Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Selson Clinics, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

June 29, 2006

Barbara Riley, Director
Ohio Department of Job and Family Services
30 E. Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Selson Clinics, Inc.
Provider Number: 0635914

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Selson Clinics, Inc. for the period April 1, 2001 through March 31, 2004. We identified $125,106 in findings that are repayable to the State of Ohio. We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make any final determinations regarding recovery of the findings and any interest accruals.

Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers and Section 117.10 of the Ohio Revised Code. The specific procedures employed during this audit are described in the scope and methodology section of this report.

Copies of this report are being sent to Selson Clinics Inc., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also available on the Auditor's web site (www.auditor.state.oh.us).

If you have questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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TABLE OF CONTENTS

ACRONYMS

AMA	American Medical Association
CPT	Current Procedural Terminology
E&M	Evaluation and Management
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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Selson Clinics, Inc. (hereafter called the Provider), Provider #0635914, doing business at 1930 State Route 59, Kent, Ohio 44240. 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 $125,106.00 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook (OMPH).

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make a final determination regarding recovery of the findings[1] and any interest accruals.[2]

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 requirements for reimbursement of Medicaid covered services.[3] 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 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

[1] *Ohio Adm.Code 5101:3-1-19.8(F) states: "Overpayments are recoverable by the department at the time of discovery…"*

[2] *Ohio Adm.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made", which in the Provider's case was March 31, 2004, the latest payment date in the random sample used for analysis.*

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

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 over utilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a physician group with a specialty in neurology.

Following a letter of notification, we held an entrance conference at the Provider's place of business on May 23, 2005 to discuss the purpose and scope of our audit. 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 April 1, 2001 through March 31, 2004. The Provider was reimbursed $438,450.88 (excluding Medicare crossovers) for 6,411 services rendered on 3,150 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 Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of services and applicable reimbursement rules. We obtained the Provider's paid 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).[4]

Prior to beginning our field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for:

4 *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.*

- Potentially duplicate payments where multiple payments were made for the same recipient, on the same date of service, for the same procedure codes, the same procedure modifier codes, and for the same dollar amount.

- Payments made for services to deceased patients for dates of service after their date of death.

- Potentially inappropriate service code combinations on claims.

The test for services to deceased patients was negative, but both the exception tests for duplicate payments and the tests for inappropriate service code combinations were positive. While performing our audit field work, we reviewed the Provider's supporting documentation for all services identified by our exception analyses with potential payment issues.

To facilitate an accurate and timely audit of the Provider's medical services not identified for review by our exception tests; we also analyzed a stratified statistically random sample of 152 recipient dates of service (RDOS). A recipient date of service is defined as all services received by a particular recipient on a specific date. Our initial review of the sample services identified a pervasive problem with neuromuscular junction testing. As a result, all affected services were backed out of our sample and the population of services being sampled, and treated as a separate exception test. This segregation of services reduced the number of services in our final sample from 578 to 544, but did not reduce the number of RDOS. This sample was drawn from the sub-population consisting of 3,148 RDOS (6,266 services) totaling $420,298.26.

Our work was performed between June 2004 and December 2005.

FINDINGS

We identified and projected findings of $107,937 for the services in the sampled population. Additionally, we identified findings of $17,169.00 for services in our exception testing. Together, our findings totaled $125,106.00. The bases for our results are discussed below.

Results of Statistical Sample

Our review of randomly selected patients' medical records found exceptions with undocumented medical services, incorrectly billed units of service, and incorrectly billed levels of evaluation and management (E&M) services. Findings from this sample were projected to the sub-population of services remaining after removal of Medicare cross-over payments and services identified by our exception testing for 100 percent review. The projected overpayment finding from our sample was $107,937. The bases for this finding are given below.

Undocumented Medical Services

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> "…A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> ***
>
> (D) 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.

We determined that 90 services lacked documentation to support the service billed. These services had the following documentation problems:

- Eighty-eight (88) services lacked documentation in the patients' medical records to verify that the services were provided.
- Two (2) services were billed using an incorrect CPT code for the service documented in the patients' medical records.

Findings were made on the amount reimbursed to the Provider for services that lacked proper documentation. Findings were calculated by taking the difference between the amounts reimbursed to the Provider for the service billed and the Medicaid maximum amount allowed for the service documented. The total of these reductions ($6,883.86) was used in calculating the findings for the sample population.

Unsupported Level of Evaluation and Management Service Billings

Ohio Adm.Code 5101:3-4-06(A)(2) 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 except for code 99211 which does not require the presence of a physician.
>
> Providers must select and bill the appropriate visit (E&M service level) code in accordance with the code definitions and the CPT instructions for selecting a level of E&M service.

The American Medical Association (AMA) defines CPT codes that are used to bill for medical services. E&M office visit services for new patients are billed using CPT codes 99201 through 99205; while E&M office visit services for established patients are billed using CPT 99211 through 99215. For new patient E&M services the provider must perform all three key components – examination, medical decision making, and history. For established patient E&M

services, the provider has to perform at least two of the key components. As the complexity of services involving these key components increases, so does the level of service a provider is entitled to bill and the corresponding reimbursement.

The Provider was paid $107,060.98 for E&M office visits (99201 – 99215), which comprised 24 percent of the total reimbursement for the audit period. The high-level E&M office visit codes 99205, 99214, and 99215, accounted for $102,439.14 or 95.6 percent of the Provider's total E&M reimbursement for the audit period.

We found the level of service billed for 52 of the E&M sampled services was not supported by the documentation in the patients' medical records. We recoded these services to the level supported by the medical documentation and took the difference between the amount paid for the service billed and the maximum Medicaid payment allowed for the recoded level of service. These differences ($1,930.28) were used in calculating findings for the sampled population.

In addition, the Provider billed for consultation office visits using CPT code 99245 which is described in the AMA's CPT book as:

> Office consultation for a new or established patient, which requires these three key components:
> - a comprehensive history;
> - a comprehensive examination;
> - and medical decision making of high complexity.
>
> Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

According to the CPT book, a consultation service is requested by another physician, and a written or verbal request for the services is to be documented in the patient's medical record. Also any service performed, or ordered by the consultant physician must be documented in the medical record and a written report must be sent to the requesting physician.

A consultation service which is not initiated by a physician but by a patient, or their family, is not reported using the initial consulting codes but may be billed using office visit or confirmatory consultation codes, as appropriate.

There were 11 billed consultation services in our sample where a physician request and/or a written report of findings were missing from the patients' medical records. As the requirements of a consultative visit were not meet, we reduced the visit to the appropriate level of an office visit service.

Findings of $500.85 were calculated by taking the difference between the reimbursement for the consultative service and the allowed Medicaid maximum for the level of office visit service documented in the patients' medical records.

The total sample finding of $2,431.13 for E&M service-related issues was used in projecting findings for the sampled population.

Incorrectly Billed Units of Service

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part 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…

We compared the units of service billed for injectable medications, neurobehavioral status examinations, and physical therapy, to the total documented in the patient medical records. In 75 instances, we found the amount documented in the medical records was less than the number of units billed by the Provider.

Findings were calculated by taking the difference between the amount reimbursed to the Provider for the number of units billed and the Medicaid maximum allowed charge for the number of units documented in the patients' medical records. The total of this difference $2,443.78 was used in calculating the findings for the sampled population.

Summary of Sample Findings

The overpayments identified for 130 of 152 recipient dates of service (228 of 554 services) from our stratified statistical random sample were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of $118,902 with a 95 percent certainty and a precision of plus or minus $13,065 (10.99 percent). Since this projection did not fully meet all criteria that our procedures require for use of a point estimate, the results were re-stated as a single tailed lower limit estimate (equivalent to method used in Medicare audits), and a finding was made for $107,937. This allows us to say that we are 95 percent certain that the population overpayment amount is at least $107,937. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of Exception Testing

Our exception testing consisted of a sample review of neuromuscular junction testing (CPT code 95937) services.

Neuromuscular Junction Testing Not Supported by Documentation

AMA's 2003 Current Procedural Terminology (CPT) Coding book defines CPT 95937 as:

> Neuromuscular junction testing (repetitive stimulation, paired stimuli), each nerve, any one method

Also, as noted above, Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part 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…

Patient records in our sample lacked documentation to support the billing for neuromuscular junction tests. We asked the Provider to submit documentation to verify the performance of these tests and were told documentation was not available because test results are normally reviewed on a computer screen instead of being printed. In addition, we were told that the computerized results for all tests had not been retained.

Since no documentation was available to verify that services were performed, we disallowed 100 percent of the reimbursement the Provider received for the 118 CPT 95937 services billed during the audit period. This resulted in a finding of $15,861.58.

Duplicate Payments

Ohio Adm.Code 5101:3-1-17.2(A) states in pertinent part that providers are required:

> To... submit claims only for services actually performed...

Our testing identified 11 instances where the Provider billed and was paid twice for identical services on the same date of service for the same patient. A review of patients' medical records only supported that the services were performed once. Therefore, we disallowed the second duplicated payment for each duplicate pair resulting in a finding of $1,307.42.

Summary of Findings

A total of $125,106.00 in combined findings resulted from our statistical sample ($107,937) and our 100 percent exception testing (17,169.00).

Management Comment

While reviewing the selected services in our sample, we reviewed documentation in patients' medical records for epidural and/or nerve block services. We noticed that all of the results were documented using the same template, with only the patient name, date of service, and spinal level differing. The dosage, medication, and amount of medication injected into the patients were the same.

The Provider told us that the amount of medication injected is sometimes greater than what is documented in the patient medical record, as he does not intend to bill for the extra medication.

Also, patients receiving spinal injections may receive valium that the Provider states is not documented in the medical records.

When physicians sign their "provider agreement" in order to render services to Medicaid recipients, they agree to fully document the extent of services rendered to those patients. We are concerned that some patient records did not accurately reflect the services actually rendered to each patient. We conveyed our concern to the Provider during a discussion with him, and he acknowledged that he needed to fully document the extent of services.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on January 3, 2006 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider submitted a response dated February 6, 2006 along with additional documentation. Based upon our review of the additional documentation, we revised our findings from $140,450.88 to $125,106.00. We also sent a detailed response to the Provider's February 6 letter on June 15, 2006 and met with the Provider's counsel on June 20, 2006 to further discuss the bases for our findings.

APPENDIX I

Summary of Sample Record Analysis for Selson Clinics, Inc. Population
For the period April 1, 2000 to March 31, 2004

Description	Audit Period April 1, 2000 – March 31, 2004
Total Medicaid Amount Paid For Non Medicare Cross-Over Payments	$438,416.98
Type of Examination	Statistical Stratified Random Variable Sample
Description of Sub-Population Sampled	All paid services net of any adjustments, excluding duplicates, exceptions, and Medicare Cross-over payments
Number of Population Recipient Dates of Service	3,148
Number of Population Services Provided	6,266
Total Medicaid Amount Paid For Sub-Population Sampled	$420,298.26
Number of Recipient Dates of Service Sampled	152
Number of Services Sampled	544
Amount Paid for Services Sampled	$43,372.65
Estimated Overpayment using Point Estimate	$118,902
Precision of Overpayment Estimate at 95% Confidence Level	+/-$13,065 (10.99%)
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits).	$107,937

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SELSON CLINICS, INC.

PORTAGE COUNTY

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

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
JUNE 29, 2006