Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Richard M. Kalapos, D.O.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

May 2005 ***AOS/HCCA-05-016C***

Auditor of State
Betty Montgomery

May 17, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Richard M. Kalapos, D.O.
Provider Number: 0592916

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Richard M. Kalapos, D.O. for the period April 1, 2000 through March 31, 2003. We identified $19,337.40 in findings that are repayable to the state of Ohio.

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.

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 any final determinations regarding recovery of the potential findings identified herein. We have advised Dr. Kalapos that if our findings are not repaid to ODJFS within 45 days of the date of this report, this matter can be referred to the Ohio Attorney General's office for collection in accordance with Section 131.02 of the Ohio Revised Code.

As a matter of courtesy, a copy of this report is being sent to Richard M. Kalapos, D.O., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also 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

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
CLIA	Clinical Laboratory Improvement Amendment of
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedural Coding System
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 Richard M. Kalapos, D.O. (hereafter called the Provider), Provider #0592916, doing business at 767 N. Garland Ave., P.O. Box 2056, Youngstown, OH 44506. 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 $19,337.40 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

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 audit initiated within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in pertinent 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, if warranted, calculate the amount of any findings due to non compliance. Within the Medicaid program, the Provider is listed as an individual osteopath in general practice.

Following a letter of notification, we held an entrance conference at the Provider's place of business on June 29, 2004 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, for which the Provider rendered services to Medicaid patients, not involving Medicare co-payments, and received payment during the period of April 1, 2000 through March 31, 2003. The Provider was reimbursed $531,380.42 for 23,970 services rendered during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of covered 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 and Medicaid Services (CMS).[2.]

Prior to beginning our field work, we performed computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for services to deceased patients or whether duplicate payments were made for the same recipient on the same date of service. The test for services to deceased patients was negative. However, our test for duplicate payments was positive. These potential duplicate payments were extracted for a separate 100 percent review.

During our field work, we noted several billing patterns that ran counter to Medicaid reimbursement rules. Consequently, we performed a computerized extraction of all payments involving the following:

- A primary diagnosis of Infertility Services, a service not covered by Medicaid.
- A primary diagnosis of Obesity Services, a service not covered by Medicaid.
- Developmental testing services (CPT code 96110) billed in conjunction with HealthChek services, which also entails developmental assessment.

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 (AMA). 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.*

To facilitate an accurate and timely test of the Provider's remaining reimbursements we selected a stratified statistical sample of 104 recipient dates of service from the population of 12,738 recipient dates of service. A recipient date of service is defined as all services received by a particular recipient on a specific date.

Our work was performed between March 2004 and April 2005.

RESULTS

We identified findings of $19,191.81 from our exception testing. Additionally, we identified $57.61 for a duplicate payment and $87.98 for the unsupported services in the sampled population. Together, our findings totaled $19,377.40. The bases for our results are discussed below.

Results of Exception Testing

Unallowable Billings for Developmental Testing

The Provider was paid $18,997.55 for 715 developmental testing services (involving 622 patients) billed as CPT code 96110. The American Medical Association (AMA) defines CPT 96110 as "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report." Medicaid pays Providers $26.57 each time CPT 96110 is billed.

According to the AMA, CPT code 96110 requires fairly extensive interpretive testing and preparation of a written report. The AMA's CPT Assistant newsletter dated July 1996 states "...When reporting these codes, calculate to the nearest full hour the time spent in planning, administering, scoring, interpreting, and reporting the assessments/tests ... these codes are used to report the services provided during the testing of cognitive function of the central nervous system." The same newsletter also states "This code, reported for limited testing, is generally used as a screening tool to identify children who should receive a more intense diagnostic evaluation or assessment."

To justify billing for CPT 96110, the Provider explained that, depending upon the child's age, discussions were held with the child and/or parent on accomplishments at home, or observations were made to determine communication, social, emotional, cognitive development skills levels. However, we are taking exception with the Provider's reimbursements for CPT code 96110 because we did not see any evidence of extensive testing or written reports in the patient records we reviewed.

We also had other reasons for taking exception with most of the Provider's CPT 96110 billings. Four of the 715 services were billed for patients over age 21, although CPT 96110 developmental testing is intended for children. In addition, 706 of the 715 services included reimbursements for "HealthChek" services (CPT codes 99391-99395 for established patients and CPT codes 99381-99385 for new patients). HealthChek reimbursements (ranging from $44.18 to $64.52 per service) also include reimbursement for developmental assessments.

The HealthChek development assessment is defined in Ohio Adm.Code 5101:3-14-03(C):

> (1) A developmental assessment shall be performed or updated at each initial and periodic screening service. The developmental assessment shall include an age-appropriate developmental history and an assessment of the individual's motor, speech, mental, and social development.
>
> (2) Formal developmental tests that are performed during the screening service will be reimbursed in addition to the "HealthChek" (EPSDT) screening service as described in rule 5101:3-14-04 of the Administrative Code.
>
> ***

Ohio Adm.Code 5101:3-14-04 (C)(1) states:

> In addition to the "HealthChek" (EPSDT) screening services, the department will reimburse providers for the following services provided during, or as part of, the "HealthChek" (EPDST) screening service.
>
> ***
>
> (c) Formal developmental test;
>
> ***

Although Ohio Adm.Code 5101:3-14-04 (C)(1)(c) indicates the Provider could have been reimbursed for an additional "formal developmental test", we did not see evidence of formalized testing in patient records, and the Provider's description of the services performed did not include use of a formal developmental test.

Therefore, we took exception with the 715 reimbursements for CPT 96110 that occurred during our audit period. This resulted in findings of $18,997.55 that are repayable to ODJFS.

Medicaid Non-Covered Services

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

> The following physician services are noncovered:
>
> ***
> (H) Services for or related to the treatment of infertility, including procedures for reversal of voluntary sterilization.
> (I) Services for the treatment of obesity, including gastroplasty, gastric stapling, or ileo-jejunal shunt.
>
> ***

Our testing showed the Provider received reimbursement of $34.35 for one service billed with a primary diagnosis of obesity and $159.91 for nine services billed with a primary diagnosis of infertility.

Because services related to infertility and obesity are not covered by Medicaid, we identified a finding of $194.26 for these services.

Duplicate Payment

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

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

Our testing identified one patient where on one occasion the Provider billed and was paid twice for identical services on the same date of service.

Findings of $57.61 resulted from the duplicated payment.

Unsupported Services in Sample

During our review of statistically selected patients' medical records, we found exceptions with the levels at which evaluation and management (E&M) services were billed.

Unsupported Level of Evaluation and Management Service Billings

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part respectively:

> …an "evaluation and management (E & M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient…
>
> 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.

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. For new patient E&M services, the provider must perform all three key components -- examination, medical decision making, and history -- defined by the American Medical Association's CPT code book. For established patient E&M services, the provider has to perform as least two of the key components. The Provider was paid $450,989.90 for E&M services, which comprised 85 percent of the total reimbursement for the audit period.

We found the level of service billed for three of 105 E&M services in our sample w as not supported by the documentation in the patients' medical records, or the documentation did not contain the required components as established by the CPT code book.

We determined the difference between the reimbursement for the unsupported level of E&M service and the maximum allowed reimbursement for the level of service supported by the documentation in the patients' medical records. We identified a finding for the difference of $36.86.

Undocumented Medical Service

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

Our review of the medical records for the statistically sampled patients found that one (1) service in our sample lacked proper documentation. The medical records reviewed did not contain documentation to verify that the services billed were performed.

We identified a finding for this service in the amount of $51.12.

Summary of Findings

Total findings repayable to ODJFS are $19,337.40, which includes $18,997.55 from unallowable reimbursements for developmental testing, $194.26 from reimbursements for non-covered Medicaid services, $57.61 for a duplicate payment, and $87.98 for the unsupported services in the sampled population. Since the error rate and overpayments found in our sample were below our criteria for materiality, we did not project the sample results to the Provider's payment population.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on April 13, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider responded on April 28, 2005 and subsequently supplied additional documentation that was used to adjust our findings. The additional documentation served to support some of the services initially identified as services not covered by Medicaid. However, our findings for unallowable developmental testing remained unchanged for reasons discussed in the results section above. The Provider's response also discussed actions being taken to prevent recurrence of the matters discussed in this report, and is attached for review and consideration by ODJFS.

R. M. Kalapos D. O.

767 North Garland Ave.
P. O. Box 2056
Youngstown, Ohio 44506

Phone 330-747-6614
Fax 330-747-0209

April 28, 2005

Ms. Kim Ousley
Lausche Building
615 Superior Ave.
Twelfth Floor
Cleveland, Ohio 44113

Dear Ms. Ousley,

This letter is in response to the results of my Medicaid audit received April 15, 2004. After review of the audit findings, the majority disallowed claims should be valid after review of the documentation that was mailed to your office earlier today.

Upon review of the claims disallowed as noncovered services, specifically obesity and infertility, were coding errors. The letter from my billing company explains this better than I can. Examination of the chart notes of the claims in question clearly show that what was coded as infertility, was in fact absence of menses. Likewise, the claims submitted with a primary diagnosis of obesity were in error as well. Those patients were all seen for primary diagnoses other than obesity. Obesity happened to be a valid diagnosis as well, but should not have been billed as the primary. Both of these errors have been corrected at the billing company and will not happen again.

Documentation has also been forwarded regarding the claims of duplicate payments, and undocumented medical services. Each of those findings were corrected with Medicaid as soon as they were discovered by my billing company. The duplicate payment was refunded. The claim submitted with an incorrect recipient number was also corrected with Medicaid. If you have any questions in this regard, please contact Linda Carney at my billing company, as per her letter.

The only remaining disallowed service is developmental testing. Unfortunately, after reviewing my Healthcheck Physical chart page, a former employee of my billing company called my staff and instructed them to bill CPT code 96110. Apparently you feel there is insufficient documentation for this code, and that my methods of developmental testing are not satisfactory. It is sad that our profession has become so obsessed with documentation that we lose sight of outcome, as I have a rather large number of children from my practice that have been identified, referred, and received treatment for their developmental delays. Many of these patients are still receiving therapy at Easter Seals and Tod Children's Hospital.

Sincerely,

Richard M. Kalapos D. O.

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

RICHARD M. KALAPOS, D.O.

MAHONING 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 17, 2005