Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Delia M. Slaga, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

January 2005 ***AOS/HCCA-05-014C***

Auditor of State
Betty Montgomery

January 13, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Delia M. Slaga, M.D.
Provider Number: 0281298

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Delia M. Slaga, M.D. for the period October 1, 2000 through June 30, 2003. We identified $47,015.92 in findings that are repayable to the state of Ohio. We also identified three patients who had two active Medicaid identification numbers, and the Provider had billed and been reimbursed for the same service under both numbers. Because the Medicaid claims processing would not identify a duplicate billing in these situations, duplicate payments occurred. To avoid the risk of future duplicate payments, we believe ODJFS should determine if a systemic problem exists that would allow one recipient to have two active recipient identification numbers. If one exists, we recommend that ODJFS rectify the situation.

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 this 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 potential overpayments identified herein. We have advised Dr. Slaga that if our findings are not repaid to ODJFS within 45 days of the date of this report, this matter can be referred to the Ohio Attorney General's office for collection in accordance with Section 131.02 of the Ohio Revised Code.

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

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

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

TABLE OF CONTENTS

ACRONYMS

AMA	American Medical Association
CLIA	Clinical Laboratory Improvement Amendment of
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
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

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Auditor of State performed an audit of Delia M. Slaga, M.D. (hereafter called the Provider), Provider #0281298, doing business at 2400 Wales Road NW, Massillon, Ohio 44646. We performed our audit 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 $47,015.92 in findings, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

We identified three patients that had two active Medicaid identification numbers, and the Provider had billed for the same service under both numbers. Because the Medicaid claims processing would not identify a duplicate billing in these situations, duplicate payments occurred. To avoid the risk of future duplicate payments, we believe ODJFS should determine if a systemic problem exists that would allow one recipient to have two active recipient identification numbers. If one exists, we recommend that ODJFS take action to rectify the situation.

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 audit initiated within the six year period is completed."

In addition, 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."

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

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."

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 findings. Within the Medicaid program, the Provider is listed as an individual physician with a specialty in pediatrics.

Following a letter of notification, we held an entrance conference at the Provider's place of business on January 14, 2004 to discuss the purpose and scope of our audit. 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, 2000 through June 30, 2003. The Provider was reimbursed $619,571.34 for 23,615 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 covered 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 and 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. The test for services to deceased patients was negative. However, our test for duplicate payments was positive. These potential duplicate payments were extracted for a separate 100 percent review. Additionally, we performed 100 percent testing of payment data in the following areas:

- Units of service

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 (AMA). 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.*

- HealthChek visit services in excess of limitations
- More than one new patient Evaluation and Management (E&M) office visit service within three (3) years

In addition, to facilitate an accurate and timely test of the Provider's remaining reimbursements we selected a stratified random sample of 103 recipient dates of service from the population of 11,872 recipient dates of service, excluding those already selected for a 100 percent review. A recipient date of service is defined as all services received by a particular recipient on a specific date. The 103 recipient dates of service encompassed 381 services.

Our work was performed between January 2004 and November 2004.

RESULTS

We identified findings of $42,220.45 for the services in the sampled population. These findings resulted from:

- Levels of E&M services that were not supported by the documentation in patients' medical records.
- Lack of proper documentation to substantiate that billed services were rendered
- Incorrectly billed services.

Additionally, we identified findings of $4,795.47 for services in our exception testing. Together, our findings totaled $47,015.92. The bases for our results are discussed below.

Unsupported Services in Sample

During our review of statistically selected patients' medical records we found exceptions with:

- levels of E&M services
- lack of documentation for services billed
- incorrectly billed vision services
- incorrectly billed laboratory services
- incorrectly billed suture removal services

Unsupported Level of Evaluation and Management Service Billings

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part respectively:

> …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…
>
> 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 AMA 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 in selecting an appropriate 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.

Counseling, coordination of care, and the nature of the presenting problem are considered ***contributory*** factors in the majority of encounters. Time is not considered a key nor contributory factor in selecting a level of service.

E&M office visit services for new patients are billed using CPT codes 99201 through 99205; while E&M office visit services for established patients are billed using CPT 99211 through 99215. For new patient E&M services the provider must perform all three of these components as defined by the CPT: history, examination and medical decision making. For established patient E&M services, the provider has to perform as least two of these key components as defined by the CPT: history, examination, or medical decision making.

The Provider was paid $377,000.15 for E&M services, which comprised 61 percent of the total reimbursement for the audit period. Fifty-seven (57) percent ($216,412.52) of E&M reimbursements was for expanded problem focused level CPT code 99213; while approximately 36 percent ($135,552.87) was for detailed level CPT code 99214. Therefore, almost 93 percent of E&M services were coded from mid-level upwards.

We found the level of service billed for 11 of 381 E&M services in our sample was not supported by the documentation in the patients' medical record, or the documentation did not contain the required components as established by the CPT code book.

The following are examples from our sample where CPT code 99213 was not supported by the medical record documentation:

To bill CPT code 99213, the provider must provide two of these three key components:

- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity

Example 1

The documentation in the patient's medical record contained:

- The patient's complaint,
- Brief history of present illness
- Problem focused examination

Therefore, the level of E&M service was reduced to CPT code 99212, since the documentation did not meet at least two of the required key components.

Example 2

The documentation in the patient's medical record contained:

- The patient's complaint
- Urinalysis results
- Problem focused history
- Examination notes which did not specify which system(s) the provider reviewed

Therefore, the level of E&M service was reduced to CPT code 99212, since the documentation did not meet at least two of the required key components.

We determined the difference between the reimbursement for the unsupported level of E&M service and the maximum allowed reimbursement for the level of E&M service supported by the documentation in the patients' medical records. These differences were used in calculating the findings of the sample population.

Undocumented Medical Services

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed.

Our review of the medical records for the statistically sampled patients found that six (6) services in our sample lacked proper documentation. The medical records reviewed did not contain documentation to verify the services billed.

We identified findings for the entire reimbursement made to the Provider for these six (6) services, and the sample findings were used in calculating the findings for the sample population.

Incorrectly Billed Vision Services Rendered During HealthChek Screenings

Ohio Adm.Code 5101:3-14-03 (E)(1) states:

> A vision assessment shall be performed as a part of each initial and periodic "HealthChek" (EPSDT) screening service using the following criteria:
>
> (a) Individuals ages birth to three years shall be evaluated by reviewing the individual's medical history for high risk factors and by performing an external (gross) observation and (internal) ophthalmoscopy.
>
> (b) Individuals ages three and older are required to be screened by:
> (i) External (gross) observation and (internal) ophthalmoscopy;
> (ii) Visual acuity test (e.g., Titmus, Snellen, or Tumbling E); and
> (iii) Ocular muscle balance test, administered at distance and near.

The Provider billed for vision services rendered during a HealthChek preventative screening using CPT code 92081 [Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)].

Upon review of the vision equipment in the provider's office and the vision test results documented in the patients' medical records, and after interviews with the Provider, all indications were that the services provided were Snellen vision screenings and not visual field examinations as billed. Although the Snellen vision service is an allowed HealthChek assessment service, it is included in the HealthChek visit and is not a separately reimbursable service.

We identified findings for the entire reimbursement made to the Provider for these five (5) services, and the sample findings were used in calculating the findings for the sample population.

Incorrectly Billed Laboratory Tests

Pursuant to Ohio Adm.Code 5101:3-11-03 (I):

> Billing the laboratory procedure codes:
>
> (1) The provider must assign the most appropriate code for each laboratory procedure performed. Some procedures are listed by the name of the substance (analyte) being measured; some are listed by methodology (e.g., RIA, EIA, TLC, Culture, etc.); some are listed by both name and methodology; . . .
>
> (2) The provider must bill the code that describes the procedure in the most detail. Codes using the term "not elsewhere specified" in the definition for the procedure may only be used when the laboratory is performing a quantitative test for a specific analyte for which there is no specific code. . . .

***

The provider used a test kit manufactured by Thermo Electron Corporation to perform Strep A testing. We reviewed the insert in the test kit to determine:

- If the description of the test insert matched the description of the CPT code billed by the provider and,
- If the described testing methodology matched the testing methodology of the CPT code billed by the provider.

According to the test kit insert for the 'Acceava Strep A Test' the intended use is ". . . the *qualitative* detection of Group A Streptococcal antigen from throat swabs or confirmation of presumptive Group A Streptococcal colonies recovered from culture." Moreover, according to information on the manufacturer's website, the proper code to bill for this particular test kit is CPT code 87430 (infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiqualitative, multiple step method; Streptococcus, group A).

Review of the Provider's claims showed CPT code 86317 (Immunoassay for infectious agent antibody, *quantitative*, not otherwise specified) was inappropriately billed for Strep A testing. Pursuant to Ohio Adm.Code 5101:3-11-03 (I), the Provider should have billed a **qualitative** test (CPT code 87430) for the Strep A test, instead of a **quantitative** test (CPT code 86317). We compared the reimbursement amount for the code billed by the Provider to the Medicaid maximum allowed charge for the appropriate code (CPT code 87430) and found the reimbursement to be $4.14 greater for CPT code 86317. Therefore, we identified a finding for the difference, and these differences were used in calculating the findings of the sample population.

Incorrectly Billed Suture Removal Services

The Provider twice billed an E&M office visit code and CPT code 12002 for the same patients on the same date of service.

The American Medical Association defines CPT code 12002 as:

> Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

The medical record documentation reviewed showed the service provided was suture removal, and not repair of a wound. The American Medical Association further states:

> Several procedures that do not have separate CPT codes are included when an E/M code is reported. . . . Another would be the removal of sutures by a physician other than the physician who initially placed the sutures.

Review of documents from other providers, which were in the medical records of these patients, showed the sutures (stitches) were placed by an Emergency Room physician a few days prior to the patients' visit with the Provider.

Therefore, we identified a finding for the service erroneously billed as CPT code 12002, and based on the service actually provided (suture removal), the reimbursement for the E&M service was reduced to the 99201 level. These findings were used in calculating the findings of the sample population.

Summary of Sample Findings

Based upon our review of the medical records of the patients whose 381 services were in our sample, we took exception with 27 services, or seven (7) percent of our sample. To arrive at the findings of the Provider we projected the correct payment amount for the 103 recipient dates of service in our stratified sample across the total population of 11,872 recipient dates of service paid to the Provider and then subtracted the estimated correct population payment amount from the actual amount paid to the Provider.

The projected correct population payment amount was $537,698.00 with a 95 percent certainty that the actual correct payment amount fell within the range of $504,343.00 to $571,053.00 (approximately +/- 6.20 percent). Subtracting the projected correct population amount ($537,698.00) from the actual amount paid to the Provider for these services during our audit period ($579,918.45) resulted in an estimated finding of $42,220.45 (point estimate).

Results of Exception Testing

Our exception testing consisted of 100 percent review of the tested populations. Findings resulted from our analyses of:

- Evaluation and Management Office Visit Services Billed as HealthChek Visit Services
- Units of service
- More than one new patient E&M visit service within a three year period
- Duplicate payments

The results of our analyses are discussed below.

Evaluation and Management Office Visit Services Billed as HealthChek Visit Services

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part respectively:

> …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…

> 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 Provider was reimbursed $114,894.37 for 2,333 Preventative E&M (i.e. HealthChek) services. Our review of the Provider's HealthChek claims showed 179 services billed as preventative visits were actually evaluation and management office visit services. A finding was made on the difference in the amount the provider received for the preventative visit and the Medicaid maximum allowed charge for the level of evaluation and management office visit documented in the medical records. Findings amounted to $4,331.18.

Incorrectly Billed Units of Service

Ohio Adm.Code 5101:3-1-60(J)(1) states in pertinent part:

> The medicaid maximums are determined as follows:
>
> For practitioner services, clinical laboratory services, x-ray services, ambulatory health care center services, and ambulance and ambulette/wheelchair vehicle services, the medicaid maximums are one hundred percent of the amounts shown in appendix DD of this rule unless otherwise stated in Chapters 5101:3-4, 5101:3-5, 5101:3-7, 5101:3-8, 5101:3-11, 5101:3-12, 5101:3-13, 5101:3-15, and 5101:3-17 of the Administrative Code. . . .

The Provider received in excess of the maximum allowed charge for nine (9) services because more than one unit of service was billed.

The difference between the amount reimbursed to the Provider and the Medicaid maximum allowed charge for one unit of the service billed resulted in findings of $125.96.

More than One New Patient Evaluation and Management Visit Service within a Three-Year Period

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 code definitions and the CPT instructions for selecting a level of E & M service.

The AMA CodeManager 2003 describes a new patient as follows:

> 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.

Our review of Provider's office visit claims determined that for two (2) patients, a new patient office visit service was billed more than once in a three year period. We accepted the amount reimbursed for the first new patient visit billed for both recipients. A finding of $61.67 was made on the difference between the amount reimbursed for the second new patient visit billed for both recipients and the maximum allowed charge for the corresponding level of an established patient office visit.

Also, our review of the Provider's Healthchek claims determined one (1) patient had a previous new patient visit service prior to their HealthChek service. As Providers can only bill the new patient level of service once within a three year period, we determined that a finding occurred. The finding of $6.52 was calculated by taking the difference between the amount reimbursed for the new patient HealthChek level of service and the maximum allowed charge for the corresponding level of an established patient HealthChek service.

Duplicate Payments

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

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

Our testing identified 17 patients where on 18 occasions the Provider billed and was paid twice for identical services on the same date of service. Our review found:

- Fourteen (14) patients whose medical records documented the services were only provided once. Therefore, a finding of $241.92 was made which represents the amount reimbursed for the second (duplicate) billing of the service.
- One (1) patient where the service could not be verified. Therefore, a finding of $28.22 was made for the total reimbursement for the twice billed service.
- Two (2) patients whose medical records supported that both identical services actually occurred. Therefore, no findings were made for these services.

Findings of $270.14 resulted from duplicate payments.

Summary of Findings

Combining the findings from our statistical sample ($42,220.45) and the exception testing of the 100 percent review ($4,795.47), our total findings for the audit period totaled $47,015.92.

Multiple Patient Identification Numbers

Each Medicaid recipient is supposed to be assigned a unique identification number, and these numbers serve to keep track of the services provided to the recipient and the reimbursements for these services. During our review of the Provider's claims of billed services, we identified three patients that had two active Medicaid identification numbers, and the Provider had billed for the same service under both numbers. Because the Medicaid claims processing would not identify a duplicate billing in these situations, duplicate payments occurred. To avoid the risk of future duplicate payments, we believe ODJFS should determine if a systemic problem exists that would allow one recipient to have two active recipient identification numbers. If one exists, we recommend that ODJFS take action to rectify the situation.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on October 7, 2004 in order to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider subsequently supplied additional documentation that was used to adjust our findings. In addition, on November 17, 2004, the Provider submitted a corrective action plan to prevent recurrence of the matters discussed in this report. The Provider's plan is attached for the review and consideration of ODJFS' Surveillance and Utilization Section.

This Page Intentionally Left Blank.

APPENDIX I

Summary of Sample Record Analysis for Delia Slaga, M.D.
Population: Paid Services
For the period October 1, 2000 to September 30, 2003

Description	Audit Period October 1, 2000 – September 30, 2003
Type of Examination	**Statistical Stratified Random Sample**
Description of Population	**All paid services net of any adjustments and excluding Medicare Cross-over payments**
Number of Population Recipient Date of Services	**11,872**
Number of Population Services Provided	**22,273**
Total Medicaid Amount Paid For Population	**$579,918.45**
Number of Recipient Date of Services Sampled	**103**
Number of Services Sampled	**381**
Amount Paid for Services Sampled	**$7,690.55**
Estimated Correct Sub-population Payment Amount	**$537,698.00**
Lower Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	**$504,343.00**
Upper Limit Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	**$571,053.00**
Estimated Overpayment (Point Estimate) = Actual Amount Paid Less Estimated Correct Sub-population Payment Amount.	**$42,220.45**
Precision of Correct Population Payment Estimate at 95% Confidence Level	**$33,355.00 (6.20%)**

This Page Intentionally Left Blank.

Delia M. Slaga, M.D., F.A.A.P.
PEDIATRICS
2400 WALES RD., N.W.
MASSILLON, OHIO 44646
TELEPHONE 330-837-4467

November 17, 2004

Ms. Stephany L. Blair, CFE, Senior Program Manager
Health Care and Contract Audit Section

Dear Ms. Blair:

I have faxed the Plan of Correction on all the areas involved in the field audit. It also includes additional documentations for the patient sample that I want to be credited.

Please send a draft of total reduction allowed after subsequent review.

Sincerely,

Delia Slaga, MD

Plan of Correction

Undocumented Medical Services

All employees were inserviced that all laboratory results should be documented properly and filed in patients chart.

Vision Service Screenings

I will discontinue billing procedure code **92081** until such time as the instrument approved for such procedure code is available.

Incorrectly Billed Laboratory Tests

Correction was already established to discontinue procedure code **86317** and use code **87430**.

Duplicate Payment

As discussed with Field Reviewer, to prevent duplication of future billings, the office personnel were made aware of the result of audit. Therefore, all encounter forms will be coded once entered.

More than one New Patient E/M Visit Service within a three year period, multiple Patient Identification Number

The charts of the patients reviewed were presented. These are foster children presented by different legal guardians and caretakers at different dates of service presenting as new patient. Foster children place to another home were issued different Medicaid recipient number. It is

difficult to bill and tract the foster parents when services were denied from the first recipient number that we billed. Often, our bills were denied, and by the time we received the second recipient number one year limitation had passed.

Billed Units of Service

Copies of all patient billing were presented to the Field Audit Reviewer. All were billed correctly at one unit (1) of service per procedure code.

The excess units of service on the audit can be explained by the error on the person in Columbus entering in computer.

Incorrectly Billed Suture Removal

Usage of CPT code **12002** will be discontinued and appropriate E&M procedure will be used.

Health Check Services in Excess of Limitation

Appropriate procedure code for each well child visit will be limited to eight (8) visits from birth to 2 years of age. American Academy of Pediatrics and Standard Pediatric Practice among my peers start well child visit at 2 weeks of age, then 1 month, 2 months , 4 months, 6 months, 9 months, 12 months, 15 months, 18 months and 2 years of age. This is a total of 10 visits from birth to 2 years of age.

I serve a class of population where parents have difficulty in keeping appointments because of work and of transportation problems. Whenever possible, missed shots are given every opportunity patient comes to the office. Also, some patients did not start any shots until they were 1 year of age, therefore, to complete the required shots, he/she will exceed the 8 visits allowed. Two (2) years of age will be limiting the quality care the patient deserves.

Hepatitis B vaccine can be started at any age, and interval time of immunization allowed is 1 month after first shot, then 6 months later; this will exceed the allowed 1 visit in a year.

State of Ohio wants immunization compliance at least about 75% - 80% in par with other states; limiting the number of visits allowed below 2 years of age at eight (8) and then one (1) per year after 2 years of age would be limiting the quality care the patient deserves.

I will write to Ohio State Chapter of American Academy of Pediatrics to allow at least 10 visits from birth to 2 years of age.

Level of Services

Appropriate E &M level will be billed with supporting documentation in the chart.

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

DELIA M. SLAGA, M.D.

STARK 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
JANUARY 13, 2005