STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Abdul M. Orra, D.O.

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

July 2000 ***AOS/FWAP-01-004C***

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Abdul M. Orra, D.O.
Provider #0582570
13535 Detroit Ave., Suite #4
Lakewood, Ohio 44107

Dear Dr. Orra:

We have completed our review of selected medical services rendered by you to Medicaid recipients during the period July 1, 1994 through June 30, 1997. In accordance with Section 117.28 of the Ohio Revised Code, we identified findings for recovery in the amount of $197,801.27. The findings represent Medicaid overpayments you received which must be repaid to the Ohio Department of Human Services.

Because you were given the opportunity under Ohio Administrative Code 5101:3-1-29 to make settlement arrangements with the Ohio Department of Human Services' Surveillance and Utilization Review Section and have not done so within 45 days after being notified that an overpayment existed, this matter is being referred to the Ohio Attorney General's office for collection. However, you may remit payment at any time by using the payment remittance form at the back of this report.

A copy of this report is being sent to the Ohio Department of Human Services, the Ohio State Medical Board, and the Ohio Attorney General. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste, and Abuse Prevention Division at (614) 728-7142.

Yours truly,

JIM PETRO
Auditor of State

July 25, 2000

Enclosure

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ABBREVIATIONS

AOS	Auditor of State
CLIA '88	Clinical Laboratory Improvement Amendments of 1988
CPT	Physician's Current Procedural Terminology
D.O.	Doctor of Osteopathic Medicine
E&M	Evaluation and Management
FWAP	Fraud, Waste and Abuse Prevention (Division of)
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
ODHS	Ohio Department of Human Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
SURS	Surveillance and Utilization Review Section

SUMMARY OF RESULTS

The Auditor of State (AOS) performed a review of Abdul M. Orra, D.O., Provider #0582570, doing business at 13535 Detroit Ave., Lakewood, Ohio 44107. During this review, we identified $197,801.27 in overpayments that occurred between July 1, 1994 and June 30, 1997. The overpayments are recoverable because they resulted from Medicaid claims submitted by Dr. Orra for improperly charged services under the Ohio Medicaid Provider Handbook and the Ohio Administrative Code (OAC). Therefore, pursuant to Ohio Revised Code (ORC) Section 117.28, a finding for recovery is issued against the Provider for improperly received monies of $197,801.27.

BACKGROUND

The Auditor of State, working in cooperation and with statistical data from the Ohio Department of Human Services (ODHS), performs audits designed to assess Ohio Medicaid providers' compliance with Federal and State service and reimbursement claim rules.

Medicaid, established in 1965 under the authority of Title XIX of the Social Security Act, is a Federal/State financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The fundamental principal underlying Medicaid is medical necessity. All services, other than those specifically categorized as "preventative" must be considered medically necessary for the patient's well-being and health. The professionals who provide services to Medicaid recipients are known as *providers*.

ODHS has direct operational responsibility for Ohio's Medicaid program. As part of that responsibility ODHS issued the Ohio Medicaid Provider Handbook, which contains the regulations that providers must follow. Pursuant to the Medicaid handbook and the OAC[1], providers are required to keep records which will disclose the extent of services rendered and upon request must provide those records. Additionally, statistical methods may be used to audit providers and to determine any amount of overpayment, which is recoverable at the time of discovery.

In accordance with federal regulations, ODHS engages a Surveillance and Utilization Review (SURS) unit. SURS is responsible for protecting the fiscal integrity of the Medicaid program by conducting health care data analysis and system reviews of provider delivery patterns of medical services to ensure that medical services rendered are in accordance with federal mandates and to determine provider compliance with Medicaid reimbursement rules.[2] SURS conducted a Report of Examination of Provider Records for the period October 1, 1987 through September 30, 1989. The report indicated overpayments of $67,292.90 resulting from partial or total disallowance for 2,503 office/hospital visits. The review resulted in a negotiation between ODHS and the Provider

[1] Ohio Medicaid Provider Handbook, Chapter 3334, Section VI, and Ohio Administrative Code Section 5101:3-1-27

[2] Ohio Department of Human Services' website: www.state.oh.us/odhs/medicaid/bpo/bposect.stm

which resulted in a Settlement Agreement for $25,000.00.

OBJECTIVE, SCOPE AND METHODOLOGY

The objectives of this review were to: 1) determine whether the Provider's claims for reimbursement of services rendered to Medicaid patients were in compliance with regulations, and 2) calculate the amount of any ODHS overpayment resulting from any noncompliance.

We reviewed the Provider's history of services billed to ODHS ("claims history") and subsequent reimbursement to determine compliance with applicable regulations. A provider's claims history is maintained in ODHS' Medicaid Management Information System (MMIS), which captures data elements from providers claims for services rendered such as: patient names, place of service, procedure/service billed, amounts billed, and dates of service.

In order to gather information necessary to tailor the scope of the review, a telephone interview was conducted on January 28, 1999. We specifically inquired whether the Provider employed social workers to provide psychotherapy services and what testing of laboratory specimens was performed on-site. During this discussion, Dr. Orra informed us of the following.

- He provided all psychotherapy services to his patients.
- Other than hemoglobin, urinalyses and glucose tests, laboratory procedures were sent to facilities outside of his office for testing.

Subsequently, an entrance conference was held via telephone with Dr. Orra on February 10, 1999 to initiate the review process and to address any questions from the Provider.

An on-site review of patients' medical records was conducted to determine the Provider's compliance with applicable program rules and to determine if the billed services could be verified by the Provider's documentation. While conducting the record review, we also examined the Provider's appointment books, billing procedures, and employee rosters. When necessary to obtain clarification, we discussed matters with the Provider or his staff. The Provider's certifications, licensure, laboratory and other testing equipment were examined to determine the appropriateness of services which were billed to and reimbursed by ODHS.

The ODHS' Medicaid Provider Handbook and the OAC were utilized as guidance in determining the extent of services and applicable reimbursement rates. Additionally, we met with representatives from ODHS' Surveillance and Utilization Review Unit.

We reviewed these procedural coding systems for determination of specific services rendered by the Provider:

- Current Procedural Terminology (CPT) – a listing published by the American Medical Association (AMA) that identifies and describes codes used to report medical services and procedures performed by physicians. These five digit codes are meant to provide a uniform language to describe services and provide nationwide communication between patients, physicians, and third-parties (e.g., insurances, etc.)

- Health Care Financing Administration's (HCFA)[3] Common Procedural Coding System (HCPCS) -- a national coding system that contains medical and dental procedure codes to bill physician and supplier services as issued by the HCFA.

- ODHS' local level codes -- codes that can be found within each specific chapter of the Medicaid Provider Handbook and in the corresponding Chapters of OAC 5101:3, that address the limitations of the covered services under Ohio's Medicaid program.

Our review of the Provider's paid claims showed that 81 percent of the total reimbursement received during the review period was for Evaluation and Management services (e.g., office visits). Therefore, in order to facilitate a timely and accurate review of paid claims, we reviewed three statistical random samples of patient medical records involving new or established patient "Evaluation and Management (E&M) services":

- Patients for whom the Provider billed and was reimbursed for *new patient E&M CPT code 99205.*

- Patients for whom the Provider billed and was reimbursed by ODHS for *established patient E&M CPT codes (99215, 99214, 99213, 99212, or 99211).*

- Patients for whom the Provider billed and was reimbursed by ODHS for *an established patient E&M CPT code and a psychotherapy CPT code (90844 or 90843) on same date of service*[4].

[3]HCFA has federal oversight of the Medicaid program.

[4]A post stratification of the instances, amount charged and amount paid were segregated from the rest of the population of these services, not falling on the same date. These E&M and Psychotherapy services were examined for the same date of service, but each were treated as separate strata for projection of estimated overpayments. This segregation was done to prevent duplication in the projection of results in other E&M service areas. A projection of the errors found in the sampled services was made to the service population, and adjustments were made for any services found as duplicated within the other samples. The noncompliance instances were projected to give an overall estimate for the service category for the portion of the service population that represented the services sampled; thereby maintaining the statistical integrity of the projection,

Any overpayments from noncompliance in these samples were projected with a 95 percent level of confidence to the patient population represented by the samples.

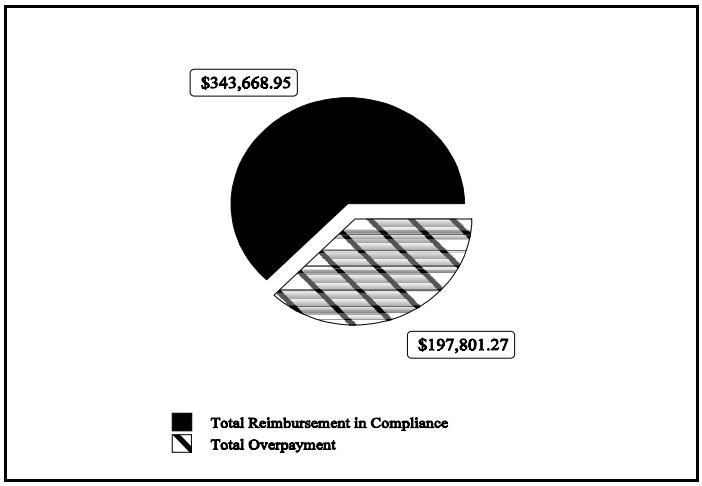
Our review was limited in scope, as it included only selected services rendered by the Provider to recipients from July 1, 1994 through June 30, 1997. Our work and reviews were conducted in accordance with generally accepted government auditing standards.

FINDINGS

During the review period the Provider was reimbursed $541,470.22 for over 19,000 services. These reimbursements included $438,645.10 for Evaluation and Management (E&M) services and $13,753.22 for psychotherapy visits.

Our finding for recovery of $197,801.27 resulted from overpayments in four Provider service claim categories. The finding for recovery represents 36 percent of the Provider's total reimbursement during the audit period.

Figure 1: Comparison of Total Overpayments to Total Reimbursements



The categories of our findings, the number of instances found, the basis for the overpayment, and the dollar amount overpaid are detailed in each section below.

EVALUATION AND MANAGEMENT (E&M) SERVICES

Eighty-one percent of all services reimbursed to the Provider were for E&M services. During our

since a projection can only be made to those items that had a chance of selection in the sample.

review of the Provider's paid claims data from ODHS' MMIS, we identified several issues with E&M services.

- Seventy (70) percent of total reimbursements were for established patient E&M visits which were comprised of primarily three codes (99213, 99214, 99215).
- For new patient reimbursements, 50 percent were for the highest level code (99205).
- Patients were identified with two "established" patient E&M visits billed and reimbursed for the same date of service.
- There were patients with two "new" patient E&M visits billed and reimbursed, both of which occurred within a three year time span.
- There were patients with established E&M visits as well as psychotherapy visits, both billed and reimbursed for the same date of service.

We found that the Provider was not documenting all components of the E&M visits which were being billed and reimbursed. Providers should bill the appropriate level of service based on CPT code definitions and instructions[5]. According to CPT code definitions, there are five levels of service available for each new or established patient which vary based on the level of service provided. The CPT[6] states:

> "The descriptors for the levels of service recognize seven components, six of which are used in defining the levels of E/M services. These components are:
>
> - history;
> - examination;
> - medical decision making;
> - counseling;
> - coordination of care;
> - nature of presenting problem; and
> - time.
>
> The first three are to be considered the key components in selecting the level of E/M service."

These components are the same for new and established patients levels of service. The CPT code book describes the difference between new and established patients as whether or not professional services were rendered by any physician of the same specialty and group practice within the past three years. In accordance with this description, the only time a new patient designation should be used is if no services were rendered within the past three years.

[5]ODHS. Ohio Provider Medicaid Handbook. Chapter 3336.

[6]American Medical Association. Physicians' Current Procedural Terminology. Chicago: 1997.

For a new patient, an E&M visit requires three key components be provided; *examination, history and medical decision making*. The descriptions as found in the CPT code book are as follows:

Table 1: New Patient Levels of Service	
99201	Problem focused history Problem focused examination Straightforward decision making
99202	Expanded problem focused history Expanded problem focused examination Straightforward medical decision making
99203	Detailed history Detailed examination Medical decision making of low complexity
99204	Comprehensive history Comprehensive examination Medical decision making of moderate complexity
99205	Comprehensive history Comprehensive examination High complexity decision making.

Note: Levels of service increase in complexity from 99201 through 99205

Also, according to CPT code instructions, for an established patient, ". . . two of the three key components must meet or exceed the stated requirement to qualify for a particular level of E/M service."

Table 2: Established Patient Levels of Service	
99211	Office or other outpatient visit for the evaluation and management of an established patient that may *not* require the presence of a physician; usually the presenting problem(s) are minimal.
99212	Problem focused history Problem focused examination Straightforward medical decision
99213	Expanded problem focused history Expanded problem focused examination Medical decision making of low complexity
99214	Detailed history Detailed examination Medical decision making of moderate complexity
99215	Comprehensive history Comprehensive examination Medical decision making of high complexity

Note: Levels of service increase in complexity from 99211 through 99215

A provider's progress notes within patients' medical charts should document the nature of the patients' chief complaint, any vitals taken, any laboratory tests ordered (as well as the results noted), the provider's orders, and any prescriptions ordered. The notes would also document any counseling given the patient, a history of current medications and information relating to the presenting problem, and a social history. Other pertinent information pertaining to the coordination of the patients' care, such as a follow up visit, other tests to be ordered, any instructions on treatment and prognosis, or referrals would also be found in the patients' records. The CPT code describes these data elements as items to consider when choosing a level of service to bill for an E&M visit.

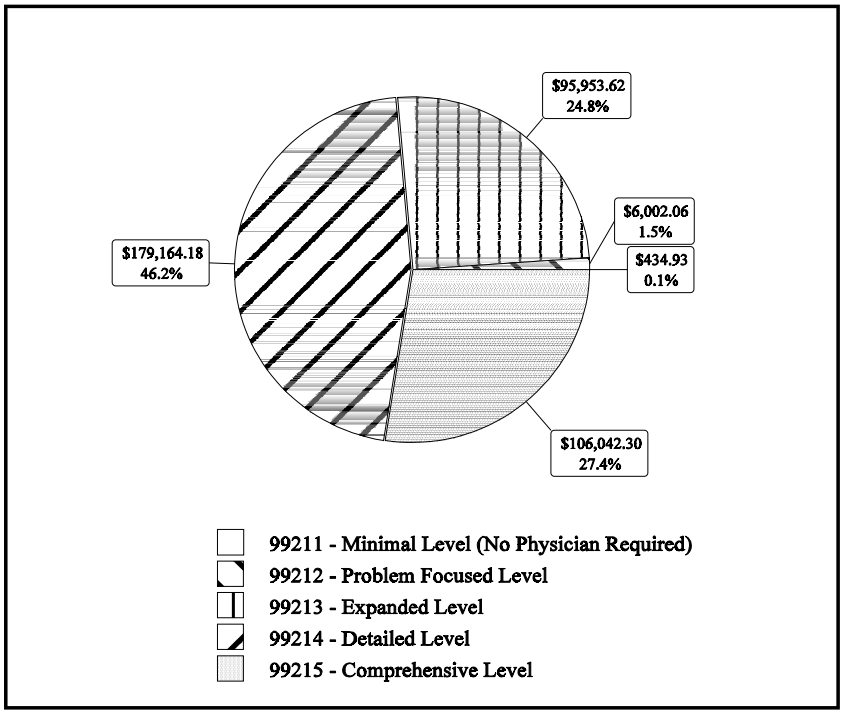
Established Patient Evaluation and Management Services

1. Unsupported Visit Levels

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Section II, Subsection A(2), (OAC Section 5101:3-4-06), providers must select and bill the appropriate visit [Evaluation & Management (E&M) service level] code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M

During our audit period, reimbursement for established patient E&M services ranged from $10.10 per visit for CPT code 99211 (increasing to $10.83 per visit on January 1, 1997) to $61.35 per visit for CPT code 99215 (increasing to $67.21 per visit on January 1, 1997). Because of the high percentage of reimbursement for high level E&M codes (73.6 percent for codes 99214 and 99215) and the large number (over 10,000) of E&M services billed, we took a statistical random sample of all patients receiving established patient E&M services to determine if the Provider's written documentation supported the various levels that were billed.

Figure 2: Levels of Service Billed for Established Patient E&M Codes.



During our reviews of patients' medical records, we found the Provider noted which specific E&M level of service code was to be billed for each encounter. Also, there were such items as orders, laboratory tests, current medications, social history, history of presenting problem, the patients' chief complaint, diagnosis or any prescriptions given. Documentation of the nature of the presenting problem, weight, temperature, height or blood pressures appearing in the notes were usually noted by staff members. Not all of these items appeared in every physician note for every encounter we reviewed.

Our review consisted of 25 randomly selected patient records with 128 instances of established patient E&M visit code billings. Of the 128 instances reviewed, 103 did not have the required documentation to meet the level billed. The physician's progress notes contained limited written documentation, and what was documented appeared to show a lower level of service performed then

had been billed. The limited documentation made it difficult to determine what actually occurred or what the Provider actually did for his patients during the encounter. Although an established patient office visit requires two of the three key components, one being an examination, the documentation did not support that examinations were conducted. Also difficult to determine was whether the limited written documentation supported a history, another one of the three key components.

For example, we found patients' medical records that only noted the chief complaint, some vitals such as the weight and/or blood pressure, the notation for which E&M visit code to bill, medications prescribed and diagnoses. Others only had the written documentation of chief complaint, a diagnosis and notation of which E&M visit code to bill. In addition, there were instances where the nature of the visit was for things such as "patient here for a refill", "patient here for a follow up", "patient needs an immunization", or "patient needs forms filled out", while the notation for which CPT visit code to bill was for high levels of service.

Table 3 provides other examples of the services as documented in the patient medical records, the requirements for the level of service billed and reimbursed, and the level of service that should have been billed.

Table 3: Examples of E&M Levels of Service As Documented and Billed

	E&M Billed	Requirement for Level of Service (two of three)	Documentation per Medical Record	E&M Indicated
Record A	***99215***	*Comprehensive history* *Comprehensive examination* *Medical decision making of high complexity.*	*•Vitals: Temperature & Weight* *•Complaint: "Shots"* *•Diagnosis: "Vaccination"* *•Physician Orders: 1) 99215, 2) MMR,, 3) DTP, 4) Hib, 5) OPV*	***99211***
Record B	***99214***	*Detailed history* *Detailed examination* *Medical decision making of moderate complexity.*	*•No vitals noted* *•Complaint: "Acne problems"* *•Diagnosis: "Acne" Physician Orders:* *1.) 99214* *•Prescriptions:* *1.) Emycin 333 #30* *2.) Retin-A 20 g.*	***99211***
Record C	***99213***	*Problem focused history* *Problem focused examination* *Medical decision making of low complexity.*	*•No vitals noted* *•Complaint: "Vacc. shots"* *•Diagnosis: "Vaccination"* *•Physician Orders:* *1.) OV 99213* *2.) Hepatitis B Vaccination #1*	***99211***
Record D	***99212***	*Problem focused history* *Problem focused examination* *Straightforward medical decision making.*	*•No vitals noted* *•Complaint: "Patient needs refill for glucometer strips and sleeping pills"* *•Diagnosis: "D. M."* *•Physician Orders:* *•1.) 99212* *•Physician Notes: "strips"*	***99211***

When the documentation did not support the higher level of service as billed, we reduced the claim to a more appropriate lower level visit code. We then projected the average of all the reductions to the total population of patients with established patient billings. This resulted in a $142,570.54 recoverable overpayment for established patient billings. Table 1 in Appendix 1 explains the basis for our projection.

2. Unsupported Visit Levels Billed With Psychotherapy Services

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Section II, Subsection A(2), (OAC Section 5101:3-4-06), providers must select and bill the appropriate visit [Evaluation & Management (E&M) service level] code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M.

During our review of the Provider's paid claims, we identified billings for patients with an established patient office visit service and a psychotherapy service on the same date. This prompted a selection of patients receiving these services, using a statistical random sample[7] in order to determine if both visits occurred.

We reviewed a statistical random sample of 136 pairs of instances [68 established patient office visits, and 68 psychotherapy services (36 CPT 90843s and 32 CPT 90844s)] for 33 patients receiving services of any established patient office visit code (CPT code 99215, 99214, 99213, 99212, or 99211) and a same day psychotherapy service. Discussion was held with ODHS' SURS staff regarding the billing and documentation requirements for these services.

We found 67 of the 68 instances of established patient E&M visits where the level of service billed did not appear to be supported by the level of service documented. We projected the error rate found in the sampled patients for the billed services across the service population of patients with billings for CPT codes 99215, 99214, 99213, 99212, 99211, and a psychotherapy service on the same date of service.

Based on our analysis, we determined that the Provider was overpaid $9,489.57, which represents the projected overpayment for the difference between the reimbursement for the unsupported services billed and maximum allowed reimbursement for the services indicated in the patients' medical records. Our finding was based on reducing the reimbursement received to the level of service supported by the patient medical record. Table 2 in Appendix 1 explains the basis for our projection.

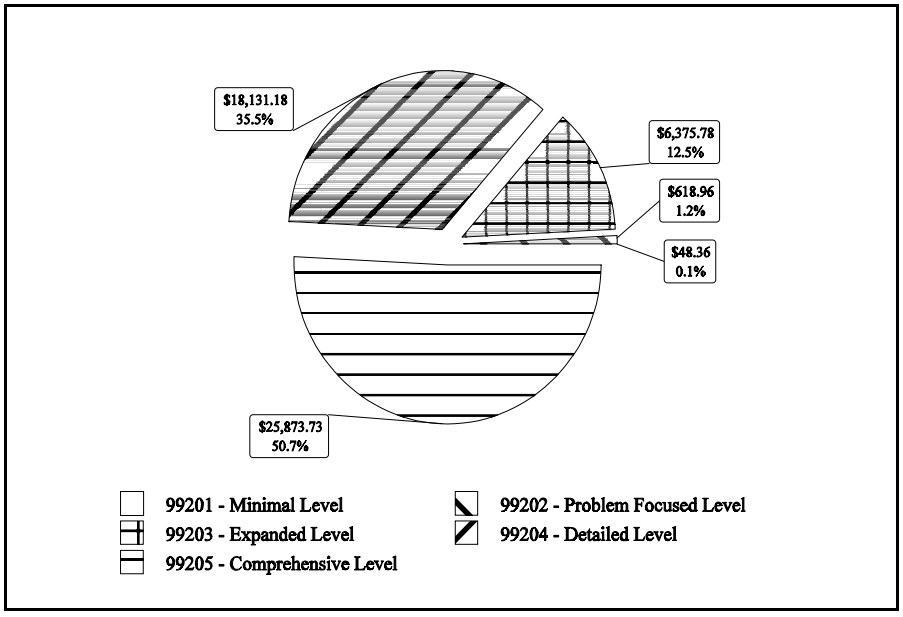
[7] Only those instances which were *not* included in the projection of established patients office visit codes were examined (see page 9). This segregation was done to prevent duplication in the findings for recovery. The errors found in the sampled services were projected to the service population, which represented the portion of the service population that had both an established patient office visit and a psychotherapy service billed and reimbursed on the same date of service.

New Patient Evaluation and Management Services

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Section II, Subsection A(2), (OAC Section 5101:3-4-06), providers must select and bill the appropriate visit [Evaluation & Management (E&M) service level] code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M.

During our review of the Provider's paid claims, we determined the Provider had been reimbursed $51,048.01 for new patient E&M services. About 50 percent of these reimbursements were for billings at the highest level code (99205), and about 86 percent were for billings at the at the two highest level codes (99204 and 99205) (see figure 3). This prompted the selection of a statistical random sample of patients receiving these services.

Figure 3: Levels of Service Billed for New Patient E&M Codes



Our review determined that in all 26 sampled instances, the documentation in the medical charts indicated a lower level of service had been performed. For example, documentation for some visits did not include one or more of the three key components required, one being examination, as it did not appear that examinations were conducted, due to the lack of documentation for this element.

Also, a comprehensive history and medical decision making of high complexity are required components for this level of service. However, patients for whom the Provider billed the highest level of service had presented problems of "cough, school physical, or vaccination," and diagnoses such as "physical, dermatitis, or tension headache". Instances such as these were reduced to a more appropriate lower level visit code (CPT code 99201, 99202, 99203, or 99204) based on the

documentation, even though not all encounters contained all three required key components.

We then projected the error rate for the billed services across the total population of patients with new patient billings and identified a recoverable overpayment of $14,974.85 for new patient billings. The overpayment was based on the difference between the reimbursement received for the billed level of service and the maximum reimbursement allowed for the level of service supported by the patient medical record. Table 3 in Appendix 1 explains the basis for our projection.

Duplicate Evaluation and Management Services

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery.

During our review of the Provider's paid claims, we determined that there were patients with two "established" patient E&M visits billed and reimbursed for the same date of service[8]. We selected these patients in order to determine if two visits actually occurred.

Our review consisted of 16 patients with 42 instances of established patient billings of E&M levels (CPT codes 99215, 99214, 99213, 99212, 99211) on the same date of service. Of the 42 instances reviewed, approximately 50 percent (20) did not have the required documentation to indicate a second E&M encounter for the same day.

A finding for recovery was calculated for $752.30 which represents the total reimbursement for the second undocumented E&M service.

Unallowed New Patient Evaluation and Management Services

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Section II, Subsection A(2), (OAC Section 5101:3-4-06), providers must select and bill the appropriate visit [Evaluation & Management (E&M) service level] code in accordance with the CPT code definitions[9] and the CPT instructions for selecting a level of E&M.

Review of the Provider's paid claims showed that two "new" patient E&M visits for some patients

[8]Only those instances which were *not* included in the projection of established patients office visit codes were examined. This segregation was done to prevent duplication in the findings for recovery.

[9]See CPT definitions on page 6 of this report.

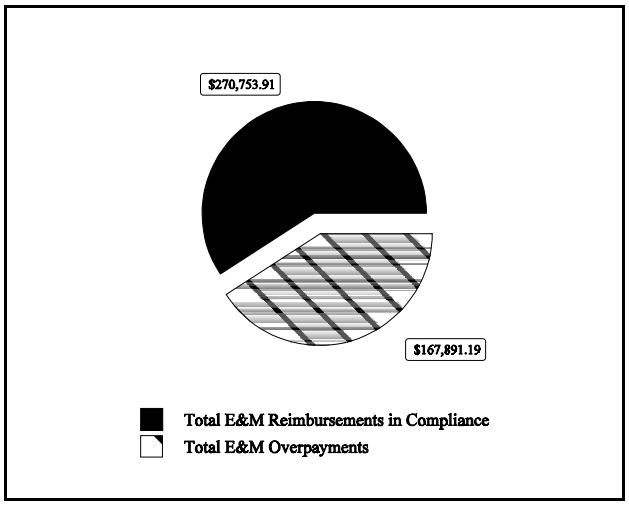
were billed to and reimbursed by ODHS within three years of each other[10].

Our review consisted of nine patients with 18 instances (two encounters per patient) of various new patient office visit codes billed (CPT codes 99202, 99203, or 99204) within a three year time span. Of the 18 encounters billed, the nine subsequent visits occurred within the defined time limit and therefore, the appropriate level of service to bill was that of an established patient. As established patient service levels are reimbursed at a lower amount than the corresponding new patient service levels, an overpayment occurred to the Provider.

As a result, we identified a $103.93 recoverable overpayment, which represents the difference between the reimbursement received by the Provider for the new patient levels of service and the maximum allowed reimbursement for corresponding established patient levels of service.

The total finding for recovery for the Evaluation and Management category amounts to $167,891.19, or 38 percent of the $438,645.10 received by the Provider for E&M services during the audit period.

Figure 4: Overpayment for E&M Services



DUPLICATE SERVICES

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery.

[10]Only those instances which were *not* included in the projection of new patient office visit codes were examined, which were the instances that did not include CPT code 99205. This segregation was done to prevent duplication in the findings for recovery.

During our review of the Provider's paid claims, we determined there were patients with two types of visit services billed and reimbursed on the same date of service. These patients not only had an established patient E&M visit service, but also, a psychotherapy service billed and reimbursed on the same day. This prompted a selection of patients receiving these services, using a statistical random sample[11].

The psychotherapy services were billed using CPT codes 90843 and 90844. These codes are defined based upon time increments: approximately 20 to 30 minutes for CPT 90843 and approximately 45 to 50 minutes for CPT 90844.

Due to the time requirement we reviewed the Providers' appointment books and interviewed the staff to determine the appointment interval for patients. According to office staff, patients' appointments are scheduled at 15 minutes intervals (as shown in the appointment books) due to "high volumes of no shows."

We reviewed a statistical random sample of 136 pairs of instances [68 established patient office visits, and 68 psychotherapy services (36 CPT 90843s and 32 CPT 90844s)] for 33 patients receiving services of any established patient office visit code (CPT code 99215, 99214, 99213, 99212, or 99211) and a psychotherapy service billed and reimbursed for the same date of service (CPT code 90844 or 90843).

We found only one instance of the 68 instances of psychotherapy codes billed that could be substantiated by documentation, therefore 67 instances were not substantiated. Since a second encounter for the date of service could not be substantiated by written documentation, these services were determined to be unsupported and thus, a duplicate billing. When we discussed our results with ODHS' Surveillance and Utilization Review Section staff, they concurred with our analysis.

We then projected the error rate in the sample to the total population of patients with billings for CPT code 90844 and 90843, and an established patient office visit on the same date of service. Our projection resulted in a recoverable overpayment of $11,814.54. Table 4 in Appendix 1 explains the basis for our projection.

LABORATORY SERVICES

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Physician Services, Section II, Subsection U, (OAC Section 5101:3-11-03): All Medicaid providers of laboratory services must

[11]Only those instances which were *not* included in the projection of established patients office visit codes were examined. This segregation was done to prevent duplication in the findings for recovery. The errors found in the sampled services were projected to the service population, which represented the portion of the service population that had both an established patient office visit and a psychotherapy service billed and reimbursed on the same date of service.

comply with the requirements set forth in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) . . . The department will continue to reimburse physicians and clinics for laboratory services rendered prior to September 1, even if the services are billed after that date, as long as the services are actually performed in a physician's office, an office of a physician's group practice or a clinic . . . Providers who possess only a certificate of waiver will be restricted to performing and billing for the procedures listed in paragraph (A) of Appendix I of Section II of this chapter and procedures listed in paragraph (B) for providers who possess only a Physician-Performed Microscopy Procedures.

A review of paid claims indicated the Provider billed and was reimbursed by ODHS for 1,430 laboratory services either *not* covered by CLIA '88 certificates held by the Provider, or the testing was not performed in the Provider's office.

The Provider is certified to conduct specific laboratory services according to following types of CLIA[12] certificates he maintained during our review period:

- Certificate of Registration, effective August 11, 1993 through September 26, 1994
- Certificate of Waiver, effective September 27, 1994 through September 26, 1996
- Certificate of Waiver, effective September 27, 1996 through September 26, 1998

The Provider's Certificate of Waiver allows him to render eight specific services. Table 4 lists the eight laboratory tests the Provider can perform and be reimbursed for.

Table 4: Waiver Laboratory Tests

81002 - Urinalysis, by dipstick or tablet
81025 - Urine pregnancy test
82270 - Blood, occult
82962 - Glucose, blood
83026 - Hemoglobin
85013 - Spun Hematocrit
85651 - Sedimentation rate
X5018 - Hemoglobin by a single analyzer instrument

[11]All providers of laboratory services are required by the Clinical Laboratory Improvements Amendment of 1988 to obtain certification to perform laboratory services. A provider may obtain a certain type of certificate depending on the laboratory tests performed at their facility. Subsequently, the provider may only be reimbursed for tests specifically listed for the type CLIA certification obtained.

We determined the Provider performed the following tests that were not allowed by his Certification:

- 82465 - Cholesterol
- 86677 - H. pylori
- 86317 - Quick view strep test

In addition, the Provider billed for other tests as though they were performed at his facility when the sample had been sent out to and testing performed by an independent laboratory. For example, the code 84702 is defined as Gonadotropin, chorionic (hCG); quantitative in the CPT code book. This test is not on the list of Waiver tests and was listed by the Provider as one that is sent out to an independent laboratory. Thus, the Provider was not allowed to bill for the test. Moreover, if the independent laboratory also billed for the test, ODHS may have reimbursed both parties.

Also, we determined the Provider billed the incorrect codes for urinalyses (CPT 81000) and glucose (CPT 82947) which resulted in an overpayment. Based upon the specific type of tests actually performed, the correct code to bill for the urinalyses and glucose tests were 81002 and 82962 respectively. The reimbursement for these codes is less than the reimbursement received by the Provider for the codes billed. Thus, the difference between the amount billed and reimbursed for the urinalyses and glucose codes, and the maximum reimbursement for the correct codes was an overpayment.

Overall, we determined that a $17,847.36 recoverable overpayment occurred because the Provider incorrectly billed for lab tests that he was not certified to perform, for tests not performed at his facility, and for incorrectly coded urinalyses and glucose tests.

OBESITY SERVICES

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3336, Physician Services, Section II, Subsection AB, (OAC Section 5101:3-4-28): The following physician services are non-covered: All services exceeding the policies and limitations defined in Chapters 5101:3-1 and 5101:3-4. . . . Services for the treatment of obesity, including, but not limited to: gastroplasty, gastric stapling, or ileojejunal shunt; . . . .

During our review of the Provider's paid claims, we determined that diagnosis code 278.0 was billed for various patients which according to the ICD-9[13], falls within the section for Obesity and other hyperalimentation. The ICD-9 defines 278.0 or 278.00 as Obesity and Obesity - unspecified, respectively. As the billing for physician services for treatment of obesity is unallowed according to Medicaid rules, this prompted the selection of all patients whose services were billed in conjunction with these diagnosis code.

[13]Medicode. Internal Classification of Diseases-9th Revision-Clinical Modification, August 1996.

We reviewed the records of 25 patients with 57 billings of diagnosis code 278.0. It was determined that these services were for treatment of obesity and are therefore not reimbursable[14]. Therefore, a $248.18 recoverable overpayment occurred, which represents the amount reimbursed to the Provider for these obesity services.

CONCLUSIONS

Our review identified $197,801.27 in recoverable Medicaid overpayments. A draft report was mailed to the Provider on February 14, 2000 and discussed with him during a February 23, 2000 exit conference. The Provider then requested and received an additional six weeks, until April 5, to provide additional documentation or otherwise respond to the audit findings in writing. No additional documentation was provided.

On May 5, 2000, the Provider was told that our results were being referred to ODHS' Surveillance and Utilization Review Section (SURS), with whom he could discuss a settlement arrangement. He was advised that he had 45 days in which to arrange a settlement, after which we would refer the overpayment to Attorney General for collection. The Provider did not contact SURS to pursue a settlement arrangement.

The Provider submitted a written response, dated June 21, 2000, in which he discussed four main areas relating to our results: Clinical Laboratory Improvement Amendment (CLIA) regulations; patient counseling; duplicate billing; and E&M codes. The Provider agreed with the issue of duplicate billings and his response indicated that he would reimburse any "duplication of billing" paid to him. However, he was not in agreement with our findings for CLIA, counseling of patients, and E&M codes:

CLIA

The Provider said that he did not understand how state Medicaid rules could differ from federal rules in terms of reimbursement for CLIA waived services. In addition, he questioned why the state would continue to pay for services if the costs of the tests were not reimbursable. Therefore, he believes that he should not have to pay back any money in this area. He did agree, however, to refrain from performing any future tests not allowed in the state Medicaid rules.

As discussed with the Provider during the exit conference and post audit meeting, states have the right to determine *which* CLIA waived services they will reimburse a provider for. It is the responsibility of the provider to know the rules in their state and to bill accordingly. Although the lab services he billed may have been listed as federally waived services, these services are not payable in Ohio as waiver services, according to the Ohio Medicaid Provider Handbook.

[14]Excluded were any services which were included in any of the previous categories of overpayment.

Counseling of Patients, ie. Psychotherapy Services

The Provider stated that this issue was previously addressed by ODHS' "Surveillance Department" (SURS), which had requested records of patients who had received counseling services. Because he was not assessed any overpayment, he considers his billings appropriate and therefore should not have to refund any monies in this area.

When the Provider brought the SURS document request to our attention during our review, we contacted SURS. We also requested written confirmation from the Provider regarding the outcome of the SURS record review. Neither party was able to provide any documentation regarding the outcome of the record review.

Additionally, when reviewing the psychotherapy services discussed in this audit, our office held discussions with SURS regarding the billing and documentation requirements for these services, and they agreed with our audit findings.

E&M Codes

In his response, the Provider stated that he did not over bill for E&M services because he spends a lot of time with his patients that is not always reflected in his patient record notes. He also discussed the makeup of his patient population, which he believes requires additional effort to understand and treat. As discussed with the Provider during our review and as explained in our report, each E&M visit code has requirements that must be met in order for a provider to bill a specific code. His notes in the patients' records did not support that these requirements had been met; therefore, we were unable to determine what actually occurred during the patients' visits.

This Provider was selected for audit because a high percentage of his E&M billings were for high level of service codes, which are reimbursed at higher rates than lower level of service codes. (See discussion in findings section). Subsequent to completion of our field work and after receiving the Provider's written response , we reviewed the Provider's billing patterns for the most recent year in which data was available (April 1, 1999 through March 31, 2000) to determine whether the Provider's billing patterns had changed as a result of our audit. The analysis showed that the percentage of high level codes (CPT codes 99204 and 99205 for new patients and CPT codes 99214 and 99215 for established patients) had decreased somewhat. High level new patient codes, which accounted for 86.2 percent of the Provider's E&M billings during our audit period, decreased to 73.9 percent for the most recent year. Correspondingly, high level established patient codes decreased from 73.6 percent to 56.8 percent of total E&M billings, respectively.

Resolution of Findings

Because the Provider's written response did not contain any new patient specific documentation to support the services provided, the finding for recovery of $197,801.27 remains unchanged.

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APPENDIX I

Table 1: Summary of Record Analysis of Unsupported Levels Established Patient E&M Services

Description	July 1, 1994 through June 30, 1997
Total *Reimbursement* for All Established Patient E&M Services (CPT code 99211, 99212, 99213, 99214 or 99215) Billed	$371,897.07
Total Number of Established E&M *Patients*	1,591
Total Number of Established E&M *Services* billed and paid	10,081
Reimbursement for Sampled Patients with billed E&M CPT code 99211, 99212, 99213, 99214 or 99215	$4,588.82
Number of Sampled *Patients* with billed CPT code 99211, 99212, 99213, 99214 or 99215	25
Number of E&M *Services* Sampled with billed CPT code 99211, 99212, 99213, 99214 or 99215	128
Dollar amount of *overpayment in reimbursement* determined for sampled patients	$1,810.24
Type of Examination	Statistical analysis using random cluster sampling
Projected Overpayment from Statistical Sample	$142,570.54
Upper Limit at 95% Confidence Level	$161,799.15
Lower Limit at 95% Confidence Level	$123,341.93

APPENDIX I

Table 2: Summary of Record Analysis of Unsupported Levels Established Patient E&M Services Billed with Psychotherapy Services

Description	July 1, 1994 through June 30, 1997
Total *Reimbursement* for Established Patient E&M Services (CPT 99213, 99214, or 99215) Billed with Psychotherapy Services (CPT 90843 or 90844) for the same date of service	$26,335.68
Total Number of *Patients* within this population	138
Total Number of *Services* within this population	316
Reimbursement for Sampled Patients within the above population	$3,247.50
Number of Sampled *Patients* within the above population	33
Number of Sampled *Services* within the above population	68
Dollar amount of *overpayment in reimbursement* determined for sampled patients	$2,042.06
Type of Examination	Statistical analysis using random cluster sampling
Projected Overpayment from Statistical Sample	$9,489.57
Upper Limit at 95% Confidence Level	$10,273.01
Lower Limit at 95% Confidence Level	$8,706.14

APPENDIX I

Table 3: Summary of Record Analysis of New Patient E&M Services

Description	July 1, 1994 through June 30, 1997
Total *Reimbursement* for All New Patient E&M Services Billed	$51,048.01
Total Number of New E&M *Patients*	944
Total Number of New E&M Patient *Services* billed	944
Reimbursement for Patients with E&M CPT code 99205	$25,873.73
Number of *Patients* with billed CPT code 99205	392
Number of *Services* with billed CPT code 99205	392
Reimbursement for Sampled Patients with billed E&M CPT code 99205	$1,729.99
Number of Sampled *Patients* with billed CPT code 99205	26
Number of E&M *Services* Sampled with billed CPT code 99205	26
Dollar amount of *overpayment in reimbursement* determined for sampled patients	$993.23
Type of Examination	Statistical analysis using random cluster sampling
Projected Overpayment from Statistical Sample	$14,974.85
Upper Limit at 95% Confidence Level	$16,368.59
Lower Limit at 95% Confidence Level	$13,581.11

APPENDIX I

Table 4: Summary of Record Analysis of Duplicate Services

Description	July 1, 1994 through June 30, 1997
Total *Reimbursement* for All Psychotherapy Services (CPT codes 90843 or 90844) Billed with Established Patient E&M Services (CPT codes 99213, 99214, or 99215) for the same date of service	$26,335.68
Total Number of *Patients* within this population	138
Total Number of *Services* within this population	316
Reimbursement for Sampled Patients from within the above population	$2,589.52
Number of Sampled *Patients* from within the above population	33
Number of Sampled *Services* from within the above population	68
Dollar amount of *overpayment in reimbursement* determined for sampled patients	$2,542.37
Type of Examination	Statistical analysis using random cluster sampling
Projected Overpayment from Statistical Sample	$11,814.54
Upper Limit at 95% Confidence Level	$12,436.25
Lower Limit at 95% Confidence Level	$11,192.84

PROVIDER REMITTANCE FORM

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

Ohio Department of Human Services
Accounts Receivable Unit
Attn.: Ms. Leslie Narcross
Post Office Box 182367
Columbus, Ohio 43218-2367

Please include your provider number on the check to ensure proper credit.

Provider:	Abdul M. Orra, D. O. 13535 Detroit Ave., Lakewood, Ohio 44107
Provider Number:	0582570
Review Period:	July 1, 1994 through June 30, 1997
AOS Finding Amount:	$197,801.27
Date Payment Mailed:	
Check Number:	

IMPORTANT: **To ensure that our office properly credits your payment, please also fax this remittance form to: Charles Carle at (614) 728-7398**.

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STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140
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800-282-0370
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ABDUL M. ORRA, M.D.

CUYAHOGA 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
JULY 25, 2000