Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Foot & Ankle Centers of Ohio

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

August 18, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Foot & Ankle Centers of Ohio
Provider Number: 0991646

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Foot & Ankle Centers of Ohio for the period July 1, 2001 through June 30, 2004. We identified $6,855.96 in findings that are repayable to the State of Ohio. 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 a final determinations regarding recovery of the findings identified herein, and any interest accruals.

Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers and Section 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.

Copies of this report are being sent to Foot & Ankle Centers of Ohio, the Ohio Attorney General, and the State Medical Board of Ohio. In addition, copies are 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

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
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

SUMMARY OF RESULTS

The Auditor of State performed an audit of Foot & Ankle Centers of Ohio (hereafter called the Provider), Provider # 0991646, doing business at 1013 E. Spring St., St. Marys, OH 45885. 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 $6,855.96 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code Ohio and the Medicaid Provider Handbook (OMPH).

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 a final determination regarding recovery of the findings identified herein, and any interest accruals.[1]

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 requirements for reimbursement of Medicaid covered services.[2] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

The scope of coverage for podiatrists is specified in the Ohio Administrative Code. Ohio Adm.Code 5101:3-7-02(A) states in part: "Podiatrists may perform covered services…which consist of the medical, mechanical and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma. The podiatrist may also treat the local manifestation of systemic disease as they appear in the hand and foot, but the patient must be concurrently referred to a doctor of medicine or a doctor of osteopathic medicine and surgery for treatment of the systemic disease itself."

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."

1 *See Ohio Adm. Code 5101:3-1-19.8(F) and 5101:3-1-25*
2 *See Ohio Adm.Code 5101:3-1-01(A) and (A)(6)*

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."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any repayable findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a podiatrist group.

Following a letter of notification, we held an entrance conference at the Provider's place of business on January 5, 2005 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 July 1, 2001 through June 30, 2004. Excluding Medicare co-payments, the Provider was reimbursed $210,164.36 for 4,785 services rendered on 3,215 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 paid 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).[3.]

3 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.

Prior to beginning our field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These tests included the following:

- Checking for services to deceased recipients for service dates after their date of death.
- Checking for potentially duplicate billed and paid services. (Defined as more than one bill for the same recipient, same date of service, same procedure, same procedure code modifier, and same payment amount occurring on different claims.)
- Checking for new patient evaluation and management services billed for patients who had received services from the Provider within the prior three-year period.
- Checking for debridement services performed on a recipient more than once in a sixty-day period.
- Determining whether supplies and durable medical equipment were potentially dispensed, billed, and paid at prices or in quantities greater than the Medicaid allowed maximum.
- Checking for evaluation and management services billed by the Provider in conjunction with surgical procedure(s) that include an evaluation and management service.
- Determining whether multiple surgeries and bilateral procedures were reimbursed appropriately.
- Checking for evaluation and management services billed during a surgical follow-up period.

The tests for deceased recipient services and duplicate claims were negative, but all other exception tests identified potentially inappropriate service code combinations. When performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we analyzed five statistically random samples and one census (100 percent) review from the subpopulation of claims not already identified for 100 percent exception review. The samples and census review included the following:

- The 28725 sample was a census review of all 20 CPT 28725 (subtalar arthrodesis grice type procedure) services.
- The 11750 sample was a simple random sample of services for CPT code 11750 (excision nail & matrix permanent removal), containing a total of 30 services.
- The 99202 sample was a simple random sample of services for CPT code 99202 (expanded history & exam; office/outpatient; new), containing a total of 32 services.
- The 99212 sample was a simple random sample of services for CPT code 99212 (focused history & exam; office/outpatient; established), containing a total of 30 services.
- The L3020 sample was a simple random sample of services for HCPCS code L3020 (Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each) containing a total of 37 services.
- The "All Other Services" sample was a stratified random sample of 184 services that were not already included in the exception analyses or other sampled subpopulations.

Our work was performed between August 2004 and May 2005.

RESULTS

We identified $3,496.18 in findings from our exception tests and $3,359.78 in findings from our statistical samples. No findings were identified in our sample of CPT 11750 services. The total findings of $6,855.96 are repayable to ODJFS. The circumstances leading to the findings are discussed below:

Exception Test Results

Multiple Surgeries

Ohio Adm.Code 5101:3-4-22(D)(2) states:

> Reimbursement for multiple surgical procedures performed on the same patient by the same provider shall be the lesser of billed charges or: (a) One hundred per cent of the medicaid maximum allowed for the primary procedure; (b) Fifty per cent of the medicaid maximum allowed for the secondary procedure; and (c) Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Our computer analysis identified 102 recipient dates of service (289 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating any services that are subject to the bilateral procedure rule and any services that MMIS does not list as being subject to multiple surgery charge adjustment, we identified 24 recipient dates of service (64 services) that were potentially overpaid. After further analysis, we determined that 12 recipient dates of service (37 services) were not properly reimbursed according to the multiple surgery rules. Therefore, we reduced the amount paid for 17 of these 37 services to the correct amount. In performing our calculation, we always considered the highest paying service to be the primary service (100 percent payable); the second highest paying service to be the secondary service (50 percent payable); and all other services to be tertiary (25 percent payable). The finding amount of $2,265.69 is the difference between what was paid and what the Provider should have been paid.

Bilateral Procedures

Ohio Adm.Code 5101:3-4-22(E)(3) states:

> The medicaid maximum for bilateral procedures is one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally.

Our computer analysis identified 102 recipient dates of service (289 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating any services subject to the multiple surgery rules, we identified nine recipient dates of service (18 services) where surgical services subject to the bilateral procedure rule had been improperly billed and resulted in an overpayment. These services (CPT 29580 - Strapping, Unna

Boot) had been billed without a procedure code modifier (code 50, bilateral procedure). This resulted in both CPT 29580 services, in each of the nine pairs, being paid at 100 percent of the Medicaid maximum (200 percent total) rather than the proper 150 percent total for the pair. We reduced the amount paid for each pair by $17.95 (50% of price per service) resulting in a finding of $161.55.

E&M Services Billed in Conjunction with a Surgical Procedure

Ohio Adm.Code 5101:3-4-06(M)(3)(c) states:

> Visits on the same day as surgery. A provider may be reimbursed for a visit on the same day as surgery, only if the procedure is identified by an asterisk in appendix DD of rule 5101:3-1-60 of the Administrative Code and it is customary for the physician to charge a visit for all patients.

According to the American Medical Association, the organization that promulgates CPT codes and definitions, the Surgical Package Definition states in pertinent part:

> In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation...subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)...

Our computer analysis identified three E&M services where a surgical procedure was also billed on the same date. After review of these services, we determined that these E&M services were not separate and identifiable from the surgical procedure being performed. Because the E&M services were included with the surgery services, we identified an $83.23 finding for the extra E&M reimbursements.

Erroneously Billed Debridement Services

Ohio Adm.Code 5101:3-7-03(C)(2) states in pertinent part:

> Surgeries…the following limitation applies: reimbursement for debridement of nails is limited to a maximum of one treatment within a sixty-day period.

Our computer analysis identified two occasions where the Provider performed and billed two debridement services in a sixty-day period. Because the maximum is limited to one treatment within a sixty-day period, we disallowed the two extra services. This resulted in a finding of $57.72.

Established Patients Billed as New Patients

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

The American Medical Association, which promulgates CPT code definitions, states:

> 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 had 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 had 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 codes 99211 through 99215. Our computer analysis identified three services where the Provider billed a new patient E&M service after providing the patients professional services within the previous three years. We recoded these services from the new patient level to the appropriate established patient level based on the documentation in the patient record; one service was recoded to 99212 and two services were recoded to 99213. We then subtracted the Medicaid maximum payment allowed for the recoded service from what was originally paid, resulting in a finding of $9.82.

Erroneous Units of Service

Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part:

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

Our computer analysis identified one service where the Provider billed and was paid for more than one E&M unit of service for the same patient on the same date of service. However, based on documentation in the patient's record, the Provider only performed one evaluation and management service. Therefore, we allowed only one unit of service and took the difference between what was paid and what should have been paid as a $34.42 finding.

Supplies Exceeding the Medicaid Maximum

Ohio Adm.Code 5101:3-10-03 states in pertinent part:

> The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A of this rule…
>
> ***

Items Dispensed in Excess of the Medicaid Maximum

Appendix A of Ohio Adm.Code 5101:3-10-03 establishes maximum dollar amounts and/or quantities that Medicaid will cover for specific items, within specified time periods. Our computer analysis identified 83 services where the Provider billed and was reimbursed for supplies that exceeded the maximum allowed. After subtracting the maximum allowed from the amount paid to the Provider, we identified $883.75 in findings for the items shown in Table 1.

Table 1: Listing of Supplies Dispensed in Excess of the Medicaid Maximum

HCPCS Code	HCPCS Name	Maximum Allowed Amount	Number of Exceptions	Repayable Finding ($)
A4580	Cast Supplies Plaster, Repair Only	1 per year	25	$63.75
A4590	Special Cast Materials, Light, Repair Only	1 per year	58	$820.00
Total			***83***	***$883.75***

Source of Medicaid Maximum Allowed: Ohio Adm.Code 5101: 3-10-03, Appendix A – Medicaid Supply List.

Source of Estimated overpayments and Exceptions: AOS analysis of the Provider's paid claims in MMIS and provider patient records for July 1, 2001 through June 30, 2004.

E&M Service Billed during a Surgical Follow-up Period

Ohio Adm.Code 5101:3-4-06(M)(3)(d)(ii)(a) states the following:

> A physician may be reimbursed for visits provided during the minimum surgical follow-up period only if the visit was provided after the day of surgery and the visit was provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure (previously) performed.
>
> ***

Appendix DD of Ohio Adm.Code 5101:3-1-60 defines the minimum surgical follow-up period, based on number of days, for each surgical procedure. During our census review of 40 services, we identified 26 services where the Provider billed for an evaluation and management visit during a surgical follow-up period which was not separate and identifiable from the surgical procedure previously performed. Therefore, the 26 services should have been included in the initial surgical procedure and not billed separately. We took exception with the reimbursements for these services, resulting in a finding of $652.56.

Level of Service Overstated

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

During our census review of 40 E&M services billed during a surgical follow-up period, we identified two services where the Provider billed for a separate and identifiable E&M service from the previous procedure. However, the two services did not meet the level of service that was billed. Based on documentation in the patient record, we reduced one service to a 99212 and one service to a 99211. This resulted in the findings of $30.53.

Non-Covered Service

Ohio Adm.Code 5101:3-7-04(B) states in pertinent part:

> In addition, the following services are noncovered, unless a recipient has a localized infection or is under the care of a doctor of medicine or a doctor of osteopathic medicine and surgery for a metabolic disease such as diabetes mellitus, or another condition which may result in a circulatory impairment or desensitization in the legs or feet:
>
> ***
> (5) The treatment of uncomplicated, chronic foot conditions such as flat feet or a sublaxated structure in the foot…
>
> ***

During our census review of 40 E&M services billed during a surgical follow-up period, we identified one service where the Provider billed for a non-covered service. The Provider billed for a recipient with flat feet; however, there was no mention of a localized infection, diabetes mellitus, or another condition which may result in a circulatory impairment in the recipient's records. Therefore, we took exception with the service reimbursement and identified a finding of $24.74.

Missing Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form as to fully disclose the extent of services provided…

During our census review of 40 E&M services billed during a surgical follow-up period, we identified one service where there was no dictation in the patient chart to support the billing of the E&M service. This exception amounted to a finding of $27.17.

Sample Results

28725 Census Review and L3020 Random Sample

Non-Covered Services

Ohio Adm.Code 5101:3-7-04(B) states in pertinent part:

> In addition, the following services are noncovered, unless a recipient has a localized infection or is under the care of a doctor of medicine or a doctor of osteopathic medicine and surgery for a metabolic disease such as diabetes mellitus, or another condition which may result in a circulatory impairment or desensitization in the legs or feet:
>
> ***
> (5) The treatment of uncomplicated, chronic foot conditions such as flat feet or a sublaxated structure in the foot…
>
> ***

From our census review of CPT 28725 (subtalar arthrodesis grice type procedure), we took exception with four of the 20 services reviewed. The Provider billed for a recipient with flat feet; however, there was no mention in the recipient's records of a localized infection, diabetes mellitus, or another condition which may result in a circulatory impairment. Therefore, these services should not have been covered. Thus, we are taking exception with these services which amount to a finding of $2,017.64.

From our stratified statistical sample of HCPCS code L3020 (foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each), we took exception with one of the 37 sampled services from the Provider's subpopulation of paid services. The exception amounted to a $105.69 overpayment and occurred because the Provider supplied a service to a patient for the treatment of flat feet.

Summary Results

Since both the error rate of services tested and the dollar amount of the overpayment found were below our criteria for materiality, we did not project the L3020 sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the actual $2,123.33 overpayment found in the 28725 census review and the L3020 sample.

99202 Random Sample

Level of Service Overstated

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

According to the AMA, which promulgates CPT definitions, new patient E&M services, CPT codes 99201 through 99205, require the Provider's documentation to include all of the key components (history, examination, and medical decision making) and to meet or exceed the stated requirements to qualify for a particular level of E&M service. In accordance with Ohio Adm.Code 5101:3-7-03, podiatrists may only bill codes 99201 through 99203 in this code series.

From our stratified random sample of paid CPT code 99202 (expanded history & exam; office/outpatient; new) services, we took exception with one service. We reduced the allowable reimbursement to a 99201 (problem focused history & exam; office/outpatient; new) because documentation in the patient record only supported that a problem focused visit had occurred.

The patient's progress notes listed a chief complaint, past complication, x-ray results, and a plan of treatment. Because the visit focused solely on one problem/issue and details were not documented, the service was performed at a problem focused level. Therefore, we took the difference between what the Provider had been paid and the Medicaid maximum allowed for a 99201 resulting in a finding of $12.61.

Missing Chart

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form as to fully disclose the extent of services provided…

We took exception with one of the 32 services from the stratified random sample of the Provider's paid CPT 99201 services because no patient medical chart could be found for review. Consequently, we took exception with the service reimbursement and made a finding of $27.53.

Summary Results

Since both the error rate of services tested and the dollar amount of the overpayment were below our criteria for materiality, we did not project the 99202 sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the actual $40.14 overpayment found in the 99202 sample.

99212 Random Sample

Missing Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form as to fully disclose the extent of services provided…

From our simple random sample of paid CPT code 99212 (problem focused history & exam; office/outpatient; established) services, we took exception with one service because there was no evidence in the patient chart that the visit took place. Therefore, we disallowed the service and made a finding of $24.74.

Since both the error rate of services tested and the dollar amount of the overpayment were below our criteria for materiality, we did not project the 99212 sample results to the Provider's payment population. Thus, the finding repayable to ODJFS is the actual $24.74 overpayment found in the 99212 sample.

All Other Services Random Sample

Unbundling of Services

Ohio Adm.Code 5101:3-7-03(F)(2)(b) states:

> Range of motion studies may not be billed separately from an examination of the foot, unless substantiated by a complete report.

Ohio Adm.Code 5101:3-10-20(B) states in pertinent part:

> The allowed reimbursement amount for any orthotic or prosthetic device listed in appendix A of this rule includes, but is not limited to, the following
>
> ***
> (2) Casting, fitting, or measuring fees
>
> ***

From our stratified random sample of 184 services from the subpopulation of all other paid services, we took exception with three services. This exception resulted because the Provider had billed for a range of motion service, but there was no complete report in the patient's records and there was no additional documentation to show a separate service was performed outside of the casting, fitting, or measuring for the patients orthotic devices. Therefore, we took exception with the reimbursements for these services, resulting in a finding of $31.53.

Level of Service Overstated

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

From our stratified random sample of all other services, we took exception with two of the sampled services because the Provider billed at a higher level of service than documented in the patient record. We reduced the services to the level supported by medical documentation and took the difference between what had been paid and the Medicaid maximum payable for the supported level of service. This resulted in a finding of $30.53.

Non-Covered Services

Ohio Adm.Code 5101:3-7-04(B) states in pertinent part:

> In addition, the following services are noncovered, unless a recipient has a localized infection or is under the care of a doctor of medicine or a doctor of osteopathic medicine and surgery for a metabolic disease such as diabetes mellitus, or another condition which may result in a circulatory impairment or desensitization in the legs or feet:
>
> ***
> (5) The treatment of uncomplicated, chronic foot conditions such as flat feet or a sublaxated structure in the foot…
>
> ***

From our stratified random sample of all other paid services, we took exception with two services reviewed because the Provider had billed for services for flat feet; however, there was no mention in the recipient's records of a localized infection, diabetes mellitus, or another condition which may result in a circulatory impairment. Therefore, these services should not have been covered. Thus, we took exception with the reimbursement for these services and identified a finding of $150.43.

Missing Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> To maintain all records necessary and in such form as to fully disclose the extent of services provided…

From our stratified random sample of all other services, we took exception with three of the 184 statistically sampled services from a stratified sample of the Provider's population of paid services. This exception resulted in a finding of $224.08 because there was no evidence in the patient chart that the service was performed.

Summary Results

Since both the error rate of services tested and the dollar amount of the overpayment were below our criteria for materiality, we did not project the all other services sample results to the

Provider's payment population. Thus, the finding repayable to ODJFS is the actual $436.57 overpayment found in the all other services sample.

PROVIDER'S RESPONSE

A draft report was sent to the Provider on June 29, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. In a letter dated July 7, 2005, the Provider agreed to repay the audit findings and identified policy and procedural changes being made to avoid future billing errors. The Provider's response is attached for ODJFS' consideration.

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APPENDIX I

Summary of Overpayment Results for:
Foot & Ankle Centers of OH
For the period July 1, 2001 to June 30, 2004

Description	Audit Period July 1, 2001 to June 30, 2004
Multiple Surgeries	$2,265.69
Bilateral Procedures	$161.55
E&M Service Billed in Conjunction with a Surgical Procedure	$83.23
Erroneously Billed Debridement Services	$57.72
Established Patients Billed as New Patients	$9.82
Erroneous Units of Service	$34.42
Supplies Exceeding the Medicaid Maximum	$883.75
E&M Service Billed during a Surgical Follow-up Period Census Review	$735.00
28725 Census Review	$2,017.64
L3020 Stratified Random Sample	$105.69
99202 Stratified Random Sample	$40.14
99212 Random Sample	$24.74
All Other Services Stratified Random Sample	$436.57
TOTAL	**$6,855.96**

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

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FOOT & ANKLE
Centers of Ohio, Inc.

Eugene R. Little, Jr., D.P.M., F.A.C.F.A.S.
Darryl M. Haycock, D.P.M., F.A.C.F.A.S.

David B. Glover, D.P.M.
Eric C. Miller, D.P.M., F.A.C.F.A.S.

July 7, 2005

Auditor of State
Betty Montgomery
Attn: Norman Hofmann
Deputy Chief Auditor
Health Care and Contract Audit Section

Dear Mr. Hofmann:

Thank you for delineating everything so clearly in each area of the audit. At this time we choose to repay the amount based on the findings. We have included no further information.

From this audit we have identified several procedural and policy changes to avoid further billing errors, some of which we have already instituted. Each billing employee, as before, reviews all changes from web sites and written materials. When procedures are paid, we now review those EOBs instead of assuming Medicaid had paid us correctly. Finally, we plan to institute a chart review process similar to yours, where the office manager would pick a topic once a month, review those cases to see if we are following guidelines set forth by Medicaid, or any insurance company.

As a new manager coming from a hospital setting, I am familiar with Quality Analysis and benchmarking studies to assure that practice is where it should be. Billing practices should be no different. Thank you for giving us this opportunity to respond.

Sincerely,

Diane Cook RN, BSN, CNOR
Office Manager
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FOOT AND ANKLE CENTERS OF OHIO

AUGLAIZE 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
AUGUST 18, 2005