Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Curtis D. White, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

February 10, 2004

Curtis D. White, M.D.
President, Marietta Gynecologic Associates
410 Second Street
Marietta, OH 45750

Re: Medicaid Audit of Curtis D. White, M.D.
Provider Number 0552852

Dear Dr. White:

We have completed our audit of selected medical services rendered to Medicaid recipients by you for the period January 1, 2000 through December 31, 2002. We identified $31,181.53 in findings, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "Provider Remittance Form" is included 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 Rev.Code 117.28 and 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 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 Services
HCPCS	Healthcare Common Procedural Coding System
M.D.	Medical Doctor
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Revised Code	Ohio Rev.Code

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SUMMARY OF RESULTS

The Ohio Auditor of State performed an audit of Curtis D. White, M.D. (hereafter called the Provider), President of Marietta Gynecologic Associates, Provider #0552852, doing business at 410 Second Street Marietta, OH 45750. Our audit was performed at the request of the Ohio Job and Family Services in accordance with 117.10 of the Ohio Rev.Code. As a result of this audit, we identified findings amounting to $31,181.53, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

In addition, we are recommending that the Provider, as president of a medical association that includes other providers who perform and bill individually for Medicaid services, obtain and bill for services under a "group" Medicaid provider number.

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 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 constitutes an over utilization of Medicaid covered services and results 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 calculate the amount of any overpayments resulting from non-compliance. Within the Medicaid program, the Provider is listed as an individual physician who specializes in providing obstetrical and gynecological services.

We notified the Provider by letter that he had been selected for a compliance audit and held an entrance conference at the Provider's place of business on June 10, 2003. 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, 2000 through December 31, 2002. The Provider was reimbursed $572,312.54 for 13,874 services rendered on 6,965 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 Medicaid Provider Handbook, Ohio Administrative Code and Ohio Revised Code 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 federally required Healthcare Common Procedural Coding System (HCPCS), which includes use of the five-digit Current Procedural Terminology (CPT)[2] coding system and ODJFS local level codes.[3]

To facilitate an accurate and timely audit, we used a combination of computerized exception analysis and statistically random samples of the Provider's paid medical services. Four groups of potentially inappropriate service codes or service code combinations were identified by our computer analysis for 100 percent review. These four groups included:

- Surgical services billed in combination with evaluation and management (E&M) codes.
- New patient E&M codes billed for patients who had received professional services from the Provider within the prior three years.
- Non-fetal stress tests billed with a professional and technical components for the same patient and same date of service.
- Urinalysis services billed in conjunction with antepartum visits.
- Services that duplicated another service paid for the same patient on the same date of service.

[2] CPT codes are published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[3] Local level codes are published in the Ohio Medicaid Providers Handbook.

In addition, two statistically random samples were drawn from the services not already chosen for 100 percent review. The first was a simple random sample of delivery services (30 of 195) billed with inclusive postpartum services. The second was a stratified random sample of all remaining recipient dates of service (147 of 6,065), which represented services (457 of 9,334) not already selected for examination.

Our work was performed between May 2003 and November 2003 and in accordance with government auditing standards.

FINDINGS

Our 100 percent review of the computer exception reports identified findings of $577.73 as follows:

- $186.88 for unallowable E&M services billed with Surgical Services.
- $153.48 for established patients billed as new patients.
- $123.90 for duplicate non-fetal stress tests.
- $113.47 for unallowable urinalysis tests billed with antepartum visits.

We did not find duplicate billings during our analysis of the Provider's MMIS data.

We also identified and projected findings of $30,603.80 for erroneously billed services in the two non 100 percent reviewed samples. These findings fell into three categories: Lack of supporting documentation in patient records, erroneously billed Physician Assistant services, and delivery services erroneously billed with inclusive postpartum services.

Together the projected and exception report findings totaled $31,181.53 that are repayable to the Ohio Department of Job and Family Services. In addition, we are recommending that the Provider, as president of a medical association that includes other providers who perform and bill individually for Medicaid services, obtain and bill for services under a "group" Medicaid provider number. The circumstances detailing our findings are discussed below.

Billing for Office Visits Not Allowed with Surgical Codes

Ohio Adm.Code 5101:3-4-06(M)(3)(c) states: "A provider may be reimbursed for a visit on the same day as a surgery, only if the procedure is identified by asterisk in appendix DD of rule 5101:1-1-60 of the Administrative Code and it is customary for the physician to charge a visit for patients." During our audit period, the Provider billed and was reimbursed six times for surgeries and office visits for the same patient on the same day, in which the office visit billings did not meet the criteria specified in Ohio Adm.Code 5101:3-4-06(M)(3)(c) and appendix DD of Ohio Adm.Code 5101:3-1-60. Therefore, we disallowed the amount paid to the Provider for the six office visits, which resulted in a finding of $186.88.

Established Patients Billed as New 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 definition 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 purpose 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.

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. We found 12 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 12 services and reduced the services to established patient CPT code 99213. This resulted in findings amounting to $153.48.

Duplicate Billings for Non-Fetal Stress Tests

Pursuant to Ohio Adm.Code 5101:3-1-19.8(F)

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

We disallowed claims for five Non Fetal Non-Stress Tests (CPT code 59025) because they duplicated reimbursement for a similar service paid for the same patient on the same date of service. In all five cases, the Provider billed and was reimbursed for both an "unmodified" CPT code (reflecting that both the technical and professional components of the test[4] were performed), and a "modified" CPT code (reflecting that just the professional component was performed). The patient records supported that only the "unmodified" CPT code should have been billed. Therefore, we took exception with the five billings for the "modified" code. This resulted in a finding for $123.90.

Urinalysis Services Billed in Conjunction with Antepartum Visits

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

[4] The "technical" component refers to performing the test. The "professional" component refers to interpretation of the test results.

(a) The antepartum visit is inclusive of:

***

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

***

***

We found 28 cases where the Provider billed for an antepartum visit (CPT 59420) and a urinalysis service (CPT 81001 and 81003) for the same patient on the same day.

We took exception with the 28 urinalysis services, amounting to $113.47 in findings.

Lack of Documentation and Erroneously Billed Physician Assistant Services

The Adm.Code 5101:3-1-27(A) states:

> 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 services provided to Medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services, the secretary of the federal department of health and human services, or the state Medicaid fraud control unit upon request.

Ohio Adm.Code 5101:3-4-03(A) states:

> "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 Rev.Code under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

Ohio Adm.Code 5101:3-4-03(B)(3) and (C)(1) provide that physician assistants are allowed to perform evaluation and management services commensurate with their training and experience; however, the reimbursement for these services will be the provider's billed charges or 85 percent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician must bill to the department using the five-digit CPT code followed by the modifier AU. Ohio Adm.Code 5101:3-4-03(C)(2) and (2)(b) further stipulate that procedures and services performed by a physician assistant may be reimbursed at 100 percent of the maximum rate if the employing physician/group also provides direct and identifiable services, including a face-to-face encounter with the patient.

We identified exceptions for 35 of the 457 services in our sample of other recipient dates of service. These exceptions are listed in Table 1 below.

Table 1: Listing Service Exceptions found in Sample Of Other Recipient Dates of Service

Basis for the Exception	Number of Services with Exceptions
The Provider could not locate any records for the patient.	**18**
The patient record did not support that a service was provided on the sampled date of service.	**5**
A Physician Assistant provided services to "new" patients.	**8**
The Provider billed for services performed by a Physician Assistant without using the appropriate AU modifier.	**4**
Total Services with Exceptions	**35**

Source: AOS analysis of Provider supporting documentation for 457 services in stratified sample of 147 recipient dates of service.

We were unable to confirm that 23 services in our sample (the first two exceptions in Table 1) were performed because the Provider did not maintain the required documentation. Therefore, we disallowed the payments for these services. Our sample also identified twelve services that were delivered by a physician assistant. Eight of these services were disallowed in their entirety because they were the initial services rendered to a new patient, which are not covered under Ohio Adm.Code 5101:3-4-03(C)(5). The remaining four physician assistant-provided services involved an evaluation and management service performed by a physician assistant without a physician having a face-to-face encounter with the patient. These services were erroneously billed and paid at 100 percent of the Medicaid maximum because they were not properly coded to indicate that just the physician assistant performed the service. We identified a finding for the 15 percent difference in what was paid and what should have been paid.

In total, we took exception with 35 of 457 statistically sampled services (12 of 147 recipient dates of service) from a stratified sample of the Provider's population of other paid services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $408,219.42, with a 95 percent certainty that the actual correct payment amount fell within the range of $386,943.35 to $429,495.49 (+/- 5.21percent). We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($408,219.42) from the amount actually paid to the Provider for this population ($432,003.07), which resulted in a finding of $23,783.65.

Delivery Codes Erroneously Billed with Inclusive Post-Partum Visits

Ohio Adm.Code 5101:3-4-08 specifies covered obstetrical services and states in pertinent part:

> ***
>
> (E) Delivery and Postpartum care.
>
> (1) 'Delivery Services' include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without forceps and/or episiotomy), or Cesarean section delivery.
>
> (2) 'Postpartum Care' includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.
>
> ***
>
> (4) The following codes should be billed:
>
> (a) For delivery and postpartum services provided to patients for which a vaginal or Cesarean delivery after a previous Cesarean delivery (VBAC) was not attempted.
>
> 59409 For a vaginal delivery when outpatient postpartum care is provided by another provider or provider group.
>
> 59410 For a vaginal delivery when outpatient postpartum care is provided by the same provider or provider group.
>
> 59514 For a Cesarean section when outpatient postpartum care is provided by another provider or provider group.
>
> 59515 Cesarean section and routine postpartum care provided by same provider.
>
> ***
>
> (5) For the reimbursement of codes 59410, 59430, 59515, 59614 or 59622, the provider must, at a minimum, render an evaluation and management service four to six weeks post-delivery.
> ***

We determined that the Provider did not perform an evaluation and management service four to six weeks after delivery for 17 of our sampled 30 delivery services billed as CPT 59410 and 59515. Since Chapter 5101:3-1-17.2(D) of the Ohio Adm.Code requires that providers maintain proper records, we reduced the reimbursement amount from that due a delivery code inclusive of postpartum care (CPT 59410 or 59515) to the proper amount for the equivalent delivery only code (CPT 59409 or 59514).

As noted above, we took exception with 17 of 30 statistically sampled delivery services from the Provider's population of 195 delivery services with inclusive postpartum service. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $129,903.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $126,880.00 to $132,925.00 (+/- 2.33 percent). We then calculated audit findings repayable to ODJFS by subtracting the correct population payment amount ($129,903.00) from the amount actually paid to the Provider for this population ($136,723.15), which resulted in a finding of $6,820.15.

Provider Should Obtain and Bill for Services under a Group Number

Ohio Adm.Code 5101:3-1-17(B) states:

> Providers eligible for enrollment in the medicaid program may be an individual, a group of individuals, a corporation, or an institution licensed or approved to provide a particular service. Provider agreements, therefore, may be issued to an individual, groups of individuals, corporations or institutions. A "group" provider agreement may only be issued to organizations composed solely of two or more individuals of the same profession who are members of a professional association organized under Chapter 1785 of the Revised Code, each of whom is licensed or approved by a standard-setting or regulatory agency to render the same kind of professional service and approved for participation in the medicaid program by the Ohio department of job and family services as individual providers.

While ODJFS does not require that physician groups obtain and bill using a group provider number, we believe the opportunities for erroneous Medicaid billings would be reduced if the Provider billed for services under a group provider number, instead of under an individual provider number. The Provider is the president of Marietta Gynecologic Associates, Inc., which at the time of our audit included five other physicians who supply and bill for Medicaid services. All of these physicians bill for Medicaid services under their individual provider numbers.

During our audit of this Provider and two other providers associated with Marietta Gynecologic Associates, Inc., we noted instances of duplicate billings (two of the providers billing for the same service on the same date for the same patient), and services provided by one doctor that were erroneously billed under another doctor's provider number. These errors would have been prevented had the services been billed under a group number. Therefore, we are recommending that the Provider, as president of Marietta Gynecologic Associates, Inc., obtain and bill for services under a "group" Medicaid provider number in accordance with ODJFS guidance.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on October 27, 2003 to afford an opportunity to provide additional documentation or otherwise respond in writing. In a

response dated December 22, 2003, the Provider acknowledged that billing errors had occurred in billing established patients as new patients and in duplicate billings.

Regarding our findings for office visits billed in conjunction with surgical procedures, the Provider's office manager explained that the physicians were unaware of Medicaid rules regarding this situation. They have modified their billing practice accordingly.

Regarding our findings for billing delivery codes inclusive of post-partum services, the Provider's office manager stated their standard practice was to bill the inclusive codes because the physicians always do a post-partum visit before the patient leaves the hospital. However, Ohio Adm.Code 5101:3-4-08(E)(5) states that a service must occur four to six weeks after delivery in order to qualify for reimbursement of the inclusive code. Patient records did not show these services occurred. Therefore, our findings for this issue did not change.

Regarding our findings for urinalysis billed in conjunction with antepartum visits, the Provider's office manager acknowledged that antepartum is inclusive of "dipstick screenings" and said the screenings were performed at no additional charge. The office manager indicated that follow on urinalysis tests are sometimes ordered and billed when a urinary infection is suspected. On those occasions, we allowed the reimbursement for the additional urinalysis claim. Our exceptions were only taken with claims when the patient record showed that just a dipstick screen occurred. Therefore, our findings for this issue did not change.

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APPENDIX I

Summary of Overpayment Results for: Curtis D. White, D.O.
D.B.A. Marietta Gynecologic Associates
For the period January 1, 2000 through December 31, 2002

Description	Audit Period: January 1, 2000 through December 31, 2002
Projection of All Other Codes	$23,783.65
Projection of Delivery Codes billed with Inclusive Postpartum services	$6,820.15
E&M Visits Not Allowed with Surgical Procedures	$186.88
Established Patients Billed as New Patients	$153.48
Fetal Non-Stress Tests	$123.90
Urinalysis Billed with Antepartum Visits	$113.47
TOTAL FINDINGS	$31,181.53

APPENDIX II

Projected Findings – All Other Non-Specialty Codes
Summary of Sample Record Analysis for: Curtis D. White, M.D.
D.B.A. Marietta Gynecologic Associates
For the period January 1, 2000 to December 31, 2000

Description	Audit Period January 1, 2000 – December 31, 2000
Type of Examination	Statistical Simple Random Sample of 457 Dates of Service
Number of Population Recipient Date of Services	6,064
Number of Population Services Provided	13,544
Number of Recipient Date of Services Sampled	147
Number of Services Sampled	457
Amount Paid for Services Sampled	$31,693.13
Total Medicaid Amount Paid For Population of all other non specialty records	$432,003.07
Point Estimate of Correct Population Payment Amount	$408,,219.42
Upper Limit Correct Population Payment Amount at 95% Confidence Level	$429,495.49
Lower Limit Correct Population Payment Amount at 95% Confidence Level	$386,943.35
Point Estimate of Overpayment Amount (Actual population payment – Point estimate of correct population payment)	$23,783.65
Upper Limit Overpayment Estimate at 95% Confidence Level (Actual population payment – Lower limit estimate of correct population payment)	$45,059.72
Lower Limit Overpayment Estimate at 95% Confidence Level (Actual population payment – Upper limit estimate of correct population payment)	$2,507.58
Precision (+ or – amount)	($21,276.07) 5.21%

APPENDIX III

Delivery Codes Inclusive with Postpartum Services
Summary of Sample Record Analysis: for Curtis D. White, M.D.
D.B.A. Marietta Gynecologic Associates
For the period January 1, 2000 to December 31, 2000

Description	Audit Period January 1, 2000 – December 31, 2000
Type of Examination	Statistical Stratified Random Sample of 30 Recipient Deliveries
Number of Population Recipient Date of Services	195
Number of Recipient Deliveries Sampled	30
Amount Paid for Services Sampled	$21,031.20
Total Medicaid Amount Paid For Population of Delivery Codes	$136,723.15
Point Estimate of Correct Population Payment Amount	$129,903.00
Lower Limit Estimate of Correct Population Payment Amount at 95% Confidence Level	$126,880.00
Point Estimate of Overpayment Amount (Actual population payment – Point estimate of correct population payment)	$6,820.15
Upper Limit Overpayment Estimate at 95% Confidence Level (Actual population payment – Lower Limit estimate of correct population payment)	$9,843.15
Lower Limit Overpayment Estimate at 95% Confidence Level (Actual population payment – Upper Limit estimate of correct population payment)	$3,798.15
Precision (+ or – amount) of Correct Population Payment Amount at 95% Confidence Level	($3,022.00) 2.33%

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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:	**Curtis D. White, MD** **Marietta Gynecological Associates Inc.** **410 Second St.** **Marietta, OH 45750**
Provider Number:	**0552852**
Audit Period:	**January 1, 2000 – December 31, 2002**
AOS Finding Amount:	**$31,181.53**
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.

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

CURTIS D. WHITE, M.D.

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
FEBRUARY 10, 2004