an invoice constitutes a business transaction, but does not constitute a record which is documentation of a medical service.

In our review of patient medical records for 124 recipient dates of service (317 services), we found claims for three services (injections) that could not be verified in patient records. Patient records supported that an office visit occurred on the dates in question, but not that injections were given. Therefore, we took exception with the injection claims.

Non-covered Services

Ohio Adm.Code 5101:3-4-28 defines non-covered physicians services and includes in pertinent part:

> (C) Services of preventative nature, such as routine laboratory procedures and annual physical checkups with the following exceptions:
>
> > ***
> > (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.

In our sample of 124 recipient dates of service (317 services), we found two services in which the Provider billed for a non-covered service. The Provider billed for a second drug screening test that was not covered by Medicaid.

Projection of Sample Findings

In our stratified sample of the sub-population of recipient dates of service for services not already selected for review by our exception analyses, we found errors with the billing for 35 of 124 recipient dates of service and 39 of 317 services sampled. To arrive at the amount overpaid, we projected the average overpayment per recipient date of service in our sample across the sub-population of recipient dates of service. This resulted in a projected overpayment point estimate of $22,103, with a 95 percent degree of certainty that the actual sub-population overpayment lies between the upper limit of $33,151 and the lower limit of $11,055. Because the difference between the upper and lower limits is greater than that required by our procedures for use of a point estimate, we are making a finding for $11,055, the lower limit overpayment amount. This allows us to say with 97.5 percent certainty that the amount of overpayment in the sampled sub-population was at least $11,055.

Provider Should Bill for Services Under a Group Number

Ohio Adm.Code 5101:3-1-17 (B) states:

> Providers eligible for enrollment in the medicaid program may be an individual, a group of individuals, a corporation, or an institution licensed or approved to provide a particular service. Provider agreements, therefore, may be issued to an individual, groups of individuals, corporations or institutions. A "group" provider agreement may only be issued to organizations composed solely of two or more individuals of the same profession who are members of a professional association organized under Chapter 1785 of the Revised Code, each of whom is licensed or approved by a standard-setting or regulatory agency to render the same kind of professional service and approved for participation in the medicaid program by the Ohio department of job and family services as individual providers.

While we are not asserting monetary findings regarding this issue, we believe the opportunities for erroneous Medicaid billings would be reduced if the Provider billed for services under a group provider number, instead of under an individual provider number. The Provider is the president of the practice which at the time of our audit included another provider who supplied and billed for Medicaid services under an individual provider number.

Although ODJFS does not require that practices with multiple providers obtain and bill under a group number, we believe doing so avoids the potential for duplicate and other unallowable billings. During the course of our audit of this Provider, we noted instances where the Provider billed the service but the service was performed by the other provider. These errors would have been prevented had the services been billed under a group number. Therefore, we are recommending that the Provider obtain a group provider number and bill in accordance with ODJFS guidance.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on January 5, 2004 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider sent us written responses dated January 16, 2004 and March 1, 2004, in which he disagreed with our findings and supplied additional supporting documentation. We also discussed our audit results with the Provider during a teleconference on January 30, 2004. As a result of the additional supporting documentation supplied by the Provider, we reduced our findings from $14,922.68 to $12,214.16. These findings are repayable to the Ohio Department of Job and Family Services.

We also asked the Provider to prepare an action plan addressing how the deficiencies identified in our report would be corrected. As of April 16, 2004, we had not received the Provider's corrective action plan. Therefore, we are referring this matter to ODFJS' Surveillance and Utilization Review Section for their follow up.

APPENDIX I

Summary of Overpayment Results for: Robert L. Sliwinski, D.O.
For the period July 1, 2000 to June 30, 2003

Description	Audit Period: July 1, 2000 to June 30, 2003
Projected findings from sample of Other dates of service not involved with census review.	$11,055.00
Actual findings from census review: • Preventative Health Visits billed Twice in a Calendar Year • Duplicate Services • Erroneous Payment billed for Units of service • Exceptions for New Patient Evaluation and Management (E&M) Service Claims	 $632.63 $ 38.72 $ 97.43 $390.38 $1,159.16
TOTAL FINDINGS	**$12,214.16**

APPENDIX II

Summary of Sample Record Analysis for: Robert L. Sliwinski, D.O.
All Other Services
For the period July 1, 2000 to June 30, 2003

Description	Audit Period July 1, 2000 – June 30, 2003
Type of Examination	**Statistical Stratified Random Sample of 124 Services**
Description of Population Sample	Sub-population of Other Recipient Dates of Service excluding services selected for census review
Number of Recipient Dates of Service in Sub-Population	11,364
Number of Services in Sub-Population	18,250
Total Medicaid Amount Paid for Sub-population of Other Recipient Services	$499,024.01
Number of Recipient Dates of Service Sampled	124
Number of Services Sampled	317
Amount Paid for Services Sampled	$11,408.22
Estimated Overpayment (Point Estimate)	$22,103.00
Upper Limit Overpayment Estimate at 95% Confidence Level	$33,151.00
Lower Limit Overpayment Estimate at 95% Confidence Level	$11,055.00
Precision of Correct Population Payment Estimate at 95% Confidence Level	$11,048 (49.99%)

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 Name & Address: Robert L. Sliwinski, D.O.
27 Walnut Street
P.O. Box 165
Ashville, OH 43103

Provider Number: 8157757

Audit Period: 07/01/00 – 06/30/03

AOS Finding Amount: $12,214.16

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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Betty Montgomery

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ROBERT L. SLIWINSKI, D.O.

FRANKLIN 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
MAY 6, 2004