STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Marymount Hospital

A Compliance Review by the:

Fraud, Waste and Abuse
Prevention Division

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

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Marymount Hospital
David Kribel, Administrative Director
Administrative Director of Behavior Health Services
12300 McCracken Road
Garfield Heights, Ohio 44125

Re: Medicaid Review of Provider Number #5575800

Dear Mr. Kribel:

We have completed our review of selected medical services rendered to Medicaid recipients by you for the period January 1, 1999 through December 31, 2001. We identified findings in the amount of $36,267.06, which must be repaid to the Ohio Department of Job and Family Services. A "provider remittance form" is located at the back of this report for remitting payment.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio Hospital Association. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

June 25, 2002

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ABBREVIATIONS

CPT	Physician's Current Procedural Terminology
FWAP	Fraud, Waste and Abuse Prevention (Division of)
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed a review of Marymount Hospital, Provider #5575800, doing business at 12300 McCracken Road, Garfield Heights, Ohio 44125. We identified findings amounting to $36,267.06. The findings are recoverable as they resulted from Medicaid claims submitted by the Provider for services that did not meet reimbursement rules under the Ohio Medicaid Provider Handbook and the Ohio Administrative Code (OAC).

BACKGROUND

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federally and state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients. The Ohio Department of Job and Family Services (ODJFS) administers Ohio's Medicaid program, and issues the rules and regulations that providers must follow in the Ohio Medicaid Provider Handbook. The fundamental concept of the Medicaid program is medical necessity of services: those which are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice[1].

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews designed to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172, (E), providers are required to: "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

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.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

[1] OAC Section 5101:3-1-01

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the Medicaid program.

PURPOSE, SCOPE AND METHODOLOGY

The purpose of this review was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and to calculate the amount of any finding resulting from non-compliance.

In particular, we focused on whether the Provider had proper documentation for Psychiatry Services billed during the audit period. A provider is eligible to bill Psychiatry services as long as the reimbursement requirements as outlined in the Ohio Medicaid Provider Handbook are followed.

We notified Marymount Hospital, via letter to their Administrative Director of Behavior Health Services, of our compliance review and an Entrance Conference was held on March 18, 2002 at the Behavior Health Center, Trudell Building. We performed an on-site review of medical records.

The scope of our review was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period January 1, 1999 though December 31, 2001. Our work was performed between December 2001 and May 2002 and was done in accordance with government auditing standards.

We used the Medicaid Provider Handbook and the OAC as guidance in determining the extent of services and applicable reimbursement rates. We obtained the provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using the five (5) digit Current Procedural Terminology (CPT)[2] coding system or ODJFS local level codes[3].

The Provider was reimbursed $1,701,558.70 for 38,031 services rendered during the audit period. In analyzing the Provider's claims history, we focused on claims for individual psychotherapy services (billed as CPT 90806), which accounted for $157,449.26 and 3,830 services reimbursed to the provider during our audit period. We selected CPT 90806 for review because psychotherapy services accounted for a significant portion of the Provider's reimbursements (9.25%) and claims for CPT 90806 accounted for 92 percent of the psychotherapy reimbursements.

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

[3] Local level codes are published via the Medicaid Handbook.

To facilitate an accurate and timely review of paid claims, we analyzed two statistical random samples of services billed as CPT 90806. The first sample was comprised of outpatient medical claims (Type 60 in MMIS) contained seventy-two (72) medical services billed as CPT code 90806, Individual psychotherapy services. This sample was further stratified into: 1) where only one unit of service was billed on the same day, and 2) where more than one unit of service was billed on the same day. The second sample consisted of outpatient hospital claims (Type 61 in MMIS) and contained Thirty-eight (38) services billed as CPT code 90806

FINDINGS

We identified findings amounting to $36,267.06 because the Provider improperly billed CPT code 90806 for services which were not properly documented, or which should have been billed under different codes. A discussion of the basis for our findings follows.

Psychiatry Services

According to the CPT, psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development[4]. Sections 5101:3-4-29(C), (D), and (G) of the OAC state in part:

> Services for the diagnosis and treatment of mental and emotional disorders are covered as physician services when the services are performed by a licensed social worker who is employed by or under contract with the physician or clinic as long as the services provided are within the licensed social worker's scope of practice as defined in Chapter 4757[5] of the Revised Code and:
>
> (1) The services performed by a clinical social worker are provided under the general supervision of a physician; or
>
> (2) The services performed by a licensed social worker who does not meet the requirements of a clinical social worker are provided;
>
> (a) Under the direct supervision of a physician; or
>
> (b) Under the general supervision of a physician and the direct supervision of a clinical social worker.
>
> A licensed social worker or a clinical social worker may not be directly reimbursed for services provided under the Medicaid program. Service of a licensed social worker or clinical social worker may only be billed by and reimbursed to the employing or contracting physician or clinic.

[4] CPT 1999, 2000, and 2001

[5] ORC 4757.26 states in part "A person licensed under this chapter to practice as an independent social worker or a social worker may diagnose and treat mental and emotional disorders…".

For reimbursement for services provided by a licensed social worker or CSW[6], the services must be billed using the following procedure codes:

- H5010 Psychotherapy, individual, by social worker, per hour
- H5020 Psychotherapy, group (maximum eight persons per group), by nonphysician, forty-five to fifty minutes, per person, per session.
- H5025 Psychotherapy, group (maximum eight persons per group), by nonphysician, 90 minutes or more, per person, per session.

We reviewed 110 paid services for outpatient CPT code 90806 which were billed and reimbursed to the provider. Within the 110 services reviewed, 49 services appeared to be double billed. We determined that three (2.7%) of the total services were supported by medical record documentation. We took exception with the remaining 107 services for the following reasons:

No Documentation

According to Medicaid Handbook, Chapter 3334, Section IV, Subsection B, providers are required to: "Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit is completed, whichever is longer".

- All 49 instances in which the Provider billed two units of service for the same patient for the same service on the same day appeared to be instances of double billing. These services are further delineated within each finding area.
- Documentation was not provided for one record which was also double billed.
- Two (1.8%) reimbursements were for the same service.
- Seventeen (15.4%) records were missing documentation to support that services were provided on the date in question. Seven of these were also double billed.

Inappropriate CPT Code Billed

The American Medical Association's Current Procedural Terminology definition of CPT code 90806 is:

> Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient.

Documentation reviewed did not always support the AMA's definition of CPT 90806.

- Fourteen (12.7%) services did not meet the requirements for billing CPT 90806, i.e. another code should have been billed instead or were over the maximum reimbursement allowed. In addition, seven of these services were also double billed. The services which were provided should have been billed using the following codes:

6 As of 10/1/01, Professional Counselors and Professional Clinical Counselors were added.

  - 90801 Initial Assessment,
  - 90804 30-minute Individual Psychotherapy,
  - 90846 Family Therapy with Patient Present,
  - 90847 Family Therapy without Patient,
  - Services billed over the maximum.
- One or more of these services was also double billed.

Codes Billed Should Have Been from Medicaid Handbook

OAC 5101:3-4-29 states in part LSWs (Licensed Social Workers) and CSWs (Clinical Social Workers), and LPCCs (Licensed Professional Clinical Counselors) after November 2001, must bill using "H" codes. We found LISWs and LPCCs were providing services billed as CPT code 90806.

- Twenty-four (21.8%) services were performed by LPCCs who were not eligible to bill, 16 of which were double billed.
- Fifty (45%) services were performed by LISWs rather than a physician, and should have been billed as H5010, 17 of which were double billed.

The reimbursements for these services were subsequently adjusted. As providers must bill the appropriate visit code in accordance with the Medicaid Handbook, findings for each of the above services were calculated using the difference between the amount reimbursed for each service as billed, and the reimbursement amount as appropriate per the documentation in the medical records.

Total Findings

Based on the errors found in our samples, we projected the error rates across the total population of 90806 services paid to the provider during the review period. This resulted in a projected combined finding of $36,267.06 for medical and outpatient 90806 services. This finding was calculated by projecting the correct population reimbursement amounts for medical and outpatient 90806 services from our sample results and taking the difference between them and the respective actual amount paid to the Provider during the audit period for these services.

The projected correct population reimbursement for medical 90806 services is $40,952.10 and has a 95 percent certainty that the true population value would fall within the range of $28,206.93 to $53,697.27, a precision of 31.12%. The corresponding projected correct population reimbursement amount for hospital outpatient 90806 services is $56,657.97 and has a 95 percent certainty that the true population reimbursement amount lies between $45,831.01 and $67,484.93, a precision of 19.11%. The large precision amounts in our samples led us to take the conservative approach of calculating overpayment by subtracting the upper limit of the projected correct population reimbursement from actual amount reimbursed. This resulted in a projected overpayment of $23,536.27 for medical 90806 services and $12,730.79 for hospital outpatient services, a total of $36,267.06. By taking this approach, we can state with 97.5 percent certainty that the actual finding would have been at least this amount had we reviewed all of the Provider's claims for the audit period.

PROVIDERS RESPONSE

On May 2, 2002, the draft report was delivered to Mr. David Kribel, Administrative Director of Behavioral Health Services. An exit conference was held May 6, 2002 to discuss the draft report projected overpayments for each level of service.

We discussed the possibility of additional documentation being located, which we agreed to review. A deadline for the provider's written response to the audit report was set for May 20, 2002, but was later pushed back to accommodate review of additional records located by the provider. On May 17, 2002, we reviewed documentation for two patients, which were not presented during the initial field review.

An explanation of adjusted findings and expiration of the response period took place via phone conversation with Mr. Kribel on May 23, 2002. The Provider responded on June 6, 2002, stating they were identifying root causes of the findings as a basis to implement process changes. It is their hope that identifying issues and taking measures to correct problem areas will prevent recurrence. Their changes were identified for our three areas of findings, as follows:

- Resolution for no documentation is being reviewed by an internal Medical Records Committee.
- The hospital had already implemented a new charge ticket to resolve billing with inappropriate CPT codes, which will provide the care giver with criteria to aid in assigning proper procedure codes.
- The hospital plans to re-educate coders and billers to prevent improper coding. They also plan to seek continuing education opportunities from ODJFS.

APPENDIX I

Table 1: Summary of Record Analysis of Type 60 (Medical Claim)
CPT 90806 Individual Psychotherapy Services
For the period January 1, 1999 through December 31, 2001

Description	January 1, 1999 – December 31, 2001
Total Medicaid Individual Psychotherapy Visit Services Paid	$77,233.54
Number of Individual Psychotherapy Visit Services	1,507
Type of Examination	Stratified statistical random sample of Medical Type 60 CPT 90806 services
Number of CPT 90806 Services Sampled	72
Amount Paid for Services Sampled	$7,412.14
Projected Correct Reimbursement for Population	$40,952.10
Upper Limit of Population Estimate	$53,697.27
Lower Limit of Population Estimate	$28,206.93
Overpayment Amount	$23,536.27

Table 2: Summary of Record Analysis of Type 61 (Institutional Claim)
CPT 90806 Individual Psychotherapy Services
For the period January 1, 1999 through December 31, 2001

Description	January 1, 1999 – December 31, 2001
Total Medicaid Individual Psychotherapy Visit Services Paid	$80,215.72
Number of Individual Psychotherapy Visit Services	2,323
Type of Examination	Statistical random sample of Hospital Outpatient Type 61 CPT 90806 services
Number of CPT 90806 Services Sampled	38
Amount Paid for Services Sampled	$1,744.48
Projected Correct Reimbursement for Population	$56,657.97
Upper Limit of Population Estimate	$67,484.93
Lower Limit of Population Estimate	$45,831.01
Overpayment Amount	$12,730.79

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PROVIDER REMITTANCE FORM

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

Ohio Department of Human Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider Name & Address: Marymount Hospital
12300 McCracken Road
Garfield Heights, Ohio 44125

Provider Number: 5575800

Review Period: 1/1/99 – 12/31/01

AOS Finding Amount: $36,267.06

Date Payment Mailed:

Check Number:

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

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OFFICE OF THE AUDITOR

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Telephone 614-466-4514
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Facsimile 614-466-4490

MARYMOUNT HOSPITAL

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
JUNE 25, 2002