Auditor of State
Betty Montgomery

Ohio Medicaid Program

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

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

July 20, 2004

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

Re: Audit of Medicaid Provider Number 0582570

Dear Dr. Orra:

We have completed our audit of selected medical services rendered to Medicaid patients by you for the period July 1, 2000 through December 31, 2002. We identified findings in the amount of $56,022.86 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 Rev.Code 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 State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director, 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

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

This Page Intentionally Left Blank.

SUMMARY OF RESULTS

The Auditor of State performed an audit of Abdul M. Orra, D.O. (hereafter called the Provider), Provider #0582570, doing business at 13535 Detroit Ave., #4; Lakewood, OH 44107. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified findings amounting to $56,022.86 based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet general principles regarding reimbursement for Medicaid covered services.[1] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Ohio Adm.Code 5101:3-1-17.2(D) 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."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in pertinent part: "…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..."

Ohio Adm.Code 5101:3-1-29(B)(2) states: " '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 overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program."

[1] *See Ohio Adm.Code 5101:3-1-01 (A) and (A)(6)*

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 finding resulting from non-compliance. The Provider is identified within the Medicaid program as an individual osteopathic physician in general practice.

Following a letter of notification, we held an entrance conference with the Provider on October 1, 2003 to discuss the audit scope. The scope of our audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of July 1, 2000 through December 31, 2002. The Provider was reimbursed $222,929.77 for 7,090 services rendered during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH 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 Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2]

Prior to beginning our field work, we performed computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for services to deceased patients or whether duplicate payments were made for the same recipient on the same date of service. The test for services to deceased patients was negative. However, our test for duplicate payments was positive. These potential duplicate payments were extracted for a separate 100 percent review, and monetary findings were identified.

To facilitate an accurate and timely test of the Provider's remaining reimbursements, we selected a stratified statistical sample of 96 recipient dates of service, which included 228 services, from the population of 4,812 recipient dates of service (7,090 services) without potential duplicate payments. A recipient date of services is defined as all services received by a particular recipient on a specific date.

Our work was performed between March 2003 and April 2004.

[2] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

FINDINGS

We identified a projected finding of $55,849.59 from the services in the sampled population. This finding resulted from:

- levels of E&M services that were not supported by the documentation in patient records
- services which were not documented in the patient records

Additionally, we identified a finding of $173.27 for patients with duplicate services billed. Together these findings totaled $56,022.86. The reasons for these findings are discussed below.

Unsupported Services in Sample

During our review of statistically selected patients' medical records we found exceptions with:

- levels of E&M services
- lack of documentation for services billed
- family planning services billed on same date as E&M services, when only one of the services was documented
- non-work related physical examinations for adults billed with diagnosis code V72.85, other specified examination

Unsupported Level of E&M Service Billings

Ohio Adm.Code 5101:3-4-06(A)(1) and (B) state in part respectively:

> …an "evaluation and management (E&M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient…
>
> 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.

The American Medical Association descriptors for levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

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

The ***key*** components in selecting an appropriate 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.

Counseling, coordination of care, and the nature of presenting problem are considered ***contributory*** factors in the majority of encounters. Time is not considered a key nor contributory factor in selecting a level of service.

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. For new patient E&M services the provider must perform all three of these components as defined by the CPT: history, examination and medical decision making. For established patient E&M services, the provider has to perform as least two of these key components as defined by the CPT: history, examination, or medical decision making.

The Provider was paid $202,950.91 for E&M services, which comprised 91 percent of the total reimbursement for the audit period. All levels of new and established patient office E&M codes were billed by the Provider.

Thirty percent ($60,981.20) of the Provider's E&M reimbursements were for detailed level code 99214; and about 10 percent ($20,016.88) were for comprehensive level code 99215. Therefore, almost 40 percent of E&M services were coded at the highest two levels of established patient services.

We found the level of service billed for 40 E&M services in our sample of 228 services was not supported by the level of service documented in the patients' medical records, or the documentation did not contain the required components as established by the CPT code book.

The following are examples of unsupported levels of E&M services found in our sample:

1. The Provider was paid for an established patient comprehensive E&M office visits (CPT code 99215). To bill this code at least two of these three key components are necessary:

   - A comprehensive history.
   - A comprehensive examination.
   - Medical decision making of high complexity.

   Documentation in the patient's medical record contained the patient's blood pressure, weight, orders for laboratory tests, and diagnoses. There was no documentation of any patient history and there were no examination notes in the documentation reviewed.

   Therefore, the level of E&M service was reduced to a CPT code 99211, since the documentation did not contain at least two of the required key components.

2. The Provider was paid for a new patient detailed E&M office visit (CPT 99203). To bill this code the provider must provide these three key components:

   • A detailed history.
   • A detailed examination.
   • Medical decision making of low complexity.

   The documentation in the patient's medical record contained the patient's complaint, weight, temperature, and the diagnosis was listed as "physical". There was no documentation of any patient history and there were no examination notes in the documentation reviewed. Therefore, a finding was made on the total amount reimbursed to the Provider for this service, since the documentation did not contain all three required key components.

To calculate our findings for the statistical sample, we took the difference between the reimbursement for the unsupported level of E&M service and the maximum allowed reimbursement for the level of E&M service supported by the documentation in the patients' medical records. The results are summarized on page 7.

Lack of Documentation

Ohio Adm.Code 5101:3-1-17.2(D) states 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.

Our review of the medical records for the statistically sampled patients found that 16 of 228 services in our sample lacked proper documentation. Either the medical records reviewed did not contain documentation for the service billed, or the documentation indicated that someone other than the Provider performed the service.

The reimbursement allowed to the Provider for these 16 services was reduced to zero ($0.00), and these errors were used in calculating the overpayment of the sample population.

Unsupported Family Planning Services Billed for the Same Date of Service as E&M Services

Ohio Adm.Code 5101:3-4-07(D)(1) and (2) state in pertinent part:

> (1) A family planning visit is any visit performed for the purpose of providing a family planning service. . . .

(2) For the reimbursement of family planning visits, providers may bill one of the following local level HCPCS codes:

> …X1453 Gynecological examination performed by a physician is a visit in which a physical examination including, at a minimum, a review of the medical history, pelvic examination, height, weight and blood pressure, is performed in conjunction with family planning services. . .

Ohio Adm.Code 5101:3-4-06 (B) states:

> 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.
>
> ***

There were two instances in our sample of 228 services where the Provider billed for a family planning visit and an E&M visit on the same date of service. Review of the patients' medical records showed:

(1) The criteria for family planning visit were not met and therefore the reimbursement for code X1453 was disallowed.

(2) The criteria for the E&M level billed were not met; therefore, a finding was made on the difference between the reimbursement made for the level billed and the maximum allowed for the E&M level documented in the patients' medical records.

Disallowed Billing for Non-Work Related Physical Examinations

Ohio Adm.Code 5101:3-4-28 states in pertinent part:

> The following physician services are noncovered:
>
> ***
>
> (C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups with the following exceptions: . . .
>
> > ***
> >
> > (10) Required physicals for employment or for participation in job training programs . . . Documentation to support that the physical was performed for employment must be in the patient's medical records.

There was one instance in our sample of 228 services, of the Provider billing for an E&M service with a diagnosis code of V72.85 (other specified examination). Our review of the medical record showed the service was a non-work related physical for an adult. Therefore, a finding was made for the amount of the reimbursement to the Provider for this service.

Summary of Sample Findings

We took exception with part or all of the reimbursements made to the Provider for 59 (or 26 percent) of the 228 services that were included in our sample of 96 recipient dates of service. To calculate the amount overpaid to the Provider, we projected the correct payment amount for the 96 recipient dates of service in our stratified sample across the total population of 4,812 recipient dates of service paid to the Provider and then subtracted the estimated correct population payment amount from the actual amount paid to the Provider. The projected correct population payment amount was $167,080.18 with a 95 percent certainty that the actual correct payment amount fell within the range of $191,327.22 to $144,167.66 (approximately +/- 14 percent). Subtracting the projected correct population amount ($167,080.18) from the actual amount paid to the Provider for these services during our audit period ($222,929.77) resulted in an estimated overpayment of $55,849.59 (point estimate).

Duplicate Billings

Pursuant to Ohio Adm.Code 5101:3-1-19.8 (F):

> "Overpayments are recoverable by the department at the time of discovery…"

Services where potential duplicate billing had occurred were excluded from the statistical sample and population of recipient dates of service and separately examined in their entirety.

Our testing identified two patients where on four occasions the Provider billed and was paid twice for identical services on the same date of service. The medical records documented that the services were only provided once. Therefore, we identified findings of $136.83, which represents the amount reimbursed for the second (duplicate) billing of the services.

In addition, the documentation in these patients' medical records for the service actually provided did not support the level of E&M service billed. The documentation supported a lower level E&M office visit. Therefore, in accordance with Ohio Adm.Code 5101:3-4-06 (B) a finding of $36.44 was made for the difference between the reimbursement for the unsupported levels of E&M service billed and the maximum allowed reimbursement for the levels of E&M service supported by the documentation in the patients' medical records.

Total findings for the four instances of duplicate billings were $173.27.

AUDITEE'S RESPONSE

A draft report was mailed to the Provider on January 29, 2004 in order to afford him an opportunity to provide additional documentation or otherwise respond in writing.

On February 11, 2004, during the exit conference, the Provider supplied copies of medical records for patients where findings had been made for lack of documentation. The Provider requested and was given an extension to provide further documentation and/or a written response. On March 26, 2004, we received additional documentation from the Provider. The documentation was reviewed and adjustments were made.

As a result of the additional supporting documentation supplied by the Provider, we reduced our findings from $61,486.98 to $56,022.86. These findings are repayable to the Ohio Department of Job and Family Services.

We also asked the Provider to prepare an action plan addressing how the deficiencies identified in our report would be corrected. On June 28, 2004, the Provider's legal representative told us the Provider had implemented processes to address the issues raised in our report, but would not be submitting a formal corrective action plan. Therefore, we are referring this matter to ODJFS' Surveillance and Utilization Review Section for their follow up.

APPENDIX I

Summary of Sample Record Analysis for Abdul M. Orra, D.O.
Population: Paid Services (Without Duplicate Payments)
For the period July 1, 2000 to December 31, 2002

Description	Audit Period July 1, 2000 – December 31, 2002
Type of Examination	Statistical Stratified Random Sample
Description of Population	All paid services net of any adjustments and excluding Medicare Cross-over payments
Number of Population Recipient Date of Services	4,812
Number of Population Services Provided	7,090
Total Medicaid Amount Paid For Population	$222,929.77
Number of Recipient Date of Services Sampled	96
Number of Services Sampled	228
Amount Paid for Services Sampled	$7,885.83
Estimated Correct Sub-population Payment Amount	$167,080.18
Upper Limit Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	$191,327.22
Lower Limit Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	$144,167.66
Estimated Overpayment (Point Estimate) = Actual Amount Paid Less Estimated Correct Sub-population Payment Amount.	$55,849.59
Upper Limit Overpayment Estimate at 95% Confidence Level = Actual Amount Paid Less Lower Limit Estimate of Correct Sub-population Payment Amount.	$78,762.11
Lower Limit Overpayment Estimate at 95% Confidence Level = Actual Amount Paid Less Upper Limit Estimate of Correct Sub-population Payment Amount.	$31,602.55
Precision of Correct Population Payment Estimate at 95% Confidence Level	$24,247.04 (14.51%) upper limit $22,912.52 (13.71%) lower limit

This Page Intentionally Left Blank.

AUDITEE 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

Auditee Name & Address: Abdul M. Orra, D.O.
13535 Detroit Ave., #4
Lakewood, Ohio 44107

Auditee Number: 0582570

Audit Period: 07/01/00 – 12/31/02

AOS Finding Amount: $56,022.86

Date Payment Mailed: _____

Check Number: _____

IMPORTANT:
To help ensure that your payment is properly credited, please also fax copies of this remittance form and your check to our office at (614) 728-7398, ATTN: Health Care and Contract Audit Section.

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

ABDUL M. ORRA, D.O.

CUYAHOGA COUNTY

CLERK'S CERTIFICATION

This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
JULY 20, 2004