
**Auditor of State**
**Betty Montgomery**

# Ohio Medicaid Program

## *Audit of Medicaid Provider Reimbursements Made to Family Health Care Center, Inc.*

*A Compliance Audit by the:*

**Fraud and Investigative Audit Group**
**Health Care/Contract Audit Section**

**Auditor of State**
**Betty Montgomery**

October 02, 2003

Family Health Care Center, Inc.
William L. Washington, MD
2800 West Broad Street
Columbus, Ohio 43204

Re: Medicaid Audit of Family Health Care Center Inc.
Provider Number: 0516516

Dear Dr. Washington:

We have completed our audit of selected medical services rendered to Medicaid recipients by Family Health Care Center, Inc. for the period October 1, 1999 through September 30, 2002. We identified findings in the amount of $47,177.15 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 receipt of this report, this matter will be referred to the Ohio Attorney General for collection.

A courtesy copy of this report is also being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, 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

# TABLE OF CONTENTS



## ABBREVIATIONS

| | |
|---|---|
| AOS | Auditor of State |
| CMS | Centers for Medicare and Medicaid Services |
| CPT | Current Procedural Terminology |
| E&M | Evaluation and Management Service |
| HCCA | Health Care/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 |
| PA | Physician Assistant |

**This Page Intentionally Left Blank**

## *SUMMARY OF RESULTS*

The Auditor of State performed a audit of Family Health Care Center, Inc., Provider #0516516, doing business at 2800 West Broad Street, Columbus, Ohio 43204. Our audit was performed at the request of the Ohio Department of Job and Family Services in accordance with 117.10 of the Ohio Revised Code (ORC). As a result of this audit, we identified findings in the amount of $47,177.15, 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."

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

In 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 results in an unnecessary cost to the Medicaid program.

## *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.

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

We notified the Provider by letter that they had been selected for a compliance audit. An entrance conference was held on January 31, 2003 at the Provider's place of business. Follow up site visits to review provider records were conducted on February 13, 2003 and August 13, 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 $627,228.81 for 24,539 services rendered on 15,404 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Medicaid Provider Handbook, OAC and ORC as guidance in determining the extent of covered services and applicable reimbursements. We obtained the Provider's claim 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 143 recipient dates of service, containing a total of 420 services. We initially focused on claims for Evaluation and Management (E&M) services because they accounted for a significant portion of the Provider's reimbursement $505,743.45 (80.6%) and services 15,071 (61.4%.) 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 also identified several issues involving services provided by physician assistants. A provider is eligible to bill for services provided by a registered physician assistant (PA) as long as the reimbursement requirements outlined in the OMPH are followed.

We also analyzed the paid claims in MMIS for duplicate payments to the Provider. We defined duplicate payments as more than one claim with the same date of service, patient, procedure code, procedure code modifier and reimbursement amount. This analysis did not identify any duplicate payments, however, our sample did identify two instances of duplicate payments of a different nature as explained in the report.

In addition, we looked at 100 percent of HealthChek visits where a recipient, over the age of two, had more than one HealthChek visit in a calendar year. A "HealthChek" visit is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT), which is a federally-mandated program of comprehensive preventive health services available to Medicaid-eligible persons

[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 Provider Handbook.

from birth through twenty years of age. This special HealthChek group consisted of 9 recipients with a total of 19 services. These 19 HealthChek services were segregated from the rest of the 24,539 services and the random sample to avoid double counting of the results.

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

## *FINDINGS*

We identified $46,902.91 in findings from our statistical sample for billings in two areas: evaluation and management services and physician assistant services. We also identified findings totaling $274.24 in the Preventative HealthChek area, for a total finding of $47,177.15. The circumstances leading to the findings are discussed below.

## Unsupported Level of E&M 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. Pursuant to the Medicaid Provider Handbook, Section 1101.2, providers must select and bill the appropriate visit E&M service level code in accordance with the CPT code definitions and the CPT instruction for selecting a level of E&M services.

The description used to determine levels of E&M services 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 to bill 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 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.

Of the 420 services in our sample, we found 21 services billed at the 99215, 99214, 99213, 99205, and 99204 levels that were not supportable because the patients' medical records did not contain the required level of service components for those CPT codes. For 16 services, the

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

documentation supported the next lowest level of service (e.g. 99213 instead of 99214), and for 5 services, the documentation supported two levels lower (e.g. 99212 instead of 99214). The following are examples of service levels we took exception with:

- The patient complained of ankle pain and asked questions about her menstrual cycle – both preexisting conditions. The physician refilled two prescriptions and advised the patient to elevate her ankle. We re-coded the service from the 99213 level to the 99212 level because the patient record lacked evidence of two of three key components for 99213: an expanded problem focused history, a problem focused examination, and a low complexity of decision making.

- The patient complained of back pain, seizures and asthma. The patient record showed that patient vitals had been taken (temperature, blood pressure, pulse rate), noted a "tenderness to palpate", and showed a prescription for pain killers was written. We re-coded the service from 99214 to 99212 because the patient record lacked evidence of two of three key components for 99214: a detailed history, a detailed exam, and a moderate complexity of decision making.

When calculating our findings, we reduced the allowable payment for the 21 services to a level supported by documentation in the patient record.

## Missing Documentation

Section 5101:3-1-27(A) of the Administrative Code states:

> All Medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of services provided to Medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services, the secretary of the federal department of health and human services, or the state Medicaid fraud control unit upon request.

Section 5101:3-1-27(C) of the Administrative Code states:

> Records, documentation and information must be available regarding any services for which payment has been or will be claimed to determine that payment has been or will be made in accordance with applicable federal and state requirements. For the purpose of this rule, an invoice constitutes a business transaction but does not constitute a record, which is documentation of a medical service.

We found that five of the 420 services in our audit were missing documentation to support billing to ODJFS. Because the Provider did not maintain the required documents, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these five services.

## Duplicate Billings

Pursuant to Section 5101:3-1-19.8(F) of the Administrative Code overpayments, duplicate payments, or payments for services not rendered are recoverable by the department at the time of discovery.

We disallowed two of the 420 services in our audit because they duplicated another service paid for the same patient on the same date of service. One services involved two different E&M services billed for the same patient on the same date of service. The Provider billed a 99213 expanded history & exam and a 99214 detailed history & exam for the same patient on the same day. The patient's record only supported that one service, the 99213, was performed, so we disallowed the 99214 service.

The other duplicate service disallowed involved duplicate bills for a diagnostic study. Our audit of the patient record determined that only one diagnostic study was performed, therefore we took exception with the second billed service.

## Insufficient Documentation

We found one of the 420 services audited did not have sufficient documentation to support the billing of medical services to ODJFS. The Provider billed a 99212 E&M service, which requires a relatively moderate level of examination, patient history and medical decision-making. However, the patient record contained no progress notes to indicate that a history and exam occurred, or that a medical decision had occurred. Without this type of information, the Provider was not eligible to bill for an E&M service.

## Physician Assistant (PA) Services

According to ORC 4730.01(A), "Physician assistant" means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

The Provider had one standard physician assistant utilization plan on file with the Ohio State Medical Board and submitted notice when bringing new PA's on staff. We audited the utilization plan and the listing of PA's rendering services to Medicaid patients during our audit period to determine if physician assistant services had been billed in accordance with Medicaid rules.

### Physician Assistant Services Billed for Established Patients without Required Modifier

OMPH Chapter 3336, Physician Services, Section 1125(A) states in part:

> A physician may be reimbursed for the following procedures provided by a physician assistant under his/her employment if the services are set forth in his/her application of registration and approved by the Medical Board. An established physician visit…

> When the procedures listed in paragraph (A) (above) are performed by a physician assistant, reimbursement will be the provider's billed charges or 85 percent of the Medicaid maximum whichever is less. For reimbursement, the physician must bill to the department using the five-digit CPT code followed by the modifier AU.

Our audit of the 420 services showed 33 services had been provided by a physician assistant and billed without using the appropriate AU modifier. Since these services had all been reimbursed at the Medicaid maximum amount, we reduced them by 15% to adjust the payments to that due for services provided by a PA.

**Physician Assistant Billed for New Patient Services**

The OMPH Chapter 3336, Physician Services, Section 1125(C)(5), states that a physician, physician group practice, or clinic may not be reimbursed for *initial* office visits provided by a physician assistant. According to OAC 5101:3-4-03(B)(4) a patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.

An audit of the 420 services rendered showed four services had been provided to "new" patients by a physician assistant. Because new patients must be seen by a physician, we disallowed the entire payment for these four services.

**Physician Assistant Saw Established Patients with New Conditions**

Pursuant to OMPH Chapter 3336, Physician Services, Section 1125(B)(1)(a), states that services/procedures provided by a physician assistant under the supervision and direction of his/her supervision physician are covered if the services are listed as standard functions for a physician assistant approved by the state medical board as described in 4731-4-01 of the Administrative Code.

According to OAC 5101:3-4-03(B)(5) an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition. In addition, OAC 5101:3-4-03(B)(7) states that in each situation described in (B)(5) of this rule, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed management with the physician assistant. Furthermore, a physician assistant is prohibited from making a diagnosis of a disease or ailment or prescribe any treatment or regimen not previously set forth by the supervising physician according to OAC 4731-4-04(A) and (B).

Our audit of the 420 randomly selected services rendered showed three services performed by the physician assistant for established patients with new conditions without the supervising physician evaluating and discussing the management of the condition with the physician's assistant or documenting the patient's medical record. We therefore disallowed these three services in their entirety.

## Summary of Findings

In summary, we identified 69 exceptions in our sample of 420 services. Table 1 shows the basis for the exceptions.

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

| Basis for Exception | Number of Exceptions |
|---|---|
| **Unsupported Level of E&M Service Billed** | 21 |
| **Missing Documentation** | 5 |
| **Duplicate Billing** | 2 |
| **Insufficient Documentation** | 1 |
| **Physician Assistant Services** | |
| Physician Assistant Billed for Established Patient w/o Required Modifier | 33 |
| Physician Assistant Billed for New Patient Services | 4 |
| Physician Assistant Saw Established Patients with New Condition | 3 |
| **Total Exceptions** | 69 |

Note: The 69 exceptions represent exceptions taken with 60 services. This occurred because we took two exceptions with bills submitted for nine services. Each of these services had been provided by a physician assistant and billed without the required modifier, and was billed at level higher than supported by documentation in patient records.

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

We calculated the amount of overpayment by projecting the correct payment amount for the sample 143 recipient dates of service across the total population of 15,400 recipient dates of service paid to the Provider and subtracted the estimated correct population payment amount from the actual amount paid to the Provider. The projected correct population payment amount was $579,232.86, with a 95 percent certainty that the actual correct payment amount fell within the range of $535,503.44 to $622,962.28 (+/-7.55 percent). This resulted in a projected finding of $46,902.91.

## Multiple HealthChek (EPSDT) Screenings in a Calendar Year

A preventative "HealthChek" visit is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT) which is a federally-mandated program of comprehensive preventive health services available to Medicaid-eligible persons from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. The scope of the services provided to an individual depends on the age, gender, family medical history, and ethnic background of the patient; and any abnormalities encountered during a "HealthChek" (EPSDT) service.

Section OAC 5101:3-14-04(B)(3) states:

One screening service per calendar year may be provided from the individual's second birthday through the day before the individual's twenty-first birthday. If any of the screenings described in paragraph (B)(1) of this rule are given in the calendar year in which the child reaches his/her

second birthday, another screening may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year.

From the MMIS claims history data we identified nine recipients over the age of two with a total of 19 HealthChek screening services within the same calendar year. We audited the patient records and found that nine of the 19 HealthChek screening were multiple services provided in the same calendar year to the same recipient. These nine services were down-coded to the appropriate E&M visit level of service provided to the patient. In addition, 1 of the HealthChek screenings was disallowed because there was no documentation in the patient's medical record to show that the service had been performed. Therefore, we took exception with 10 of the 19 HealthChek services amounting to $274.24 in additional findings.

Table 2 details the basis for exception with 10 of the 19 services included in our HealthChek screening audit.

**Table 2: Summary of Exceptions from HealthChek Audit of Provider Records For the Period October 1, 1999 – September 30, 2002**

| Basis for Exception | Number of Services with Exceptions |
|---|---|
| **Multiple HealthChek (EPSDT) Screenings in a Calendar Year** | 9 |
| **No Documentation to Show Service Performed** | 1 |
| **Total HealthChek Services with Exception** | 10 |

## Provider's Response to our Findings

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on July 1, 2003. The Provider sent us a written response on July 11, 2003, followed by additional documentation to support some of the claims for services we took exception with. We also returned to the Providers place of business to review further documentation before finalizing our findings. As a result of additional information supplied by the Provider, we reduced our findings from $76,256.35 to $47,177.15. These findings are repayable to the Ohio Department of Job and Family Services.

## APPENDIX I

### Summary of Sample Record Analysis of Family Health Care Center, Inc. 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 143 Recipient Dates of Service |
| Number of Population Recipient Date of Services | 15,400 |
| Number of Population Services Provided | 24,520 |
| Number of Recipient Date of Service Sampled | 143 |
| Number of Services Sampled | 420 |
| Amount Paid for Services Sampled | $13,814.30 |
| Total Medicaid Amount Paid During Audit Period | $626,135.77 |
| Lower Limit Correct Population Payment Amount at 95% Confidence Level | $535,503.44 |
| Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount) | $90,632,33 |
| Upper Limit Correct Population Payment Amount at 95% Confidence Level | $622,962.28 |
| Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount) | $3,173.49 |
| Point Estimate of Correct Population Payment Amount | $579,232.86 |
| Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level | $43,729.42 (7.55%) |
| Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount) | $46,902.91 |

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

### Summary of Audit Findings for Family Health Care Center, Inc. For the Audit Period October 1, 1999 to September 30, 2002

| Description of Audit Finding | Dollar Amount of Finding |
|---|---|
| Evaluation & Management Services Physician Services & Physician Assistant Services | $46,902.91 |
| Preventative HealthChek Services | $274.24 |
| Total Audit Findings | $47,177.15 |

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:** | Family Health Care Center, Inc.<br>William L. Washington, MD<br>2800 West Broad Street<br>Columbus, Ohio 43204 |
| **Provider Number:** | 0516516 |
| **Audit Period:** | October 1, 1999 through September 30, 2002 |
| **AOS Finding Amount:** | $47,177.15 |
| **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 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

**FAMILY HEALTH CARE CENTER, INC.**

**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**
**OCTOBER 9, 2003**