Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to New Family Physicians Associates, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

October 20, 2005

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

Re: Audit of New Family Physicians Associates, Inc.
Provider Number: 0380912

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to New Family Physician Associates, Inc. for the period January 1, 2001 through June 30, 2003. We identified $37,901.81 in findings that are repayable to the State of Ohio. 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 a final determination regarding recovery of the findings and any interest accruals.

Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers and Section 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.

Copies of this report are being sent to New Family Physicians Associates, Inc., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also available on the Auditor's web site (www.auditor.state.oh.us).

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
CPT	Current Procedural Terminology
CMS	Centers for Medicare and Medicaid Services
E&M	Evaluation and Management
HCCA	Health Care and Contract Audit Section
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
PA	Physician Assistant

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Auditor of State performed an audit of New Family Physicians Associates, Inc. (hereafter called the Provider), provider number 0380912, doing business at 5187 Mayfield Road #20, Lyndhurst, Ohio 44124. 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 $37,901.81 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code Ohio and the Medicaid Provider Handbook (OMPH).

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 a final determination regarding recovery of the findings[1] and any interest accruals.[2]

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 requirements for reimbursement of Medicaid covered services.[3] 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 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

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

2 Ohio Adm.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made", which in the Provider's case was June 23, 2003, the latest payment date in the random sample used for analysis.

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

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."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a general practice physician group.

Following a letter of notification, we held an entrance conference at the Provider's place of business on November 3, 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 January 1, 2001 through June 30, 2003. The Provider was reimbursed $448,081.74 for 20,291 services rendered on 9,020 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 paid 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).[4.]

Prior to beginning our field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests to determine if:

4 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.

- Potentially duplicate payments were made for the same recipient, on the same date of service, for the same procedure codes, the same procedure modifier codes, and for the same dollar amount.
- Payments were made for services to deceased patients for dates of service after the date of death.

The test for payments for deceased patients was negative, but the exception test for duplicate payments was positive. These potentially duplicate payments were extracted for a separate 100 percent review. Additionally, we performed 100 percent testing of payment and medical record data for services billed with diagnoses codes V70.0 (Routine health checkup excluding health checkup of infant or child) and V70.3 (other medical examinations for administrative purposes excluding pre-employment and medical certificate exams) to determine if the services were allowable.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed a stratified statistical sample of Evaluation and Management (E&M) office visit services for 92 recipient dates of service (RDOS) comprising 93 services. A recipient date of service is defined as all services received by a particular recipient on a specific date.

Our work was performed between August 2003 and September 2005.

RESULTS

We identified and projected findings of $36,366 for the services in the sampled population. Additionally, we identified findings of $1,535.81 for services in our exception testing. Together, our findings totaled $37,901.81. 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 billed levels of evaluation and management (E&M) services, undocumented medical services, and incorrectly billed physician assistant (PA) 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 American Medical Association (AMA) defines CPT codes that are used to bill for medical services. 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 key components – examination, medical decision making, and history. For established patient E&M services, the provider has to perform at least two of the key components.

The Provider was paid $221,226.71 for E&M office visits, and these visits comprised 49 percent of the total reimbursement for the audit period. We sampled high level E&M office visit codes 99204, 99205, 99214, and 99215. These codes accounted for $117,581.89 or 26 percent of the Provider's total reimbursement for the audit period.

We found the level of service billed for 60 of 93 E&M sampled services was not supported by the documentation in the patients' medical records, or the documentation did not contain the required components as established by the AMA.

We determined the difference between the reimbursement for the unsupported level of E&M services and the maximum allowed reimbursement for the level of service supported by the documentation in the patients' medical records. These differences ($2,181.30) were used in calculating findings for the sampled 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.

We determined that four (4) services lacked documentation to support that the service occurred. The amount paid for these unsupported services ($245.68) was used in calculating the findings for the sample population.

Incorrectly Billed Physician Assistant (PA) Services

Ohio Adm.Code 5101:3-4-03 states in pertinent part:

> ***
>
> (B)(4) A patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.
>
> ***

> (7) …the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant.
>
> ***
>
> (C)(1) …reimbursement for services described in paragraph (B) of this rule will be the provider's billed charge or eight-five per cent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit code followed by the UD modifier.
>
> ***

Our review of patients' medical records showed one (1) instance where a PA rendered services to a new patient and there was no evidence that the supervising physician was physically present, saw and evaluated the patient; or discussed patient management with the PA.

In one (1) other instance, a modifier was not used when billing the service rendered by a PA and therefore, the Provider was incorrectly reimbursed. We adjusted this payment to 85 percent of the maximum allowed.

These findings ($127.93) were used in calculating the findings of the sample population.

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 two (2) 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 $400.83.

Summary of Sample Findings

The overpayments identified for 67[5] of 93 services (67 of 92 recipient dates of service) from our stratified random sample were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of $43,349 with a 95 percent certainty and a precision of plus or minus $8,321. Since the precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate (equivalent to method used in Medicare audits), and a finding was made for $36,366. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $36,366.

Results of Exception Testing

Our exception testing consisted of 100 percent review of the populations of duplicate payments and services billed with diagnoses codes V70.0 and V70.3 (physicals).

Duplicate Payments

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for service actually performed…
>
> ***

Our testing identified four (4) patients where, on four occasions, the Provider billed and was paid twice for identical services on the same date of service. A finding of $68.83 was identified for the duplicated payments.

Services Billed with Diagnoses Codes V70.0 and V70.3

> Ohio Adm.Code 5101:3-4-28 states in pertinent part:
>
> The following physician services are noncovered:
>
> ***

[5] One of these services is included in two findings categories (unsupported level of evaluation and management service billings and incorrectly billed units of service) because the Provider made two billing errors.

> (C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups…
>
> ***

In our review of 230 services billed with diagnoses codes V70.0 (general medical exam) and V70.3 (other medical exam for administrative purposes), we found that 24 of the services ($391.80) were not allowed because the visit was preventative in nature.

While reviewing the remaining services, we did not find problems surrounding the physical diagnoses codes, but we identified other issues listed below:

- Five (5) laboratory services were not documented in the medical record as ordered by the physician.
- Twenty-eight (28) services were ordered by a physician assistant without a supervising physician's countersignature.
- Thirteen (13) E&M office visit services were reduced to a level of service supported by the documentation in the medical records.
- Thirteen (13) HealthChek services were reduced to E&M office visits as the service rendered did not contain all required HealthChek components.
- Nine (9) services lacked documentation within the medical record to show that the service occurred.
- One (1) service billed which is included in another service billed for the patient on the same date of service.
- One (1) service rendered by a physician assistant which is payable at 85 percent, instead on 100 percent of the Medicaid maximum.

Laboratory Services Not Ordered

Ohio Adm.Code 5101:3-11-03 states in pertinent part:

> ***
>
> (B) A laboratory service is only covered if: . . . (3) The laboratory service is performed at the written or electronic request of an authorized practitioner."
>
> ***

There were 5 laboratory services for which we could not find orders in the patients' medical records. Therefore, findings were made for the amount paid to the Provider for these services, totaling $84.14.

Services Ordered By a Physician Assistant (PA) without Supervising Physician Countersignature

Ohio Rev.Code 4730.21(D) states in pertinent part:

> ***

> …The supervising physician named on the order shall review each medical order written by the physician assistant not later than twenty-four hours after the order is written . . . After reviewing an order, the supervising physician shall countersign the order if the supervising physician determines that the order is appropriate….

Our review showed 28 services ordered by a PA without the countersignature of a supervising physician. Findings were made for the amounts paid to the Provider for these services totaling $295.33.

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.

Our review found 13 E&M services where documentation in the patients' medical records did not support the level of service billed. Findings of $361.01 were made for the difference in the amount reimbursed to the Provider and the Medicaid maximum allowed charge for the level of E&M office visit documented in the medical records.

Evaluation and Management Office Visit Services Erroneously Billed as HealthChek Visit Services

Ohio Admin. Code 5101:3-14-01 defines the "HealthChek" program, otherwise known as the early and periodic screening, diagnosis and treatment program (EPSDT).

> (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.
>
> ***
>
> C) The "HealthChek" (EPSDT) program under medicaid includes the services listed below:
>
> (1) Screening services which are comprised of the components described in rule 5101:3-14-03 of the Administrative Code.

(2) Vision services as described in Chapter 5101:3-6 of the Administrative Code.
(3) Dental services as described in Chapter 5101:3-5 of the Administrative Code.
(4) Hearing services as described in rule 5101:3-14-05 of the Administrative Code.
(5) Other services which are covered under the medicaid program and are determined by the department to be medically necessary as defined in rule 5101:3-1-01 of the Administrative Code.

We identified 13 billed HealthChek services (i.e. preventive E&M services) where reviews of the patients' medical records determined that all required components of a HealthChek visit were not performed. A $255.42 finding was made for the difference between the amount reimbursed to the Provider for the HealthChek visits and the Medicaid maximum allowed payment for the level of E&M office visit documented in the medical records.

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.

We determined, after a review of patient medical records, that there were nine (9) services which lacked documentation to support that the service had occurred. Findings of $61.55 were made for undocumented medical services.

Services Rendered by Physician Assistant

Ohio Adm.Code 5101:3-4-03 states in pertinent part:

> ***
>
> (C)(1) …reimbursement for services described in paragraph (B) of this rule will be the provider's billed charge or eight-five per cent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit code followed by the UD modifier.

For one service (1), the Provider did not use a modifier when billing a service rendered by a PA and therefore, the Provider was incorrectly reimbursed. We adjusted this payment to 85 percent of the maximum allowed for a finding of $12.16.

Billed Laboratory Services Included in a Panel Test

The Provider billed for a laboratory service which is included in a panel test performed for the same patient on the same date of service. Therefore, a finding of $5.57 is made on the amount reimbursed for the duplicative test.

Summary of Findings

Our combined findings from the statistical sample ($36,366) and our exception testing ($1,535.81) totaled $37,901.81 for the audit period.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on May 6, 2005 to afford an opportunity to submit additional documentation or otherwise respond in writing. A post audit conference was held with the Provider on June 15, 2005 at which time the Provider discussed their concerns. Subsequently, additional documentation was supplied that was used to adjust our findings. The Provider did not submit a corrective action plan to address the deficiencies identified in our report; however, during our June 15 conference, the Provider stated that educational instruction was being given to the groups' physicians concerning levels of evaluation and management coding.

APPENDIX I

Summary of Sample Record Analysis for New Family Physicians Associates, Inc.
Population:
For the period January 1, 2001 to June 30, 2003

Description	Audit Period January 1, 2001 – June 30, 2003
Type of Examination	Statistical Stratified Random Sample
Description of Population	All paid High Level E&M services less 100% examined exception cases
Number of Population Recipient Date of Services	2,004
Number of Population Services Provided	2,005
Total Medicaid Amount Paid For Population	$117,581.89
Number of Recipient Date of Services Sampled	92
Number of Services Sampled	93
Amount Paid for Services Sampled	$6,866.79
Estimated Overpayment using Point Estimate	43,349
Precision of Overpayment Estimate at 95% Confidence Level	$6,984
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	$36,366

This Page Intentionally Left Blank.

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

NEW FAMILY PHYSICIANS ASSOCIATES, INC.

CUYAHOGA 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
OCTOBER 20, 2005