Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Emmart Y. Hoy, D.O.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

August 7, 2003

Emmart Y. Hoy, D.O.
5797 Beechcroft Road, Suite F
Columbus, Ohio 43229

Re: Medicaid Audit of Emmart Y. Hoy, DO
Provider Number 0623687

Dear Dr. Hoy:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period October 1, 1999 through September 30, 2002. We identified findings in the amount of $25,071.59, 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. The attached report details the basis for the findings.

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 the report date, 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 Medical Board. If you have any questions, please contact Cynthia Callender, Chief, 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

TABLE OF CONTENTS

ABBREVIATIONS

AOS	Auditor of State
CMS	Centers for Medicare and Medicaid Services
CPT	Physician's Current Procedural Terminology
E&M	Evaluation and Management Services
HCCA	Health Care and Contract Audit Section
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
ORC	Ohio Revised Code

This Page Intentionally Left Blank

SUMMARY OF RESULTS

The Auditor of State performed a audit of Emmart Y. Hoy, D.O., Provider #0623687, doing business at 5797 Beechcroft Road, Suite F, Columbus, Ohio 43229. Our audit was performed at the request of the Ohio Job and Family Services in accordance with 117.10 of the Ohio Revised Code (ORC). As a result of this audit, we identified findings amounting to $25,071.59, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) 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 (OMPH). 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 audits to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

Pursuant to Ohio Administrative Code Section 5101:3-1-17.2(D), 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."

Pursuant to Ohio Administrative Code Section 5101:3-19.8(F) "overpayments are recoverable by the department at the time of discovery

In addition, OAC Section 5101:3-1-29(A) 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."

OAC Section 5101:3-1-29(B)(2) "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 over utilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program.

[1] OAC Section 5101:3-1-01(A) and (A)(1)

PURPOSE, SCOPE AND METHODOLOGY

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

We notified the Provider by letter that they had been selected for a compliance audit and an Entrance Conference was held on January 17, 2003 at the Providers' place of business. A second follow up audit was conducted on February 10, 2003.

The scope of our audit was limited to claims not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 1999 through September 30, 2002. The Provider was reimbursed $352,239.91 for 14,687 services rendered on 9,564 recipient dates of service during the audit period. A recipient date of services is defined as all services received by a particular recipient on a specific date.

We used the OMPH, OAC and ORC 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].

To facilitate an accurate and timely audit of the Provider's medical services, we analyzed a statistically random sample of 159 recipient dates of service, containing a total of 383 services.

We initially focused on claims for Evaluation and Management (E&M) services because they accounted for a significant portion of the Provider's reimbursements and services: $281,961.45 (80 percent of total reimbursements during our audit period) and 9,250 services (63 percent of total services). An Evaluation and Management service is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient.

In the course of auditing claims for E&M services, we identified issues involving unsupported levels of E&M services, procedure codes inclusive of each other that were billed for the same recipient and date of service, and missing/insufficient documentation, which are discussed in detail in the findings section of this report.

We also analyzed paid claims in MMIS for duplicate payments to the Provider. We defined duplicate claims as one or more claims with the same date of services, patient, procedure code, procedure code modifier and reimbursement amount. We did not find any duplicates during our analysis of the Provider's MMIS data.

Our work was performed between October 2002 and February 2003 and was done in accordance with government auditing standards.

[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 in the Ohio Medicaid Providers Handbook.

FINDINGS

We identified findings of $25,071.59 in three areas: Unsupported level of service billings, comprehensive procedure codes incorrectly billed together, and missing documentation. The circumstances leading to the findings are discussed below.

Unsupported Level of (E&M) Service Billings

An Evaluation and Management service is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient. Pursuant to the Medical Provider Handbook, Section 1101.2, provider must select and bill the appropriate visit (E&M service level) code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M service.

The descriptors used to determine levels of E&M service involve seven components:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The key components[4] in selecting a level of E&M service billed are history, examination and medical decision-making – the more complex the services involving these components, the higher the level of service billed and the more a provider is reimbursed. 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.

Section 5101:3-4-06(B) of the Administrative Codes states the Providers must select and bill the appropriate visit (E&M service level) code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M service.

We found 21 of 383 services where the level of service billed was not supported by the level of service documented in the patient's medical record or supported by the required components as established by the CPT. Patient records for these services contained minimal information for the history, exam and medical decision making. Without proper supporting documentation, we could not verify the required level of service was provided. Therefore, the Provider was not entitled to bill the higher level E&M codes. We adjusted the 21 E&M codes billed to ODJFS to an appropriate lower level E&M code, and the difference is repayable to ODJFS.

4 Other contributory factors are counseling, coordination of care, and nature of the presenting problem. The component, time, is not considered a key or contributory component.

Comprehensive Procedure Codes Incorrectly Billed Together

Section 5101:3-4-07(D) (1) of the Administrative Code states:

A "family planning visit" is any visit performed for the purpose of providing a family planning service. The visit may be performed either by a physician and/or a health professional or social service professional qualified under the Revised Code. The visit may or may not include a physical examination.

In our sample of 383 services, 34 services were for family planning office visits, of which 25 services were billed as procedure code X1451 and 9 services were billed as procedure code X1453. Pursuant to OAC 5101:3-4-07(D)(2), the two CPT codes are defined as follows:

> X1451: Family planning counseling is a visit conducted by a health professional other than a physician, such as a registered nurse or a trained medical/psychiatric or social worker, regarding medical history, medical complaints, general reproductive health, genetic problems, and contraceptive methods.
>
> X1453: Gynecological examination performed by a physician is a visit in which a physical examination including, at a minimum, a audit of the medical history, pelvic examination, height, weight and blood pressure, is performed in conjunction with family planning services. The visit also includes, when appropriate, all or a combination of the following services: breast examination, collection of a pap smear, collection of vaginal smears or cultures, evaluation and interpretation of laboratory procedures, checking an IUD, contraceptive counseling, genetic counseling, and the prescription of contraceptive pharmaceuticals and supplies.

We are taking exception with claims for 28 family planning visit services, along with four E & M office visit services. The Provider incorrectly billed for a family planning visit along with an E&M office visit, when the latter already covers services provided during a family planning visit.

In the case of 25 services, the Provider billed for both the family planning visit code X1451 and an E&M office visit code, but the patient medical records did not indicate that services beyond an office visit were performed. In addition, the physician was the only health professional in the practice, and in order to bill for the family planning code, the OAC states that this service is "conducted by a health professional other than a physician, such as a registered nurse or a trained medical/psychiatric or social worker, regarding medical history, medical complaints, general reproductive health, genetic problems, and contraceptive methods". The E&M codes billed for the 25 services were:

> 99202 Expanded history & exam; office/outpatient; new, 1 occasion,
> 99203 Detailed history & exam; office/outpatient; new, 3 occasions,
> 99212 Focused history & exam; office/outpatient; established, 9 occasions,
> 99213 Expanded history & exam; office/outpatient; established, 10 occasions,
> 99214 Detailed history & exam; office/outpatient; established, 2 occasions.

As a result, we accepted the billing of the above E & M office visit codes, but disallowed all 25 billings of the family planning code X1451.

In addition, the Provider billed the family planning visit code X1453 for nine services in conjunction along with the following E & M office visit codes. The E&M codes billed for the nine services were:

99203 Detailed history & exam; office/outpatient; new , 1 occasion,
99213 Expanded history & exam; office/outpatient; established, 1 occasion,
99214 Detailed history & exam; office/outpatient; established, 7 occasions.

For six of the nine X1453 services, the patient records supported that a gynecological service occurred, justifying the billing for X1453. However, for the remaining three services, the patient records did not indicate that services beyond an office visit were performed. Therefore, for these three services, we accepted the billing of the E & M office visit code, but disallowed billings of the family planning code X1453. In addition, for four of the nine E&M services, we disallowed the claim for the E & M service because patient files did not support that any service beyond a gynecological exam occurred.

Missing Documentation

Pursuant to Ohio Administrative Code Section 5101:3-1-17.2(D), 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.

We found that 7 of 383 services in our audit were missing documentation to support that services were actually provided on the date of service billed to ODJFS. Because the Provider did not maintain the required documents, we were unable to confirm that the services were actually rendered. Therefore, reimbursements made to the Provider for all 7 services are repayable to ODJFS.

Summary of Findings

In summary, we took exception to 60 of the 383 services included in our sample of 159 recipient dates of service. Table 1 shows the basis for exception and the number of services related to each exception.

Table 1: Summary of Exceptions from Sample Audit of Provider Records for the Period October 1, 1999 – September 30, 2002

Basis for Exception	Number of Services with Exceptions
Unsupported Level of E&M Services Billings	21
Comprehensive Procedure Codes Incorrectly Billed Together	32
Missing Documentation	7
Total Services with Exceptions	60

We calculated the amount of overpayment by projecting the correct payment amount for the sampled 159 recipient dates of services across the total population of 9,564 recipient dates of service paid to the Provider and subtracting the estimated correct population payment amount

from the actual amount paid to the Provider. The projected correct population payment amount was $327,168.32 with a 95 percent certainty that the actual correct amount fell with a range of $312,876.09 to $341,460.55 (+/- 4.37 percent). This resulted in a projected finding of $25,071.59. Appendix I provides additional details about our findings calculation.

Provider's Response to our Findings

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on June 4, 2003. The Provider's legal representative sent us a written response on June 17, 2003, followed by additional documentation to support some of claims for services we took exception with. We also met with the Provider and his legal representative on July 2, 2003 to further discuss the bases for our findings. As a result of additional information supplied by the Provider, we reduced our findings from $28,373.38 to $25,071.59. These findings are repayable to the Ohio Department of Job and Family Services.

APPENDIX I

Summary of Record Analysis of Emmart Y. Hoy, DO
For the period October 1, 1999 to September 30, 2002

Description	Audit Period October 1, 1999 – September 30, 2002
Type of Examination	**Statistical Random Sample of 159 Recipient Dates of Services**
Number of Population Recipient Date of Services	**9,564**
Number of Population Services Provided	**14,687**
Number of Recipient Date of Service Sampled	**159**
Number of Services Sampled	**383**
Amount Paid for Services Sampled	**$11,291.83**
Total Medicaid Amount Paid During Audit Period	**$352,239.91**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$312,876.09**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$39,363.82**
Upper Limit Correct Population Payment Amount at 95% Confidence Level	**$341,460.55**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$10,779.36**
Point Estimate of Correct Population Payment Amount	**$327,168.32**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$25,071.59**

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

This Page Intentionally Left Blank

PROVIDER REMITTANCE FORM

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

Ohio Department of Job and Family Services
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Emmart Y. Hoy 5797 Beechcroft Road, Suite F Columbus, Ohio 43229
Provider Number:	#0623687
Audit Period:	October 1, 1999 through September 30, 2002
AOS Finding Amount:	$25,071.59
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: Thomas M. Tedeschi at (614) 728-7389.

This Page Intentionally Left Blank

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

EMMART Y. HOY, DO

FRANKLIN 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 7, 2003