



**Auditor of State
Betty Montgomery**

Ohio Medicaid Program

*Review of Medicaid Provider Reimbursements Made to
Marietta Health Care Systems, Inc.*

A Compliance Review prepared by the:

Health Care/Contract Audits Section



**Auditor of State
Betty Montgomery**

April 1, 2003

David Casto, M.D., President
Marietta Health Care Systems, Inc.
800 Pike Street #2
Marietta, Ohio 45750

Re: Medicaid Review of Provider Number 0230931

Dear Dr. Casto:

We have completed our review of selected medical services rendered to Medicaid recipients by you for the period October 1, 1999 through September 30, 2002. We identified findings in the amount of \$17,122.90, which must be repaid to the Ohio Department of Job and Family Services. A provider remittance form is located at the back of this report for remitting payment. The attached report details the basis for the findings.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General and the Ohio State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director, Fraud and Investigative Audit Group at (614) 466-4858.

Sincerely,

A handwritten signature in cursive script that reads "Betty Montgomery".

Betty Montgomery
Auditor of State

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ABBREVIATIONS

CPT	Physician’s Current Procedural Terminology
E&M	Evaluation and Management Services
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
PA	Physician Assistant
TCN	Transaction Control Number

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SUMMARY OF RESULTS

The Auditor of State performed a review of Marietta Health Care Systems, Medicaid Provider Number 0230931, doing business at 800 Pike Street, Number 2, Marietta, Ohio 45750. Our review was performed at the request of the Ohio Job and Family Services in accordance with 117.10 of the Ohio Revised Code. As a result of this review, we identified \$17,122.90 in findings that did not meet reimbursement rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code (OAC).

BACKGROUND

The Auditor of State, working with the Ohio Department of Job and Family Services, performs reviews to assess Medicaid providers' compliance with federal and state claims reimbursement rules. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients.

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The Ohio Department of Job and Family Services (ODJFS) administers the Medicaid program. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Medicaid Provider Handbook (OMPH).

ODJFS' Medicaid Provider Handbook, Chapter 3334, General Information, Section II, subsection (B) states, "Medical necessity" is the fundamental concept underlying the Medicaid program. A physician must authorize medical services within the scope of his/her licensure and based on their professional judgment of those services needed by an individual. Medically necessary services are services which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172, (E), 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 initiated audit is completed, whichever is longer".

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.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud 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."

“Abuse” is defined in rule 5101:3-1-29 (B) as “...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the Medicaid program.”

**PURPOSE, SCOPE AND
METHODOLOGY**

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and to calculate the amount of any finding resulting from non-compliance.

We used the Ohio Medicaid Provider Handbook and the OAC as guidance in determining the extent of 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 the five (5) digit Current Procedural Terminology (CPT)¹ coding system or ODJFS local level codes².

The scope of our review was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period October 1, 1999 through September 30, 2002. The Provider was reimbursed \$657,677.74 for 18,413 Medicaid services rendered during the audit period. Our review focused on the following five areas.

The first area of focus was the Provider's claims for evaluation and management (E&M) services. E&M services (or office visits) are billed using CPT codes 99201 to 99205 for *new patients*, and CPT codes 99211 to 99215 for *established patients*. The higher-numbered codes within each series are to be billed when higher levels of services are provided. Correspondingly, reimbursements also increase when higher levels of service are provided. We focused on the Provider's billings for CPT code 99213 because they accounted for 73 percent of established patient office visits billed during our review period. The Provider was reimbursed \$13,470.17 for new patient E&M services and \$370,154.30 for established patient services during our audit period, of which \$274,641.99 was for established patient code 99213. Our field work entailed testing whether documentation maintained in the Provider's files justified the level of service that was billed.

A second area of focus was the Provider's reimbursements for radiology services (billed using CPT codes in the 70000 series) and laboratory services (billed using CPT codes in the 80000 series). These services accounted for \$20,565.87 and \$47,462.22, respectively, of the reimbursements paid to the Provider during our audit period. We designed our field work to determine whether or not the Provider had the proper certifications and equipment to justify the services that were billed, and whether patient records supported that services had been provided.

¹ The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

² Local level codes are published in the Ohio Medicaid Providers Handbook.

To facilitate an accurate and timely review of E&M, radiology and laboratory services, we analyzed a statistically random pilot sample of 60 TCN's (typically a TCN represents one Provider claim for reimbursement). We did not identify any problems in our pilot sample, so we ended our testing of these areas.

A third area of focus involved the Provider's reimbursements for services provided by physician assistants. We matched physician assistant (PA) service data furnished by the Provider with MMIS paid claims data to determine whether the Provider properly modified billings to indicate which services were performed by physician assistants (PA). Services provided by PAs accounted for \$107,935.72 and 4,672 services reimbursed to the Provider during our review period.

A fourth area of focus was the Provider's reimbursements for Healthchek services. Healthchek is a special program of comprehensive prevention health services available to Medicaid eligible persons from birth through the age of 20. The program is designed to maintain health by providing early intervention to discover and treat health problems. The Healthchek program includes services for Screening, Vision, Dental, Hearing and other services covered under the Medicaid program. The codes for billing Healthchek Services are listed in the "Physicians' Current Procedural Terminology (CPT)," under preventative medicine services (99381-99397). OAC 5101:3-14-04 (B)(3) allows a maximum of one screening service per calendar year from the individual's second birthday through the day before the individual's twenty-first birthday. Using MMIS paid claims data, we tested whether the Provider billed and was reimbursed for more than one Healthchek service during a calendar year. The Provider billed \$79,895.16 for 1,617 Healthchek services during our audit period.

Finally, we analyzed all paid claims in MMIS for duplicate payments made to the Provider. We defined duplicate claims as two or more claims with the same date of service, patient, procedure code, procedure code modifier, and reimbursement amount. We did not identify any problems in this area.

We announced our review in a letter to the Provider dated November 24, 2002 and met with the Provider on January 6, 2003 to further explain the purpose of our review and to commence field work. In attendance were Dr. David Casto, President; Sandy Albrecht, Practice Manager; and Pam Walters, Billing Manager.

A draft report was mailed to the Provider on February 14, 2003 to afford them an opportunity to provide additional documentation, or respond in writing. Subsequently, the Provider submitted a written response on March 3, 2003. The Provider's position regarding our findings have been incorporated into the report. Overall, our work was performed between October 2002 and March 2003 and was done in accordance with government auditing standards.

FINDINGS

We identified findings of \$17,122.90 in two categories: erroneously billed physician assistant services and erroneously billed Healthchek screening services. The bases for the findings are detailed below.

Erroneous Billings for Physician Assistant Services

According to Ohio Revised Code (ORC) 4730.01, "Physician assistant" means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

Marietta Health Care Systems, Inc. has one standard utilization plan on file with the Ohio State Medical Board and submits affidavits of supervision, along with payment, and notice of new PA's as they are brought on staff. We reviewed the utilization plan, the affidavits of supervision and the listing of PA's who rendered services to Medicaid patients during our audit period.

A database supplied by the State Medical Board of Ohio confirmed that Marietta Health Care Systems, Inc. employs PA's. Because the Provider's claims did not properly modify the billing code when services were provided by PA's, we were not able to use MMIS data to identify services rendered by PA's. However, the Provider voluntarily agreed to furnish data identifying PA-provided services during the audit period. We then matched the Provider's data with claim information in MMIS to determine the amount reimbursed to the Provider for services performed by PA's.

Physician Assistant Services Billed for New Patients

Section 5101:3-4-03(C)(5) of the OAC states that a physician, physician group practice, or clinic may not be reimbursed for *initial* office visits provided by a physician assistant.

Our match between Marietta Health Care System's, Inc. data and MMIS data, found 44 new patient E&M visits with a reimbursement of \$2,103.16, which were rendered by PA's. Therefore, a finding of \$2,103.16 was made.

Associated with new patient E&M patient visits, the Provider also billed and was reimbursed \$297.04 for 36 services relating to labs, injections, etc. However, Section 5101: 3-4-02(2)(d) of the OAC states:

Services provided under direct supervision are covered only if the following conditions are met:

The service must be furnished in connection with a covered physician service which was billed to the department.

Because the 36 services were not furnished in connection with a covered physician service, we also identified the \$297.04 as a finding.

Total findings for the new patient evaluation and services issue area were \$2,400.20.

Physician Assistant Services Billed for Establish Patients without Required Modifier

OAC 5101:3-4-03(A) states that a "Physician assistant" means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant in accordance with Chapter 4730 of the Revised Code under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

A physician may be reimbursed for the following procedures provided by a physician assistant under his/her employment if the services are set forth in his/her application of registration and approved by the Medical Board. An established physician visit. . . .

When the procedures listed in paragraph (A) (above) are performed by a physician assistant, reimbursement will be the provider's billed charges or 85 percent of the Medicaid maximum, whichever is less. For reimbursement, the physician must bill to the department using the five-digit CPT code followed by the modifier AU.

Our comparison of the Provider's data with MMIS data identified 2,753 established patient evaluation and management services performed by PA's which were not modified with "AU" when billed. After giving the Provider credit for 85% of the reimbursement rate -- the amount allowed for PA services by Medicaid -- we identified the remaining 15%, or \$13,863.74, as a finding.

Erroneous Billings for Healthcek Screening Services

The OAC 5101:3-14-04(B)(3), states that one screening service per calendar year may be provided from the individual's second birthday through the day before the individual's 21st birthday.

Our comparison of the Provider's data with MMIS data identified 84 instances, totaling \$4,446.76 in reimbursement, where the Provider performed and was reimbursed for more than one Healthcek screening for the same patient in the same calendar year. Because the Provider performed a service during the second screening, we decided to give the Provider credit for an E&M office visit billed as CPT code 99213, reflecting the level of service being performed. This resulted in an adjusted finding for \$764.51, which represents the difference between what was paid for a Healthcek visit and what would have been paid for a 99213 office visit.

Additionally, the Medicaid Provider Handbook Chapter 3336, Physician Services, Section 1105.2(A), states the following:

The new patient codes, 99381 through 99385, may be used for patients who have not received any professional services from the provider within the past three years. The established patient codes, 99391 through 99395, must be used for patients who have

received professional services from the physician within the past three years.

Our comparison of the Provider's data with MMIS data identified 14 instances in which CPT codes 99381 through 99385 were billed for patients who had received professional services from the Provider within the past three years. These 14 codes were reduced to the established code (CPT 99391 through 99395) at the same level. A finding of \$94.45 was made for the difference between a new and an established patient visit.

Therefore, total findings for the Healthchek Services area were \$858.96.

Provider's Response to our Findings

The Provider acknowledged the billing errors identified above and has since hired outside coding consultants to ensure the accuracy of future billings. The Provider also commented that the rules for billing physician assistant services are not easily understood and requested that ODJFS consider providing additional educational assistance to the provider community. We agreed to make ODJFS aware of the Provider's request.

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider Name & Address: Marietta Health Care Systems, Inc.
800 Pike Street, Number 2
Marietta, Ohio 45750

Provider Number: 0230931

Review Period: 10/01/1999 through 9/30/2002

AOS Finding Amount: \$17,122.90

Date Payment Mailed: _____

Check Number: _____

IMPORTANT:

To ensure that our office properly credits your payment, please also fax a copy of this remittance form to: Thomas Tedeschi at (614) 728 - 7398.

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**Auditor of State
Betty Montgomery**

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P.O. Box 1140
Columbus, Ohio 43216-1140
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800-282-0370
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MARIETTA HEALTH CARE SYSTEMS, INC.

WASHINGTON 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
APRIL 1, 2003**