Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Kristin K. Titko, D.P.M.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 30, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Kristin K. Titko, D.P.M.
Provider Number: 0962561

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Kristin K. Titko, D.P.M. for the period January 1, 2001 through December 31, 2003. We identified $22,015.91 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 any final determinations regarding recovery of the findings identified herein, 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 also being sent to Kristin K. Titko, D.P.M., the Ohio Attorney General, and the Ohio State Medical Board. In addition, 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

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Kristin K. Titko, D.P.M. (hereafter called the Provider), Provider # 0962561, doing business at 10475 Reading Rd. Ste 306, Cincinnati, OH 45241. 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 $22,015.91 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio 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.

The scope of coverage for podiatrists, according to Ohio Adm.Code 5101:3-7-02(A) states in part: "Podiatrists may perform covered services…which consist of the medical, mechanical and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma. The podiatrist may also treat the local manifestation of systemic disease as they appear in the hand and foot, but the patient must be concurrently referred to a doctor of medicine or a doctor of osteopathic medicine and surgery for treatment of the systemic disease itself."

[1] *Ohio Adm.Code 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 December 31, 2003, the latest payment date in the exception reports used for analysis.*

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

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 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 an individual podiatrist. The Provider is also a member of a podiatry group practice, Podiatry of Hamilton, and billed services to Medicaid under the group's Medicaid number during the audit period.

Following a letter of notification, we held an entrance conference at the Provider's place of business on August 31, 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 December 31, 2003. The Provider, excluding Medicare co-payments, was reimbursed $178,693.86 for 4,382 services rendered on 1,745 recipient dates of service during the audit period. This payment total includes services billed under the Provider's individual Medicaid number (0962561) and the Podiatry of Hamilton group number (2207767). 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.]

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

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:

- Checking for services to deceased recipients for service dates after their date of death.
- Checking for potentially duplicate billed and paid services. (Defined as more than one bill for the same recipient, same date of service, same procedure, same procedure code modifier, and same payment amount occurring on different claims.)
- Checking for debridement services performed and billed on a recipient more than once in a sixty-day period.
- Checking for evaluation and management services billed by the Provider in conjunction with surgical procedure(s) that included an evaluation and management service.
- Determining whether multiple surgeries and bilateral procedures were reimbursed appropriately.

The test for deceased recipients was negative, but all other exception tests identified potentially inappropriate service code combinations. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a stratified statistically random sample of 145 recipient dates of service, containing a total of 399 services. The statistical sample was taken from a subpopulation of the Provider's claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review.

Our work was performed between April 2004 and October 2005.

RESULTS

We identified $12,727.70 in findings from our exception tests and $9,288.21 in projected findings from our statistical sample. The total findings of $22,051.91 are repayable to ODJFS. The circumstances leading to these findings are discussed below:

Exception Test Results

Multiple Surgeries

Ohio Adm.Code 5101:3-4-22(D) states:

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.

(1) A "multiple surgery" is defined as two or more consecutive surgical procedures performed by a single physician at the same operative site during the same operative session.

(2) Reimbursement for multiple surgical procedures performed on the same patient by the same provider shall be the lesser of billed charges or: (a) One hundred per cent of the medicaid maximum allowed for the primary procedure; (b) Fifty per cent of the medicaid maximum allowed for the secondary procedure; and (c) Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Our computer analysis identified 535 recipient dates of service (1,323 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating any services that are subject to the bilateral procedure rule and any services that MMIS does not list as being subject to multiple surgery charge adjustment, we identified 228 recipient dates of service (361 services) that were potentially overpaid. After further analysis, we determined that 49 recipient dates of service (117 services) were not properly reimbursed according to the multiple surgery rules. Therefore, we reduced the amount paid for 65 of the 117 services to what they should have been reimbursed. In performing our calculation, we always considered the highest paying service to be the primary service (100 percent payable); the second highest paying service to be the secondary service (50 percent payable); and all other services to be tertiary (25 percent payable). The finding amount of $2,892.67 is the difference between what was paid and what the Provider should have been paid.

Bilateral Procedures

Ohio Adm.Code 5101:3-4-22(E) states:

(1) "Bilateral procedures" are defined as surgical operations performed on both the right and left side of a patient's body during the same operative session requiring separate sterile fields and a separate surgical incision.

(2) Bilateral procedures should be billed to the department using the appropriate code for the procedure modified by the modifier 50 (e.g., 6943350 would mean a tympanostomy was performed on both ears. Code 69433 billed without a modifier would mean the procedure was performed on one ear).

(3) The medicaid maximum for bilateral procedures is one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally.

Our computer analysis identified 535 recipient dates of service (1,323 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating any services subject to the multiple surgery rules, we identified 64 recipient

dates of service (129 services) where surgical services subject to the bilateral procedure rule had been improperly billed resulting in an overpayment. These services (CPT 29580 - Strapping, Unna Boot) had been billed without a procedure code modifier (code 50, bilateral procedure). This resulted in the second CPT 29580 service being paid at 100 percent of the Medicaid maximum (200 percent for the pair), rather than the proper 50 percent (150 percent for the pair). We reduced the amount paid for 64 services by $17.95 (50 percent of price per service) and one service by $35.90 (100 percent of price per service) since it was a duplicated third strapping billed on that date. This resulted in a finding of $1,184.70.

E&M Service Incorrectly Billed in Conjunction with a Surgical Procedure

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

> Visits on the same day as surgery. A provider may be reimbursed for a visit on the same day as surgery, only if the procedure is identified by an asterisk in appendix DD of rule 5101:3-1-60 of the Administrative Code and it is customary for the physician to charge a visit for all patients.

Our computer analysis identified 264 E&M services billed in combination with surgical procedures, not identified by an asterisk in appendix DD. After reviewing the medical documentation supporting these services; we determined that 230 of the 264 E&M services were overpaid. The exceptions that we noted with these E&M services included: 1) service not separate and identifiable from the surgical procedures being performed; 2) service billed on same date as a strapping procedure; 3) no documentation in patient medical record that service was rendered; 4) service billed during a covered post operative period; and 5) service level billed not supported by medical record. We identified one monetary finding in those cases where an E&M service had multiple reasons for taking an exception. The total findings made for E&M services billed in conjunction with surgical procedures was $7,329.11.

In addition, while reviewing patient medical records for the E&M service, we were unable to verify that 18 surgical or strapping services were actually performed; therefore, we took exception with the reimbursement for the 18 services and identified an additional finding for $476.19. The reimbursement for these 18 services was also backed out of the sampled subpopulation prior to overpayment projection to avoid double counting. The circumstances leading to these findings are discussed below.

E&M Services Part of a Surgical Procedure

The American Medical Association's Surgical Package Definition states in pertinent part:

> In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation...subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)...

After reviewing the 264 E&M services billed in conjunction with surgical procedures, we determined that 114 E&M services were not separate and identifiable services from the surgical procedure being performed. Therefore, the E&M service was considered an "inclusive" service of the surgery and the extra charge for the E&M service was disallowed.

E&M Service Incorrectly Billed on the Same Date as a Strapping Procedure

Ohio Adm.Code 5101:3-4-22(H)(2) states:

> The casting, splinting and strapping procedures listed at the end of the musculoskeletal surgery section (codes 29000 through 29799) may be billed only when the casting, splinting or strapping is performed as a replacement procedure during or after the period of follow-up care. A visit may not be billed with any of the casting, splinting, or strapping codes.

After reviewing the 264 E&M services billed in conjunction with surgical procedures, we determined that 112 E&M services were billed with a strapping procedure where an E&M service should not have been billed. Therefore, we disallowed the extra charge for the E&M service.

Missing Documentation

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…

Our review of the 264 E&M services billed in conjunction with surgical procedures identified 14 services where the Provider did not have documentation in the chart to support that an E&M service had been provided. In addition, while reviewing patient medical records for the E&M services, we were unable to verify that 18 surgical or strapping procedures were performed. Thus, on these occasions, we took exception with the reimbursement for the surgical or strapping procedure and permitted the E&M service.

E&M Billed During a Post Operative Period

Ohio Adm.Code 5101:3-4-06(M)(3)(d)(ii)(a) states:

> A physician may be reimbursed for visits provided during the minimum surgical follow-up period only if the visit was provided after the day of surgery and the visit was provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure (previously) performed.

Our review of E&M services billed in conjunction with surgical procedures also identified two services where the Provider billed for an evaluation and management visit during a surgical follow up period. We disallowed the reimbursement for these two services because the services

were not provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure previously performed.

Level of Service Overstated

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.

According to the AMA, which promulgates CPT definitions, new patient E&M services (billed as CPT codes 99201 through 99205) require the Provider's documentation to include all of the key components (history, examination, and medical decision making) and to meet or exceed the stated requirements to qualify for a particular level of E&M service. In accordance with Ohio Adm.Code 5101:3-7-03, podiatrists may only bill codes 99201 through 99203 in this code series. Our review of E&M services billed in conjunction with surgical procedures identified one service where the Provider appropriately billed for an E&M visit that was separate and identifiable from the previous procedure; however, the level of service was overstated. Therefore, we reduced the service from a 99203 (a detailed new patient visit) to a 99202 (an expanded problem focused new patient visit). We took the difference between what was paid and the Medicaid maximum payment allowed for the service level that should have been billed to determine the finding amount.

Erroneously Billed Debridement Services

Ohio Adm.Code 5101:3-7-03(C)(2) states in pertinent part:

> Surgeries…the following limitation applies: reimbursement for debridement of nails is limited to a maximum of one treatment within a sixty-day period.

Our computer analysis identified 30 occasions (total of 60 services) where the Provider performed more than one debridement service within a sixty-day period. Because the maximum is limited to one treatment within sixty-days, we disallowed the 30 additional services. After adjustment for multiple surgery overpayments, this resulted in a finding of $822.51.

Duplicate Claims

Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part:

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

Our computer analysis identified one potential duplicate billing where the Provider charged more than once for the same procedure code for the same recipient, on the same day, and for the same amount. We determined, by a review of the patient's medical record, that the service was billed

and paid twice, but was only performed once. Therefore, we disallowed the reimbursement for the second billed service. This resulted in a finding of $22.52.

Sample Results

Our sample was a stratified random sample of 145 recipient dates of service, containing a total of 399 services. This statistical sample was taken from a subpopulation of the Providers claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review. This sample identified 18 services that were overpaid resulting in projected findings of $9,288.21. The bases for these findings are presented below.

Level of Service Overstated

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.

According to the AMA, which promulgates CPT definitions, established patient E&M services, CPT codes 99211 through 99215, require the Provider's documentation to include at least two out of the three components (history, examination, and medical decision making) and to meet or exceed the stated requirements to qualify for a particular level of E&M service. In accordance with Ohio Adm.Code 5101:3-7-03, podiatrists may only bill codes 99211 through 99213 in the 99211 to 99215 code series for established patients.

We took exception with the level of service billed for one of the 399 statistically sampled services (one of the 145 RDOS). The error occurred because the patient record lacked documentation to support an E&M 99213 (expanded problem focused history & exam; office/outpatient; established) level. We reduced the service to a 99212 (problem focused history & exam; office/outpatient; established) because documentation in the patient record only supported that a problem focused visit had occurred.

The patient's progress note listed a chief complaint, brief examination, diagnoses, and a plan of treatment. Because the visit focused solely on one problem/issue, the service was performed at a problem focused level. Therefore, we took the difference between what the Provider had been paid and the Medicaid maximum allowed for a 99212.

Missing Documentation

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…

We also disallowed the reimbursement for 17 of the 399 statistically sampled services (11 of the 145 RDOS) from the Provider's subpopulation of paid services because of a lack of proper documentation. The patient medical records for these 17 services either did not have any documentation in the patient record for the date of service billed or the documentation listed for that date did not support that the service billed was performed.

Sample Projection

We took exception with 18 of 399 statistically sampled recipient services (12 of 145 recipient dates of service) from a stratified random sample of the Provider's population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review.) Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $155,544.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $146,940.00 to $164,148.00 (+/- 5.53 percent.) We then calculated audit findings repayable to ODJFS by subtracting the correct population amount ($155,544.00) from the amount paid to the Provider for this population ($164,832.21), which resulted in a finding of $9,288.21. A detailed summary of our statistical sample and projection results is presented in Appendix I.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on August 19, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider submitted a response regarding the matters discussed in this report which is attached for the review and consideration of ODJFS' Surveillance and Utilization Section.

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APPENDIX I
Summary of Statistical Sample Analysis of Kristin K. Titko, D.P.M.
Audit Period: January 1, 2001 – December 31, 2003

Description	Audit Period Jan. 1, 2001 – Dec. 31, 2003
Type of Examination	**Stratified Random Sample of RDOS**
Number of Population Recipient Dates of Service (RDOS)	**1,728**
Number of Population RDOS Sampled	**145**
Number of Population Services Provided	**4,065**
Number of Population Services Sampled	**399**
Total Medicaid Amount Paid for Population	**$164,832.21**
Actual Amount Paid for Population Services Sampled	**$35,441.05**
Projected Correct Population Payment Amount	**$155,544.00**
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	**$164,148.00**
Lower Limit Correct Population Payment Estimate at 95% Confidence Level	**$146,940.00**
Projected Overpayment Amount = Actual Amount Paid for Population Services – Projected Correct Population Payment Amount	**$9,288.21**
Precision of Estimated Correct population Payment Amount as the 95% Confidence Level	**$8,604.00 (+/- 5.53%)**

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

Appendix II
Summary of Overpayment Results for:
Kristin K. Titko, D.P.M.
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 to December 31, 2003
Multiple Surgeries	$2,892.67
Bilateral Procedures	$1,184.70
E&M Service Incorrectly Billed in Conjunction with a Surgical Procedure	$7,329.11
Surgical Services Missing Documentation that Service Performed	$476.19
Erroneously Billed Debridement Services	$822.51
Duplicate Claims	$22.52
Projected Findings for Statistical Sample	$9,288.21
TOTAL	**$22,015.91**

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

CENTER FOR FOOTCARE
MEDICINE AND SURGERY OF THE FOOT AND ANKLE

DR. KRISTIN TITKO • DR. JERRY TITKO • DR. DEREK HINDMAN • DR. RODNEY ROOF • DR. GARRY NELTNER • DR. BRYAN FALLIS • DR. CYNTHIA MILLER

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45219

8474 WINTON ROAD
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WESTERN HILLS, OHIO
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(859) 341-0575

3215 DIXIE HIGHWAY
ERLANGER, KENTUCKY
41018

Dear Mr. Lidman:

Re: Medicaid Audit
Dr. Kristin Titko
Dr. Derek Hindman
Dr. Rodney Roof
Dr. Bryan Fallis

We have reviewed many of our charts following your audit. We agree that payment errors did exist in various cases.

The audit essentially is limited to Multiple Surgeries, Bilateral Procedures and E & M with a surgical procedure. We do not understand and would appreciate clarification regarding "Projected Findings for Statistical Sample".

Our billing department, which consists of 6 full time experienced employees, bills all insurance companies in almost an identical manner. We use modifiers to explain Multiple Surgeries and Bilateral Procedures. Unfortunately, for whatever reason, only Medicaid does not accept these nationally recognized modifiers.

Regarding E&M Service in conjunction with a surgical procedure. Only Medicaid, to our knowledge, does not recognized payment for the 30 minute E & M Service along with the 20-30 minutes to perform the Surgical Procedures. All other insurances pay for both codes. As I explained before, our billing department bills all insurance essentially the same. The employees of the insurance companies then determine what codes they individually pay.

We would like to ask for two things:

1) We would prefer to negotiate a settlement and close this matter swiftly.

2) We would appreciate meeting with someone from Medicaid to avoid any future audits. From our point of view, the problems seems to be Medicaid not accepting the modifiers used by all other insurance companies. We would also appreciate knowing why Medicaid does not recognize and pay for an E & M service in conjunction with a Surgical Procedure.

Thank you.

Sincerely,

Dr. Jerry L. Titko
JLT:kr

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KRISTIN K. TITKO, D.P.M.

HAMILTON 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
DECEMBER 30, 2005