STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Consultant Anesthesiologist, Inc.

A Compliance Report prepared by the

Fraud, Waste and Abuse
Prevention Division

STATE OF OHIO
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Consultant Anesthesiologist, Inc.
Attn: Jennifer Harris
6161 Busch Blvd
Columbus, Ohio 43229

Re: Medicaid Review of
Provider Number 0106825

Dear Ms. Harris:

We have completed our review of selected medical services rendered to Medicaid recipients by Consultant Anesthesiologist, Inc. for the period January 1, 1995 through March 31, 2000. We identified $17,572.80 in overpayments. The attached report details the basis for the overpayment.

We appreciate your prompt response when notified of our findings and the check remitted to the Ohio Department of Job and Family Services for full payment of the findings.

As a matter of policy, a copy of this report is being sent to the Ohio Department of Human Services, the Ohio Attorney General, and the State Medical Board. If you have any questions, please contact Robert I. Lidman, Deputy Chief, Fraud, Waste and Abuse Prevention Division, at (614) 728-7216.

Yours truly,

JIM PETRO
Auditor of State

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ABBREVIATIONS

CPT	Physicians' Current Procedural Terminology
FWAP	Fraud, Waste and Abuse Prevention Division
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
ORC	Ohio Revised Code
MMIS	Medicaid Management Information System

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SUMMARY OF RESULTS

The Auditor of State performed a review of Consultant Anesthesiologist, Inc., Provider #0106825, doing business at 793 West State Street, Columbus, Ohio 43222. During this review, findings in the amount of $17,572.80 were identified for recovery. The cited funds are recoverable as they resulted from Medicaid claims submitted by Consultant Anesthesiologist, Inc., for services that were improperly billed and reimbursed under the Ohio Medicaid Handbook and Ohio Administrative Code (OAC). Therefore, pursuant to Ohio Revised Code Section (ORC)117.28, a finding for recovery is issued against the Provider for improperly received monies in the amount of $17,572.80.

BACKGROUND

In the State of Ohio, the Ohio Department of Job and Family Services (ODJFS) is delegated with the responsibility of administering the Medicaid Program. Within federal guidelines, ODJFS establishes reimbursement policy, service rules and regulations, arranges with providers to render their services to patients, and pays provider claims.

PURPOSE, SCOPE AND METHODOLOGY

The Auditor of State has identified billings for multiple units of services for the same patient on the same day as an area where some providers could be over billing. A computer analysis of this issue resulted in the selection of providers for audit.

The purpose of our review was to determine whether this Provider's claims for reimbursement of medical services billed with multiple units of service were made in compliance with regulations and to calculate an overpayment amount in the event of any noncompliance. Our review was limited to include only selected services billed with multiple units of service, which the Provider rendered to Medicaid recipients during the period January 1, 1995 through March 31, 2000.

To determine whether a noncompliance occurred, we reviewed paid claim information[1] residing in ODJFS' Medicaid Management Information System (MMIS) for instances where a provider billed and was paid for more than one unit of service when data and/or the definition of the code billed indicated only one unit of service could have been performed. In such instances, an overpayment would be made on the difference between the amount reimbursed the provider and the established maximum fee allowed for one unit of service.

We utilized ODJFS' Medicaid Provider Handbook and the Ohio Administrative Code (OAC) as guidance in determining the applicable regulations and applicable reimbursement rates.

[1]The computerized paid claims data included provider number, recipient name, recipient number, procedure codes, warrant number, date of service, amount billed and paid, and overpayment amount.

Work performed on this review was done in accordance with government auditing standards

FINDINGS

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), OAC Section 5101:3-1-198: Overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery. . .

We reviewed one cardiac catheterization CPT code billed by the Provider. The review showed 40 paid claims where the Provider billed multiple units of service for one cardiac catheterization code, for the same patient and for the same date of service. For example, the Provider billed for performing CPT code 93503 ; *Insertion and placement of flow directed catheter (e.g., Swan-Ganz) for monitoring purposes* with 10 units of service in a single day for the same patient. For this code, a unit of service is one patient visit. The Provider should have billed only one unit of service for the date performed because only one visit occurred.

The amount of the overpayment received by the Provider resulted from how ODJFS calculates the Medicaid maximum fee. For the example of CPT code 93503, the maximum reimbursable fee was calculated by multiplying the number of units billed (10 in this case) by the established maximum fee allowed for the service ($110.68[2]). The Provider will then receive the billed charge ($550) or the Medicaid maximum ($110.68 x 10 = $1,106.80), whichever is less. In this instance, the Provider received the billed charge of $550 for one unit of service provided. Therefore, an overpayment occurred between the difference of what was paid to the Provider and the established maximum fee for one unit ($550 - $110.68 = $439.32 in this example).

CONCLUSION

A finding for recovery is made for $17,572.80 for the 40 instances in which the Provider billed and was paid for ten units of service in lieu of the established maximum fee for one unit.

A draft of this report was mailed to the Provider on June 7, 2000, to afford the Provider an opportunity to provide additional documentation or otherwise respond in writing. Subsequent to an extension period, the Provider responded on June 29, 2000 . They concurred with our findings and submitted a check in the amount of $17,572.80.

[2] Maximum fees are periodically revised. This was the maximum fee for this code from May 1, 1994 through December 31, 1996.