



**Auditor of State
Betty Montgomery**

Ohio Medicaid Program

*Audit of Medicaid Provider Reimbursements
Made to SOMC Medical Care Foundation*

A Compliance Audit by the:

**Fraud and Investigative Audit Group
Health Care and Contract Audit Section**



**Auditor of State
Betty Montgomery**

May 06, 2004

SOMC Medical Care Foundation
Mary Beth Dever, Administrative Director
1735 27th St., Bldg. C, Suite B-06
Portsmouth, OH 45662

Re: Audit of SOMC Medical Care Foundation
Provider Number: 0916512

Dear Ms. Dever:

We have completed our audit of selected medical services rendered to Medicaid recipients by SOMC Medical Care Foundation for the period October 1, 1999 through September 30, 2002. We identified \$96,022.85 in findings, 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 bases for the findings.

Please be advised that in accordance with Ohio Rev.Code 131.02, if repayment is not made to the Ohio Department of Job and Family Services within 45 days of the date 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 contact Cynthia Callender, Director of the 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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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
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 SOMC Medical Care Foundation, (hereafter called the Provider), Provider #0916512, doing business at 1735 27th St., Bldg. C, Suite B-06, Portsmouth, OH 45662. 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 findings amounting to \$96,022.85, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook (OMPH).

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 initiated audit 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."

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 to identify any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a physician group practice providing general practice services.

We sent a letter of notification to the Provider on August 28, 2003 requesting copies of billing and medical record data. We then used this data to conduct a review of the Provider's patient medical records. 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 October 1, 1999 through September 30, 2002. The Provider was reimbursed \$1,433,101.61 for 29,777 services rendered on 25,141 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 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

We ran a series of computer assisted analyses and exception tests on the Provider's paid claims prior to drawing a statistically random sample and beginning our review of the Provider's records.

We analyzed the Provider's claims involving Psychiatric Diagnosis or Evaluative Interview procedures, psychiatric therapeutic procedures, and other psychiatric services or procedures (CPT codes 90801 through 90862) for duplicate billings and invalid code combination. No exceptions were noted in these areas.

We also compared the Provider's Evaluation & Management (E&M) levels of service billings with statewide averages for general practitioners during state fiscal years 2000 to 2002. The

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.

Provider's billings were consistent with the statewide averages. Therefore, we did no further testing of E&M level of service billings.

Our analyses identified the following potential exceptions, and the claims affected by them were extracted for 100 percent testing:

- ▶ New patient service codes billed for established patients.
- ▶ Multiple evaluation and management codes billed together.
- ▶ Family planning codes billed with evaluation and management codes.
- ▶ Multiple HealthChek screenings in a calendar year for patients two or more years old.
- ▶ Billing for non-covered services.
- ▶ Billing urinalysis tests with antepartum services.

We next audited the Provider's claims for anesthesiology services because these claims accounted for a significant percentage (38 percent or \$543,931.23) of the Provider's payments. To facilitate an accurate and timely audit of the Provider's anesthesiology services, we analyzed a statistically random sample of 97 anesthesia delivery services involving CPT code 59410 (vaginal delivery, with or without forceps and episiotomy). Our sample of anesthesiology services was limited to this particular code because it accounted for 34 percent of anesthesiology payments and all other codes individually represented less than five percent of anesthesiology billings.

Our work was performed between November 2002 and September 2003 and was done in accordance with government auditing standards.

FINDINGS

We identified findings of \$5,155.85 from our 100 percent audit exception tests and \$90,867.00 from the projected results of our anesthesia delivery sample. The circumstances leading to our total findings are discussed below:

Results of Exception Tests

The following presents the results of our six exception tests.

New Patient Service Codes Billed for Established Patients

An Evaluation and Management (E&M) service is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient.

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 CPT code definitions and the CPT instructions for selecting a level of E&M service.

The American Medical Association's Evaluation and Management (E&M) Service Guidelines state that:

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

We found 253 services where the Provider billed new patient CPT codes for established patients who were rendered professional services within the past three years. We took exception with these 253 services and reduced the services to established patient CPT codes. The reduction of these 253 services resulted in findings amounting to \$3,435.99.

Duplicate Payments for E&M Services

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

We identified 21 E&M services (office visits) that included services which appeared to have been billed and paid more than once for the same patient on the same date of service. In one instance, the Provider billed 99203 (Detail History & Examination; Office/Outpatient; New) in conjunction with 99204 (Comprehensive History & Examination: Office/Outpatient; New) and 99213 (Expanded History & Examination; Office/Outpatient; Established) on the same date of service for the same patient. In the other instances, two like services were billed and paid for the same patient on the same day.

Because the Provider was unable to support that multiple visits occurred on the same day for the same patient, we took exception with the 11 services that were duplicates. This resulted in \$461.12 in findings.

Family Planning Codes Incorrectly Billed with Office Visit Codes

Ohio Adm.Code 5101:3-4-07(D)(1) states:

A "family planning visit" is any visit performed for the purpose of providing a family planning service. The visit may be performed either by a physician and/or a health professional or social services professional qualified under the Revised Code. The visit may or may not include a physical examination.

Ohio Adm.Code 5101:3-4-07(D)(2) defines CPT code X1453 as follows:

X1453 Gynecological examination performed by a physician is a visit in which a physical examination including, at a minimum, a review of the medical history,

pelvic examination, height, weight, and blood pressure, is performed in conjunction with family planning services. The visit also includes, when appropriate, all or a combination of the following services: breast examination, collection of a pap smear, collection of vaginal smears or cultures, evaluation and interpretation of laboratory procedures, checking an IUD, contraceptive counseling, generic counseling, and the prescription of contraceptive pharmaceuticals and supplies.

We identified 11 services for family planning office visits (procedure code X1453) that were billed concurrently with E&M office visits and/or a postpartum visit. We are taking exception with nine E&M visit services, one post partum care visit, and one family planning visit because documentation in patient records did not support that these particular services was provided. These exceptions resulted in findings of \$400.70.

Multiple HealthChek (EPSDT) Screenings in a Calendar Year

Ohio Adm.Code 5101:3-14-04(B)(3) states³:

One screening service per calendar year may be provided from the individual's second birthday through the day before the individual's twenty-first birthday. If any of the screenings described in paragraph (B)(1) of this rule are given in the calendar year in which the child reaches his or her second birthday, another screening may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year.

We identified 35 HealthChek screening services for recipients over the age of two that included more than one service billed within the same calendar year. We requested documentation from the Provider to determine if the additional services qualified for reimbursement. The Provider was unable to provide the necessary documentation for 18 services, and therefore, these services were down-coded to the appropriate E&M visit level of service provided to the patient. The down-coding resulted in findings amounting to \$347.18.

Billing Non-Covered Services

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

The following physician services are noncovered:

(C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups with the following exceptions:

(1) All healthChek (EPSDT) services;

³ This rule was in effect during our audit period. Effective July 1, 2003, ODJFS revised its requirements for the frequency of HealthChek screening services to coincide with those followed by the American Academy of Pediatrics.

(10) Required physicals for employment or for participation in job training programs, when the employer (or other available funds) does not provide a physical free of charge. Documentation to support that the physical was performed for employment must be in the patient's medical records.

We identified 21 services for recipients who were over the age of twenty-one that the Provider billed for routine physical examinations. We requested documentation to verify the basis for the physicals, e.g. to determine if they were performed for employment or for participation in a job training program. Because the recipients were over age 21 and the Provider could not verify that the physicals were for employment purposes, we took exception with all 17 services resulting in \$456.48 in findings.

Urinalysis Services Billed in Conjunction with Antepartum Visits

Ohio Adm.Code 5101:3-4-08(D)(1) states:

(a) The antepartum visit is inclusive of:

(ii) Routine urinalysis screening tests (dipstick) to detect the presence of sugar or protein;

We found 15 services where the Provider erroneously billed CPT code 59420 (Antepartum care) in conjunction with CPT code 81002 (Urinalysis service.) Because routine urinalysis screening tests are included in the reimbursement for antepartum care, we took exception with the billing for the 15 urinalysis services, amounting to \$54.38 in findings.

Summary of Exception Tests

Of the 418 services segregated from the sampled population for special examination, we took exception with 325 services. Table 1 summarizes the exceptions found by reason and overpayment amounts.

**Table 1: Summary of Service Billing Exceptions Found
For the Period October 1, 1999 – September 30, 2002**

Basis for Exception	Number of Services with Exceptions	Amount of Overpayment
New Patient Service Codes Billed for Established Patients	253	\$3,435.99
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	18	\$347.18
Billing Non-Covered Services	17	\$456.48
Urinalysis Services Billed in Conjunction with Antepartum Visits	15	\$54.38
Family Planning Codes Incorrectly Billed with Office Visit Codes	11	\$400.70
Duplicate Payments for E&M Services	11	\$461.12
Total Services with Exceptions	325	\$5,155.85

Source: AOS analysis of the Provider's MMIS claims history

Results of Vaginal Delivery Anesthesia Services Sample

As noted in the Purpose, Scope and Methodology section of this report, we also analyzed a statistical sample of the Provider's anesthesiology services involving vaginal deliveries. We chose this group of services because they comprised the only significantly large group (34 percent or \$185,951.85) of the Provider's total reimbursements \$543,931.23 for anesthesiology services. The following Ohio Administrative Code sections were those in effect during our October 1, 1999 to September 2002 audit period.

Pursuant to Ohio Adm.Code 5101:3-4-21(A) for anesthesia services:

The department will reimburse a physician for general, regional, or supplementation of local anesthesia services provided during a surgical or diagnostic procedure. Anesthesia services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluid and/or blood products incident to the anesthesia or surgery, and the usual monitoring procedures...

Additionally, Ohio Adm.Code 5101:3-4-21(C) states:

The department will reimburse a physician for anesthesia services only if the following conditions are met.

- (1) Except as provided for in paragraph (C)(5) of this rule, the physician is acting exclusively as an anesthetist and is not also acting as the surgeon or assistant surgeon;
- (2) For each patient, the physician:
 - (a) Performs a preanesthetic examination and evaluation;
 - (b) Prescribes the anesthesia plan;
 - (c) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

- (d) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
 - (e) Monitors the course of anesthesia administration at frequent intervals;
 - (f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and
 - (g) Provides indicated post anesthesia care.
- (3) The physician either personally performs the services itemized in paragraph (C) (2) of this rule, without the assistance of a CRNA, resident, intern, fellow, or other qualified anesthetist; or the physician uses assistance of CRNA, resident, intern, fellow or other qualified anesthetist in the performance of the service in paragraph (C) (2) of this rule, directs no more than four anesthesia procedures while providing medical direction.

Anesthesiologist Did Not Monitor the Course of Anesthesia Administration

Of the 97 services in our sample, we took issue with 83 services regarding the anesthesia administration monitoring. The patient records showed that the physician anesthesiologist monitored the patient for the first 20 to 30 minutes and then turned the patient monitoring over to the nursing staff. Because the physician did not personally perform the services or ensure a qualified individual (i.e., CRNA, resident, intern, fellow, or other qualified anesthetist) performed the service, we are taking exception with these 83 services. When calculating our findings, we reduced the number of minutes for the 83 services to a level supported by anesthesiologist documentation in the patient record.

Anesthesia Service Billed in Excess of the Time Documented in the Patient Record

We found two services in our sample of 97 services, where the time billed for an anesthesia service was not supported by the time documented in the patient record. Therefore, we reduced the number of minutes for the two services to the time documented in the patient record.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

... all medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of the services provided to medicaid consumers, and to document significant business transactions...

Of the 97 services in our sample, we were unable to verify that two services were actually rendered because the patients' medical records were missing. Because the Provider did not maintain the required documents, we disallowed the payments received for these two services.

Projected Findings from Anesthesia Services Sample

Overall, we took exception with 87 of 97 services from a stratified random sample of the Provider's population of 594 vaginal delivery anesthesia services. We then calculated potential audit findings by projecting this error rate to the Provider's population of paid vaginal delivery anesthesia services. This resulted in a projected finding of \$112,552.00, with a 95 percent degree of certainty that the true population overpayment fell within the range of \$90,867.00 to \$134,237.00, a precision of plus or minus \$21,685.00 (19.3%). Since the precision achieved was greater than our procedures require for use of a point estimate, the audit finding determined to be repayable to ODJFS was set at \$90,867.00, the lower limit estimate amount. This allows us to say with a 97.5 percent degree of certainty that the audit finding is at least \$90,867.00. See Table 2 below for a summary of the services we took exception with, and Appendix I for more details concerning our projected finding.

**Table 2: Summary of Exceptions from Sample Audit of Provider Records
For the Period October 1, 1999 – September 30, 2002**

Basis for Exception	Number of Services with Exceptions
Anesthesiologist Did Not Monitor the Course of Anesthesia Administration	83
Anesthesia Service Billed in Excess of the Time Documented in the Patient Record	2
Missing Documentation	2
Total Services with Exceptions	87

Source: AOS analysis of a sample of 97 anesthesia delivery services not included in exception tests

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on January 29, 2004. The Provider sent us a written response on February 19, 2004, along with additional documentation to support some of the claims for services we had taken exception with. The additional documentation caused us to re-categorize several exceptions, and resulted in a reduction of our projected overpayment from \$105,747.00 to \$90,867.00. Including the findings from our 100 percent record reviews, we identified \$96,022.85 in total findings that are repayable to the Ohio Department of Job and Family Services.

In addition, the Provider committed to correcting the deficiencies identified by our audit. In an April 16, 2004 email, the Provider's Vice President of Finance and the Administrative Director outlined the following educational initiatives, process changes, and computer edits to address our audit results:

- **New Patient Codes Billed for Established Patients**
 - In 1999, our billing service converted to a new Billing Software program. The conversion took over 6 months. During that time we discovered that the software was not identifying patients as established when they have seen a physician in the same group within 3 years.

- Our billing staff since then has done a name search in the software for all new patients to ensure this standard is observed.
- Our two certified coders perform a “Pre-Practice Coding Seminar” for every new physician we bill for which includes education of this requirement.
- **Duplicate Payments for E & M Services**
 - Our billing staff reviews patient listings for duplicate visits to prevent this.
 - Our two certified coders perform a “Pre-Practice Coding Seminar” for every new physician we bill for which includes education of this requirement.
- **Family Planning Codes Billed with Office Visit Codes**
 - We billed this code inappropriately and educated the staff accordingly.
 - Our billing staff has been educated that Medicaid did away with “X codes” and not to utilize them any further. We are no longer utilizing “X codes” when billing for services rendered to Medicaid recipients.
- **Multiple Health Check Screenings in a Calendar Year**
 - Our billing staff reviews the patient’s history to make sure that no other health screenings have been given during the year to prevent inappropriate billing.
 - Our two certified coders perform a “Pre-Practice Coding Seminar” for every new physician we bill for which includes education of this requirement.
- **Billing Non-Covered Services**
 - We have educated our office staff that physicals for people over the age of 21 are only permitted when the recipient presents with documentation to support that the physical is for employment purposes.
 - Our two certified coders perform a “Pre-Practice Coding Seminar” for every new physician we bill for which includes education of this requirement.
- **Urinalysis Services Billed in Conjunction with Ante partum Visits**
 - We have educated the office staff and physicians that this may not be done.
 - Our two certified coders perform a “Pre-Practice Coding Seminar” for every new physician we bill for which includes education of this requirement.
- **Anesthesiologist Did not Monitor the Course of Anesthesia and Anesthesia Service billed in Excess of time Documented**
 - We have out sourced our anesthesiology group and no longer bill professional services for this service.
 - The contracted anesthesiology group is aware of the billing concerns and can communicate those issues with the physicians.

A copy of the Provider’s corrective action plan has been forwarded to ODJFS’ Surveillance and Utilization Review Section for their review and disposition.

APPENDIX I

Summary of Sample Analysis Audit Period: October 1, 1999 – September 30, 2002

Description	Audit Period
	October 1, 1999 – September 30, 2002
Type of Examination	Stratified Random Sample
Number of Services in Population	594
Total Medicaid Amount Paid for the 594 Services	\$185,951.85
Number of Service Sampled	97
Amount Paid for Services Sampled	\$48,731.18
Upper Limit Overpayment Estimate at 95% Confidence Level	\$134,237.00
Lower Limit Overpayment Estimate at 95% Confidence Level	\$90,867.00
Point Estimate of Projected Overpayment at 95% Confidence Level	\$112,552.00
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	(\$21,685) +/- 19.3%

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

APPENDIX II

Summary of Audit Findings for SOMC Medical Care Foundation Audit Period: October 1, 1999 to September 30, 2002

Description of Audit Finding	Dollar Amount of Finding
Medicaid Services Sample Excluding Exceptions	\$90,867.00
New Patient Service Codes Billed for Established Patients	\$3,435.99
Duplicate Payments for E&M Services	\$461.12
Billing Non-Covered Services	\$456.48
Family Planning Codes Incorrectly Billed with Office Visit Codes	\$400.70
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	\$347.18
Urinalysis Services Billed in Conjunction with Antepartum Visits	\$54.38
Total Audit Findings	\$96,022.85

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

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
Accounts Receivable
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider: SOMC Medical Care Foundation
1735 27th St., Bldg. C, Suite B-06
Portsmouth, OH 45662

Provider Number: 0916512

Audit Period: October 1, 1999 through September 30, 2002

AOS Finding Amount: \$96,022.85

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 (614) 728-7398: ATTN: Health Care and Contract Audit Section.

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**Auditor of State
Betty Montgomery**

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SOMC MEDICAL CARE FOUNDATION

SCIOTO 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
MAY 6, 2004**