Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to William L. Schlotterer, D.O.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

March 17, 2005

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

Re: Audit of William L. Schlotterer, D.O.
Provider Number: 0468319

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to William L. Schlotterer, D.O. for the period January 1, 2001 through December 31, 2003. We identified $33,553.00 in findings that are repayable to the State of Ohio. 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 overpayments identified herein. A check for $33,553, issued by Dr. Schlotterer to repay our audit findings, was forwarded to the Department's Office of Fiscal Services on February 22, 2005.

As a matter of courtesy, a copy of this report is being sent to William L. Schlotterer, D.O., 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

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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
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of William L. Schlotterer, D.O. (hereafter called the Provider), Provider #0468319, doing business at 1031 Pierce St., Suite C, Sandusky, OH 44870. 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 $33,553.00 in findings, 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 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."

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."

[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, if warranted, identify any findings resulting from noncompliance. Within the Medicaid program, the Provider is listed as a general practice osteopathic physician.

Following a letter of notification, we held an entrance conference at the Provider's place of business on July 21, 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 was reimbursed $43,659.46 for 543 services rendered during the audit period that did not involve Medicare co-payments.

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 & Medicaid Services (CMS).[2.]

Prior to beginning our field work, we performed two computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for potentially inappropriate services or service code combinations. These computerized tests checked for paid services billed for deceased patients after their dates of death; and potentially duplicate billed and paid services. Duplicate payments were defined as more than one bill for the same recipient, same date of service, same procedure, same procedure modifier, and same payment amount occurring on different claims. Both tests were negative.

To facilitate an accurate and timely test of the Provider's reimbursements, we selected and analyzed a stratified statistically random sample of two sub-populations. The first sampled sub-population consisted of all Medicaid patients with a billed primary or secondary diagnosis of human immunodeficiency virus infection (HIV: diagnosis code 042). The second sample was extracted from the sub-population of patients with a non-HIV diagnosis. We performed separate tests of these subpopulations because we reasoned that HIV patients might need more intensive

2 *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

treatment and justify billing a higher level service. However, the audit findings discussed below were common to both sub populations[3] and therefore are discussed concurrently.

Our work was performed between March 2004 and February 2005.

RESULTS

We identified projected findings of $33,553.00 for the services in the two sampled sub-populations.

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 billed services
- billing for non covered "weight loss" 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 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

[3] Our samples included 39 of 134 total services billed with diagnosis code 042, and 62 of 407 recipient dates of service for patients with other diagnoses. A recipient date of service is defined as all services received by a recipient on a particular date of service. In this instance, our recipient date of service sample included 64 of the 409 total services in this subpopulation.

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.

E&M services for new patients are billed using CPT codes 99201 through 99205; while E&M services for established patients are billed using CPT 99211 through 99215. For new patient E&M services, the provider must perform all three key components -- examination, medical decision making, and history -- defined by the American Medical Association's CPT code book. For established patient E&M services, the provider has to perform as least two of the key components.

The Provider was paid $43,611.69 for E&M services, and these services comprised 99.9 percent of the total reimbursement for the audit period. Of the $43,611.69, $40,682.08 (93.2 percent) was paid for the highest level established patient E&M service (CPT code 99215), and another $2,111.28 in reimbursements (4.8 percent) were for the highest level new patient E&M service (CPT code 99205). Thus, 98 percent of E&M service reimbursements were for services billed using the two highest paying E&M office visit codes. State wide, for osteopaths in general individual practice, payments for CPT codes 99215 and 99205 accounted for about 1.4 percent and 9.6 percent of established and new patient E&M reimbursements, respectively, during a similar time period.

Our samples of 103 services included billings for 101 E&M services. We found that the levels of service billed for 91 of the 101 E&M services were not supported by the documentation in the patients' medical records, or the documentation did not contain the components required by the CPT code book.

Example of Unsupported CPT Code 99215 Level of Service in Samples

To bill a code 99215, the provider must provide two of these three key components: a comprehensive history; a comprehensive examination; or medical decision making of high complexity.

The Provider's physician notes in the patient's medical record for this example only included:

- "Meets all criteria" was written with no indication of what criteria were being used.
- "PE ok" was noted, but there was no indication of the system (s) examined
- In the prescription/instruction section of the physician notes, "Same" was written.
- "HCMDM[4] + counseling" was noted but no details were included.
- Patient vitals were present in the medical record.

There was no notation of: a comprehensive history, a history of the current illness, chief complaint, name and/or dosage of any prescriptions written. Therefore, we reduced the level of E&M service to CPT code 99211 because the patient record supported only a minimal level of service.

4 According to the Provider this abbreviation means "Highly Complex Medical Decision Making"

The documentation pattern noted above was typical of the services billed as code 99215 in our two samples.

Example of Unsupported CPT code 99205 Level of Service in Samples

To bill this code 99205, the provider must have *all three* of these key components: a comprehensive history; a comprehensive examination; and Medical decision making of high complexity

The physician notes in the patient's medical record only included the following:

- "√ up" was noted with no further explanation.
- "Cough" was noted without any additional explanation as to type, onset or duration.
- "PE ok" was written in the record without any description of what system(s) were examined.
- A diagnosis was noted in the patient record.
- A prescription was noted by name, however, no other information such as strength, dosage, patient instruction, etc., was indicated.

There were no notations of a comprehensive history or a history of the current illness. Also, there was no indication of what system(s) was examined and the actual results of that examination. Therefore, the level of E&M service was reduced to CPT code 99201 because the patient record supported only a minimal level of service.

The documentation pattern noted above was typical of the services billed as code 99205 in our two samples. Additionally, prescription information was often either missing or inadequate.

For both samples, we calculated repayable findings by taking 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.

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 patients' medical records for the statistically sampled services found that six services in our samples lacked proper documentation to verify that a billable physician service was performed.

As an example, the Provider billed code 99215, comprehensive level of an established patient office E&M service. The physician notes only listed vitals for the date of service billed. Therefore, as documentation does not exist that the Provider actually examined the patient, this service was categorized as "undocumented".

The reimbursement the Provider received for these six services was reduced to zero ($0.00) and a finding made for the entire amount paid.

Non Medicaid Covered Services

Ohio Adm.Code 5101:3-4-28 states in pertinent part:

> The following physician services are noncovered:
>
> ***
>
> (I) Services for the treatment of obesity, including gastroplasty, gastric stapling, or ileo-jejunal shunt.
>
> ***

Our review of the patients' medical records for the statistical sampled services, found that the Provider billed code 99215, comprehensive level established patient office visit, for two services involving obesity treatment. As obesity treatment is not covered by Medicaid, we identified findings for the entire reimbursement made for these two services, and they were used in calculating the findings for the sampled population.

Summary of Sample Findings

Overall, we took exception in whole or in part with billings for 99 of the 103 services in our samples. The exceptions resulted in $33,553 in total projected findings that are repayable to ODJFS ($7,916 for services with diagnosis code 042 and $25,637 for services with a diagnosis code other than 042). The bases for the projections are detailed in Appendix I and Appendix II.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on February 8, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. We subsequently met with the Provider on February 16, 2005 to discuss our audit findings in more detail. At the meeting, the Provider opted to repay our audit findings in full and subsequently remitted payment, which was forwarded to ODJFS' Office of Fiscal Services on February 22, 2005. In lieu of a corrective action plan to correct the deficiencies identified in our report, the Provider told us he planned to no longer participate in the Medicaid program.

APPENDIX I

Summary of Sample Record Analysis for William L. Schlotterer, D.O.
Sub-Population of Services for Patients with Diagnosis Code 042
Audit Period January 1, 2001 to December 31, 2003

Description	Audit Period Jan. 1, 2001 – Dec. 31, 2003
Type of Examination	**Stratified Random Sample**
Number of Population Services Provided	**134**
Number of Population Services Sampled	**39**
Total Medicaid Amount Paid for Population	**$10,881.98**
Amount Paid for Population Services Sampled	**$3,183.00**
Projected Population Overpayment Amount	**$7,916.00**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$8,185.00**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$7,647.00**
Precision of population overpayment projection at the 95% Confidence Level	**$269 (+/- 3.40%)**

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

APPENDIX II

Summary of Statistical Sample Analysis of William L. Schlotterer, D.O.
Sub-Population of Services for Patients with a Diagnosis Code other than 042
Audit Period: January 1, 2001 – December 31, 2003

Description	Audit Period Jan. 1, 2001 – Dec. 31, 2003
Type of Examination	**Stratified Random Sample**
Number of Population Recipient Dates of Service	**407**
Number of Population Recipient Dates of Service Sampled	**62**
Number of Population Services	**409**
Number of Population Services Sampled	**64**
Total Medicaid Amount Paid for Population	**$32,777.48**
Amount Paid for Population Services Sampled	**$4,818.68**
Projected Population Overpayment Amount	**$25,637.00**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$26,633.00**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$24,640.00**
Precision of population overpayment projection at the 95% Confidence Level	**$996.00 (+/- 3.89%)**

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

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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

WILLIAM SCHLOTTERER, D.O.

ERIE 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
MARCH 17, 2005