Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Todd R. Myers, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

February 10, 2004

Todd R. Myers, M.D.
410 Second Street
Marietta, OH 45750

Re: Medicaid Audit of Todd R. Myers, M.D.
Provider Number: 2150925

Dear Dr. Myers:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period April 1, 2000 through March 31, 2003. We identified $7,659.79 in findings, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "Provider Remittance Form" is included 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 117.28 and 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 of the 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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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
HCPCS	Healthcare Common Procedural Coding System
M.D.	Medical Doctor
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 Revised Code	Ohio Rev.Code

SUMMARY OF RESULTS

The Ohio Auditor of State performed an audit of Todd R. Myers, M.D. (hereafter called the Provider), Provider #2150925, doing business at 410 Second Street, Marietta, OH 45750. Our audit was performed at the request of the Ohio Job and Family Services in accordance with 117.10 of the Ohio Rev.Code. As a result of this audit, we identified findings amounting to $7,659.79, 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 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 constitutes an over utilization of Medicaid covered services and results 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 identify the amount of any finding resulting from non-compliance. Within the Medicaid program, the Provider is listed as an individual physician who specializes in providing obstetrical and gynecological services.

We notified the Provider by letter that he had been selected for a compliance audit, and an entrance conference was held on June 10, 2003 at the Provider's 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 April 1, 2000 through March 31, 2003. The Provider was reimbursed $510,149.95 for 9,257 services rendered on 4,920 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 Medicaid Provider Handbook, Ohio Administrative Code and Ohio Revised Code 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 federally required Healthcare Common Procedural Coding System (HCPCS), which includes use of the five-digit Current Procedural Terminology (CPT)[2] coding system and ODJFS local level codes.[3]

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. Four groups of potentially inappropriate service codes or service code combinations were identified by our computer analysis for 100 percent review. These four groups included:

- Urinalysis services billed in conjunction with antepartum visits.
- Surgical services billed in combination with evaluation and management (E&M) codes.
- New patient E&M codes billed for patients who had received professional services from the Provider within the prior three years.
- Non-fetal stress tests billed with both comprehensive (technical and professional) and professional only components for the same patient and same date of service.

In addition to the exception analyses, a statistically random sample of 60 recipient dates of service (comprising 130 services) was drawn from the subpopulation of services not already chosen for review (comprising 4,655 recipient dates of service and 9,215 services).

[2] CPT codes are 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.

We also ran two analyses of paid claims in MMIS for duplicate payments to the Provider. We defined duplicate claims as two or more claims with the same date of service, patient, procedure code, procedure code modifier and reimbursement amounts. The first duplicate analysis checked for duplicate claims within the claims billed by the Provider. The second duplicate analysis looked for duplicate claims between those billed by the Provider and the other physicians in the group practice that the Provider belonged to. We did not find any duplicate billings within the Provider's claims, but we did find duplicate billings between the Provider and the other physicians in the Provider's group practice.

Our work was performed between May 2003 and November 2003 and in accordance with government auditing standards.

FINDINGS

Our computer exception analysis and 100% record reviews identified findings in three areas:

(1) Duplicate billed and paid services between the Provider and the other physicians in the group practice in the amount of $464.40.
(2) Components of fetal-non stress tests billed and paid twice, resulting in an overpayment of $74.34.
(3) Urinalysis services improperly billed in conjunction with antepartum services, resulting in an overpayment of $59.05.

No payment exceptions were identified in the analyzed test for evaluation & management codes billed with surgical procedures on the same date of service.

Additionally, our analysis of a sample of the remaining population of recipient dates of service resulted in projected findings of $7,062.00. These findings were in two categories:

1) Missing documentation for the dates of service billed.
2) Delivery service codes billed for inclusive postpartum care where no documentation was found to show that postpartum care was provided.

The circumstances leading to the total finding of $7,659.79 are discussed below.

Duplicate Billings

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

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

We disallowed 13 services for the following reasons:

(1) For 10 services, the Provider billed an exact duplicate of another service paid for the same patient, on the same date of service, and for the same dollar amount. Information in the patients' medical records only documented that one service had been provided.

(2) Three recipient dates of service in our sample had duplicate fetal non-stress tests (CPT 59025) billed for the same patient on the same date of service. On each date, one service was billed with procedure code modifier 26 (professional component only) and the other service had no modifier, indicating that both the technical and professional components were performed. Since documentation in the patient records supported that only one non-stress test had been performed, and the test included both the technical and professional components, the three modified (professional component only) services were disallowed.

Total findings for duplicate billings were $538.74.

Urinalysis Services Billed in Conjunction with Antepartum Visits

Ohio Adm.Code 5101:3-4-08(D)(1) states in part:

> (a) The antepartum visit is inclusive of:
>
> ***
>
> (ii) Routine urinalysis screening tests (dipstick) to detect the presence of sugar or protein.
>
> ***
>
> ***

We found 17 antepartum visits where the Provider billed the Antepartum visit (CPT 59420) in conjunction with urinalysis services (CPT 81001 and 81003) for the same patient on the same day.

We took exception with these 17 services amounting to a finding of $59.05.

Results from Sample of Remaining Recipient Dates of Service

Our audit of 60 recipient dates of service (comprising 130 services) drawn from the subpopulation of services not already chosen for review identified the following:

Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) 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 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 control unit upon request.

We found that 4 of the 130 services in our audit of 60 randomly selected recipient dates of service lacked documentation to show they had been performed. The payments for these four services without documentation were disallowed and a finding made for the amount paid.

Inclusive Delivery Codes Billed Without Required Follow-up Office Visit

Ohio Adm.Code 5101:3-4-08 specifies covered obstetrical services and states in pertinent part:

> ***
>
> (E) Delivery and Postpartum care.
>
> (1) 'Delivery Services' include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without forceps and/or episiotomy), or Cesarean section delivery.
>
> (2) 'Postpartum Care' includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.
>
> ***
>
> (4) The following codes should be billed:
>
> (a) For delivery and postpartum services provided to patients for which a vaginal or Cesarean delivery after a previous Cesarean delivery (VBAC) was not attempted.
>
> 59409 For a vaginal delivery when outpatient postpartum care is provided by another provider or provider group.
>
> 59410 For a vaginal delivery when outpatient postpartum care is provided by the same provider or provider group.
>
> 59514 For a Cesarean section when outpatient postpartum care is provided by another provider or provider group.
>
> 59515 Cesarean section and routine postpartum care provided by same provider.
>
> ***

> (5) For the reimbursement of codes 59410, 59430, 59515, 59614 or 59622, the provider must, at a minimum, render an evaluation and management service four to six weeks post-delivery.
> ***

The Provider's patient records did not support that an evaluation and management service was provided for three of the 130 services in our sample. Since Chapter 5101:3-1-17.2(D) of the Ohio Adm.Code requires that providers maintain proper records, we reduced the reimbursement amount from that due a delivery code inclusive of postpartum care (CPT 59410 or 59515) to the proper amount for the equivalent delivery only code (CPT 59409 or 59514).

Projected Findings from Sample Results

We disallowed or reduced the payments received by the Provider for seven services from seven different recipient dates of service in our sample. The overpayments for these seven recipient dates of service were then projected to the population of the Provider's recipient dates of service not already selected for one of the 100 percent reviews. This projection resulted in an overpayment point estimate of $27,458 with a 95 percent certainty that the true amount of overpayment fell between a lower limit of $7,062 and an upper limit of $47,853, a precision of plus or minus 74.28 percent. Since this precision was larger than that required for use of the point estimate by our procedures, a finding was made for $7,062, the lower limit. This allows us to say with a 97.5 percent level of certainty that the amount of overpayment for the sampled population is at least $7,062. The service exceptions noted in our sample are presented in Table 1 below. The basis for our sample projections are further detailed in Appendix II.

Table 1: Summary of Service Exceptions Found in Random Sample

Basis for the Exception	Number of Service Exceptions
Missing Documentation	4
Inclusive Delivery Service Codes Paid Without Follow up Evaluation and Management Service	3
Total Service Exceptions found in Sample	7

Source: AOS review of patient medical records for random sample of 60 recipient dates of service with 130 services

Provider Should Bill for Services Under a Group Number

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

> 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 associated with this matter, we believe the opportunities for erroneous Medicaid billings could be reduced if the Provider had billed for services under a group provider number, instead of under an individual provider number. The Provider was a member of Marietta Gynecologic Associates, Inc., which at the time of our audit included five other physicians who provided and billed for Medicaid services. All of these physicians currently bill for Medicaid services under their individual provider numbers.

Although ODJFS does not require that practices with multiple providers obtain and bill under a group number, we believe doing so would avoid the potential for duplicate and other unallowable billings. During the course of our audit of this Provider and two other providers associated with Marietta Gynecologic Associates, Inc., we noted instances of duplicate billings (two of the providers billing for the same service on the same date for the same patient), and services provided by one doctor that were erroneously billed under another doctor's provider number. These errors would have been prevented had the services been billed under a group number. Therefore, we are recommending that Marietta Gynecologic Associates, Inc. obtain a group provider number and bill in accordance with ODJFS guidance.

PROVIDER'S RESPONSE

On November 21, 2003, we sent the Provider a draft report discussing our findings and to afford an opportunity to provide additional documentation or otherwise respond in writing. In a response dated December 22, 2003, the Provider acknowledged that billing errors had occurred in billing established patients as new patients and in duplicate billings.

Regarding our findings for billing delivery codes inclusive of post-partum services, the Provider's office manager stated their standard practice was to bill the inclusive codes because the physicians always do a post-partum visit before the patient leaves the hospital. However, Ohio Adm.Code 5101:3-4-08(E)(5) states that a service must occur four to six weeks after delivery in order to qualify for reimbursement of the inclusive code. Patient records did not show this occurred. Therefore, our findings for this issue did not change.

Regarding our findings for urinalysis billed in conjunction with antepartum visits, the Provider's office manager acknowledged that antepartum is inclusive of "dipstick screenings" and said the screenings were performed at no additional charge. The office manager indicated that follow on urinalysis tests are sometimes ordered and billed when a urinary infection is suspected. On those occasions, we allowed the reimbursement for the additional urinalysis claim. Our exceptions were only taken with claims when the patient record showed that just a dipstick screen occurred. Therefore, our findings for this issue did not change.

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APPENDIX I
Summary of Overpayment Results for: Todd R. Myers, M.D.
D.B.A. Marietta Gynecologic Associates
For the Period: April 1, 2000 through March 31, 2003

Description	Audit Period: April 1, 2000 through March 31, 2003
Projected Findings - All Other Codes (See Appendix II)	$7,062.00
Duplicate Billings	$538.74
Urinalysis Services Billed in Conjunction with Antepartum Visits	$59.05
TOTAL FINDINGS	**$7,659.79**

Source: AOS review of patient medical records and MMIS claims payment information

APPENDIX II

Projected Findings – All Other Non-Specialty Codes
Summary of Overpayment Results for: Todd R. Myers, M.D.
D.B.A. Marietta Gynecologic Associates
For the Period: April 1, 2000 through March 31, 2003

Description	Audit Period April 1, 2000 – March 31, 2003
Type of Examination	Statistical Simple Random Sample of 130 Recipient Services
Number of Population Recipient Dates of Services	4,655
Number of Population Services Provided	9,215
Total Medicaid Amount Paid For Population of all other non specialty records	$509,991.47
Number of Recipient Date of Services Sampled	60
Number of Services Sampled	130
Amount Paid for Services Sampled	$8,921.05
Point Estimate of Overpayment Amount	$27,458.00
Upper Limit Overpayment Estimate at 95% Confidence Level	$47,853.00
Lower Limit Overpayment Estimate at 95% Confidence Level	$7,062.00
Precision (+ or – amount)	$20,395.00 (74.28%)

Source: AOS review of patient medical records and MMIS claims payment information

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:	Todd R. Myers, M.D. Marietta Gynecologic Associates, Inc. 410 Second St. Marietta, Ohio 45750
Provider Number:	2150925
Audit Period:	April 1, 2000 – March 31, 2003
AOS Finding Amount:	$7,659.79
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.

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

TODD R. MYERS, M.D.

WASHINGTON 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
FEBRUARY 10, 2004