Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Martin M. Hajjar, MD

A Compliance Audit by the:

Health Care and Contract Audit Section

August 2003 **AOS/HCCA-04-002C**

Auditor of State
Betty Montgomery

August 5, 2003

Martin M. Hajjar, MD
Northern Adams Medical Center
17862 State Route 247
Seaman, Ohio 45679

Re: Medicaid Audit of Martin M. Hajjar, MD
Provider Number 0997417

Dear Dr. Hajjar:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period January 1, 1999 through December 31, 2001. We identified findings amounting to $83,778.42, which must be repaid to the Ohio Department of Job and Family Services. The attached report details the basis for the findings.

Our understanding is that your legal representative has approached the Ohio Department of Job and Family Services to arrange repayment. Your cooperation in this matter is appreciated. Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment arrangements are not made with the Ohio Department of Job and Family Services within 45 days of the date of this report, this matter will be referred to the Ohio Attorney General's office for collection. A provider remittance form is also located at the back of this report for remitting payment.

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 State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Chief, Fraud and Investigative Audit Group at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

TABLE OF CONTENTS

SUMMARY OF RESULTS 1

BACKGROUND 1

PURPOSE, SCOPE AND METHODOLOGY 2

FINDINGS 3
- Physician Services 3
  - Missing Documentation 3
  - Unsupported Level of Evaluation and Management Billings 3
  - Documentation That Changed After Our First Field Audit 4
- Physician Assistant Services 5
  - Physician Assistant Billed for New Patient Services 6
  - Physician Assistant Billed for Established Patients without Required Modifier 6
  - Physician Assistant Saw Established Patients with New Conditions 6
- Summary of Findings 7
- Provider's Response to our Findings 7

APPENDIX I 9

PROVIDER REMITTANCE FORM 11

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
PA	Physician Assistant

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Martin M. Hajjar, MD, Provider #0997417, doing business at 17862 State Route 247, Seaman, Ohio 45679. 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 $83,778.42, 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."

OAC Section 5101:3-1-29(B)(1) "Fraud" is defined as an intentional deception, false statement or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or another person. It includes any act that constitutes fraud under applicable federal or state law. If fraud is suspected or apparent, referral of the case to the attorney general's Medicaid fraud control unit and/or the appropriate enforcement officials will be made.

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 any non-compliance.

We notified the Provider by letter that they had been selected for a compliance audit and an Entrance Conference was held on November 8, 2002 at the Providers' place of business. A second follow up audit was conducted on November 14, 2002.

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 January 1, 1999 through December 31, 2001. The Provider was reimbursed $188,113.21 for 8,382 services rendered on 4,296 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 services and applicable reimbursement rates. 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, dates of service, and services 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 140 recipient dates of service, representing 269 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 $139,452.44 (74.1%) and services 3,983 (47.5%). 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 instructions for selecting a level of E&M service.

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 registered physician assistants (PA's) as long as the reimbursement requirements outlined in the OMPH are followed.

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 service, patient, procedure code, procedure code modifier and reimbursement amount. We did not find any duplicates during our analysis of the Provider's data.

[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

Additionally, we analyzed the Provider's pharmacy claims for our audit period. Pharmacy claims history records revealed that the Provider wrote 65,158 prescriptions (including refills) during this period, with reimbursement to dispensing pharmacies totaling $3,305,181.44. We did not identify any issues with prescriptions during our analysis of the Provider's data.

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

FINDINGS

We identified findings of $83,778.42 relating Physician Services and Physician Assistant Services. These findings are based on exceptions we took with 188 (70 percent) of the 269 services in our sample. The circumstances leading to the findings are discussed below.

Physician Services

From our sample of 269 services, we took exception with 88 services that related to Physician Services. The basis for our exceptions fell into three areas: Missing Documentation, Unsupported Level of Evaluation and Management Services, and Documentation Changes.

Missing Documentation

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

> "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 the services provided to Medicaid consumers, and to document significant business transactions.

Patient records for 16 of the 269 services sampled in our audit did not contain documentation showing that services were provided on the dates billed to ODJFS. These services included office visits (see definition of Evaluation and Management services below) and ancillary services associated with these visits (lab tests, shots, etc.). 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 16 services are repayable to ODJFS.

Unsupported Level of Evaluation and Management Billings

An Evaluation and Management service is a face-to-face encounter (typically an office visit) with a patient by the physician for the purpose of medically evaluating or managing the patient. Pursuant to Section 5101:3-4-06(B) of the Administrative Code and Section 1101.2 of the Medical Provider Handbook, a 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 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 codes 99211 through 99215.

We found that 29 of the 269 services in our sample did not have sufficient documentation to support the level of medical services billed to ODJFS. These services were billed as E&M services at the 99213 and 99214 levels, which require a relatively high level of examination, patient history and medical decision-making. Patient records for these services contained only minimal information, such as a note on the patient's chief complaint with basic vitals on weight and/or blood pressure, but did not contain progress notes to indicate that a history and exam occurred or a medical decision had occurred. 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 29 E&M codes billed to ODJFS to an appropriate lower level E&M code, and the difference is repayable to ODJFS.

We also took exception with reimbursements for another 35 services billed in conjunction with the above E&M codes. These services were for injections, lab work and surgical procedures. Patient records did not show that the physician ordered the services, or that the services had been performed. Because we were unable to confirm that the Provider ordered and/or performed the services, we determined that reimbursements for all 35 services are repayable to ODJFS.

Documentation That Changed After First Field Audit

Section 5101:3-1-17.2 (D) of the Ohio Administrative Code states that providers are required:

"To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

A key component of this rule is that a provider may not create supporting records after receiving payment for a service, since the records would not have been present "from the date of receipt of payment".

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.

Following an initial field audit, our procedure is to allow providers additional time to locate documentation that was not made available. Providers are advised not to change, add, or create new documentation for any of the recipient medical records (services) selected for audit.

Following our initial field audit, we scheduled a second field audit to review documentation that was not made available during the initial audit. A listing of missing recipient data was provided to the Provider prior to our arrival for the second visit. This listing inadvertently included patient records for eight services previously copied during our initial field visit. After analyzing new information obtained from the Provider, we found that documentation for the eight services had been augmented or changed, such that we observed instances of different patient complaints, patient vital statistics (weight, blood pressure, etc.) and/or progress notes. We made this determination by comparing the new information received from the Provider with copies we had made from the initial field audit. Because documentation for the eight services had been added or created following our initial field audit, we did not accept the documentation as support for claims submitted by the Provider for reimbursement and determined that reimbursements made to the Provider are repayable to ODJFS.

In responding to a draft of this report, the Provider's legal representative stated: "…neither Dr. Hajjar nor anyone in his office changed, altered, or "created" any documentation after the Auditor's field visits." The legal representative further stated, "The simple explanation is that physician intakes were inadvertently completed twice for the same patient during extremely busy times and the filing system in place at the time allowed for misplaced documentation." The representative went on to say our instructions to look for additional documentation that may have been misplaced and not located in the patient charts caused a significant amount of filing that occurred following our initial visit and resulted in the location of the second record.

We believe an inadvertent duplication of intake records is inconsistent with the changes in patients' vitals and patient complaints that we saw from one set of the records to the next. At a minimum, we believe these variations in patient data pose questions about the quality of patient care, given the difficulty one would have assembling an accurate patient history. Therefore, we are still taking exception with the eight services in question.

Physician Assistant Services

According to ORC 4730-01(A), a "Physician assistant" is 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.

Out of our sample of 269 services, we took exception with 100 services that were provided by a Physician Assistant employed by the Provider. The basis for the exceptions are discussed below.

Physician Assistant Billed for New Patient Services

The OMPH Chapter 3334, 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 269 services rendered showed 54 services had been provided to "new" patients by physician assistants. Therefore, we determined that reimbursement for these services are repayable to ODJFS.

Physician Assistant 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 269 services showed 43 services had been provided by a physician assistant and billed without using the appropriate AU modifier.

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 Ohio 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 269 randomly selected services showed three services performed by the physician assistant for established patients with new conditions that did not include documentation of the supervising physician's involvement.

Summary of Findings

In summary, we took exception with 188 of the 269 services included in our sample of 140 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 January 1, 1999 – December 31, 2001

Basis for Exception	Number of Services with Exceptions
Physician Services	
Missing Documentation	16
Unsupported Level of Evaluation and Management Billings	29
Ancillary Services Billed in Conjunction with Unsupported E&M Codes	35
Documentation That Changed After First Field Audit	8
Physician Assistant (PA) Services	
Physician Assistant Billed for New Patient Services	54
Physician Assistant Billed for Established Patients w/o the Required Modifier	43
Physician Assistant Saw Established Patients with New Conditions	3
Total Services with Exceptions	188

We calculated the amount of overpayment by projecting the correct payment amount for the sampled 140 recipient dates of service (totaling 269 services) across the total population of 4,296 recipient dates of service paid to the Provider and subtracting the estimated correct population payment amount from the actual amount paid to the Provider. This resulted in a projected finding of $97,854.25, with a 95 percent certainty that the actual findings fell within a range of $83,778.42 to $111,930.08. Because this range, a 15.59 percent spread, is larger than we require when projecting a sample result, we are making a finding for $83,778.42, which is the lower amount of our range. We believe that using the lower amount is conservative because we can state with 97.5 percent certainty that the actual finding would have been at least this amount had we audited all of the Provider's services for the audit period.

Provider's Response to our Findings

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on April 10, 2003. On May 7, 2003, we received additional information from the Provider's legal representative that resulted in a reduction in findings from $85,582.74 to $83,778.42. We also added information to reflect the Provider's position on certain items. Subsequently, the Provider's legal representative indicated that they had approached ODJFS to arrange repayment of the findings.

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APPENDIX I

Table 2: Summary of Record Analysis of Martin M. Hajjar, MD
For the period January 1, 1999 to December 31, 2001

Description	Audit Period January 1, 1999 – December 31, 2001
Type of Examination	Statistical Random Sample of 140 Recipient Dates of Service
Number of Population Recipient Date of Services	4,296
Number of Population Services Provided	8,382
Number of Recipient Dates of Service Sampled	140
Number of Services Sampled	269
Amount Paid for Services Sampled	$6,171.03
Total Medicaid Amount Paid During Audit Period	$188,113.21
Lower Limit Correct Population Payment Amount at 95% Confidence Level	$76,183.13
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	$111,930.08
Upper Limit Correct Population Payment Amount at 95% Confidence Level	$104,334.79
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	$83,778.42
Point Estimate of Correct Population Payment Amount	$90,258.96
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	$97,854.25

Note: Our Finding is $83,778.42 because the range around our point estimate ($97,854.25) is larger than we required when projecting a sample result. Therefore, we are using the lower amount of our range.

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

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

Provider:	Martin M. Hajjar, MD
	Northern Adams Medical Center
	17862 State Route 247
	Seaman, Ohio 45679
Provider Number:	#0997417
Review Period:	January 1, 1999 through December 31, 2001
AOS Finding Amount:	$83,778.42
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.

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Auditor of State
Betty Montgomery

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P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

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MARTIN M. HAJJAR, MD

ADAMS 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 5, 2003