Auditor of State
Betty Montgomery

Ohio Medicaid Program

Independent Auditor's Report on Medicaid Reimbursements Made to Ironton Medical Rehab, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

October 14, 2004

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

Re: Audit of Ironton Medical Rehab, Inc.
Provider Number: 2070351

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Ironton Medical Rehab, Inc. for the period July 1, 2000 through June 30, 2003. We identified $223,251.47 in findings that are repayable to the State of Ohio. 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.

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 identified herein. We have advised Ironton Medical Rehab, Inc. that if our findings are not repaid to ODJFS within 45 days of the date of this report, this matter can be referred to the Ohio Attorney General's office for collection in accordance with Section 131.02 of the Ohio Revised Code.

As a matter of courtesy, a copy of this report is being sent to Ironton Medical Rehab, 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

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

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ACRONYMS

AMA	American Medical Association
CLIA	Clinical Laboratory Improvement Amendments
CMT	Chiropractic Manipulative Treatment
CPT	Current Procedural Terminology
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Ironton Medical Rehab, Inc. (hereafter called the Provider), Provider #2070351, doing business at 213 South 6th St., Ironton, OH 45638. 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 $223,251.47 in repayable findings, 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 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 results 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 Medicaid rules. Within the Medicaid program, the Provider is listed as a physical medicine and rehabilitation group practice.

Following a letter of notification, we held an entrance conference with the Provider on January 22, 2004 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 July 1, 2000 through June 30, 2003. The Provider was reimbursed $585,178.72 for 27,081 services rendered on 12,818 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 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 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:

- Billing physical therapy services without the proper license certification.
- Billing radiology services in excess of the allowed two units of services.
- Billing multiple units of radiology services for the same recipient, the same date of services for the same procedure code and modifier.
- Billing laboratory services without the proper Clinical Laboratory Improvement Amendment (CLIA) certification.
- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and the same payment amount.

[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.*

The exception tests identified potentially inappropriate service combinations in each category. Therefore, when performing our audit field work, we requested the Provider's supporting documentation for all related reimbursement claims.

To facilitate an accurate and timely audit of the Provider's remaining medical services; we also extracted and analyzed a statistically random sample from the subpopulation of services not already identified with potential exceptions. This sample consisted of 160 recipient dates of services, containing a total of 278 services. Our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between September 2003 and February 2004.

RESULTS

We identified $222,054.47 in findings from our exception tests and $1,197.00 in projected findings from our statistical sample. The circumstances leading to the findings are discussed below:

Results of Exception Tests

The following presents the results of our exception tests.

Improper Billing for Physical Therapy Services

Ohio Adm.Code 5101:3-8-02 states:

> (A) Definitions:
>
> > (1) "Physical therapy and rehabilitation services" means covered therapeutic modalities and/or procedures prescribed by a physician which require the skilled services of a licensed professional to restore a patient's loss of function through therapy. Rehabilitation services are for medical conditions which are expected to improve within a reasonable and predictable period of time.
>
> ***
>
> (D) Physical therapy and rehabilitation services provided by a physical therapist, physical therapy group practice, or clinic which meet the provisions specified in rule 5101:3-4-02 of the Administrative Code may be reimbursed, only if the following conditions are met:
>
> ***
>
> > (3) The services billed must be directly and specifically related to a written plan of treatment determined by the physician to be medically necessary and reasonable for the treatment of the patient's condition.

(a) The written plan of treatment incorporates specific treatment or procedures that are expected to result in improvement of the documented limitation in a reasonable and generally predictable period of time;
(b) The plan of treatment must be reviewed by a physician at least every thirty days;
(c) Changes in the plan of treatment must be noted in the patient's record; and
(d) The services billed must correspond to the services listed in the written plan of treatment.

(4) The patient's plan of treatment must include but is not limited to:
(a) Specific physical therapy treatment modalities and procedures which will be used;
(b) The patient's diagnosis;
(c) Goals;
(d) The expected duration/length of the treatment;
(e) The frequency of services;
(f) The level or degree of improvement expected for a designated period of time; and
(g) The amount and frequency of all modalities, procedures, and services.

Ohio Adm.Code 5101:3-4-02 states:

(A) Direct and general physician supervision

(1) "Direct supervision" in the physician's office, group practice, or clinic setting means that the physician must be present in the office suite throughout the time the nonphysician is providing the service and immediately available to provide assistance and direction throughout the time the nonphysician is performing services. Direct supervision does not mean the physician must be in the same room while the nonphysician is providing services. The availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct supervision.

***

(B) Services performed under direct supervision

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(2) Services provided under direct supervision are covered only if the following conditions are met:

***

> (d) The service must be furnished in connection with a covered physician service which was billed to the department. Therefore, the patient must be one who has been seen by the physician, and
>
> (e) There must have been a personal professional service furnished by the physician to initiate the course of treatment on which the service being performed is an incidental part. In addition, there must be subsequent services by the physician of a frequency that reflects his/her continuing participation in the management of the course of treatment.
>
> ***
>
> (D) When services are provided by nonphysicians, the service rendered must be within the nonphysician's scope of licensure (if licensure is required) or a service for which the nonphysician is legally authorized to provide under Ohio law and documented in the patient's medical records. The records must be reviewed and countersigned by the supervising physician...
>
> ***

We identified 537 recipients with 11,529 physical therapy services (billed as CPT codes 97001, 97010, 97012, 97014, 97032, 97035, 97110, 97140, and 97750) that were provided by nonphysicians. We reviewed the credentials of the individuals providing these physical therapy services for the Provider and determined that they were unlicensed. The Provider acknowledged that the rehab technician was not a licensed physician or physical therapist; but asserted that the services were being provided by a "qualified exercise physiologist" with a Bachelor of Arts degree in Exercise Science. The Provider also claimed that the billing for these services was appropriate because the person providing the services was directly supervised by a physician. According to the Provider, direct supervision occurred by virtue of the supervising physician's office being across the hallway from where the services were provided.

However, patient files failed in whole or in part to meet other Ohio Administrative Code requirements:

- The requirement that there must have been a personal professional service furnished by the physician to initiate the course of treatment and that there must be subsequent services by the physician of a frequency that reflects his/her continuing participation in the management of the course of treatment [see Ohio Adm.Code 5101:3-4-02(B)(2)(e) above];
- The requirement that patient records must be reviewed and countersigned by the supervising physician [see Ohio Adm.Code 5101:3-4-02(D)]; and
- The requirement that physical therapy services will only be reimbursed if the services are directly and specifically related to a written plan of treatment determined by the physician; and that the plan of treatment must specify the physical therapy treatment modalities and procedures that will be used, the amount and frequency of all modalities,

> procedures, and services; and the level or degree of improvement expected for a designated period of time [see Ohio Adm.Code 5101:3-8-02(D)(3)]; and Ohio Adm.Code 5101:3-8-02(D)(4)].

Because patient records we reviewed showed limited or no physician involvement and did not meet all of the above requirements, we took exception with all 11,529 physical therapy services, resulting in findings of $174,505.98.

Billing Radiology Services in Excess of the Allowed Two Units of Service

Ohio Adm.Code 5101:3-8-11(D) states:

> ***
>
> (2) Diagnostic x-rays to determine the existence of a subluxation are covered with certain limitations. Two units of service, as defined below will be covered during any six-month period unless otherwise stated. For purposes of this rule, the six-month period begins on the date the diagnostic x-ray is taken and ends one hundred eighty days from the date. The covered units of service are as follows:
>
> (a) Spine, entire; survey study, anterior-posterior, and lateral. Only two units per one year (three hundred and sixty five days) period are covered.
> (b) Spine, cervical; antero-posterior, and lateral.
> (c) Spine, cervical; antero-posterior, and lateral; minimum of four views
> (d) Spine, cervical; antero-posterior, and lateral; complete, including oblique and flexion and/or extension studies.
> (e) Spine, thoracic; anterior-posterior, and lateral views.
> (f) Spine, thoracic; complete, including obliques; minimum of four views.
> (g) Spine, thoracolumbar; antero-posterior lateral views.
> (h) Spine, lumbosacral; antero-posterior, and lateral views.
> (i) Spine, lumbosacral; complete, with oblique views; and
> (j) Spine, lumbosacral; complete, including bending views.
>
> ***
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> ***

We identified 252 recipients with 287 radiology services involving 574 units of service that exceeded the allowable number of units that can be billed during a six-month period. Therefore, we took exception with these services because they exceeded the allowed two units during a six-month period, resulting in findings of $15,964.80.

Upcoded Radiology Services

The American Medical Association's CPT Manual Radiology Guidelines section (page 265 of the 2004 edition) states the following number of x-ray views is required to bill a particular CPT code:

***Spine and Pelvis
72010 Radiologic examination, spine, entire, survey study, anteroposterior and lateral
72020 Radiologic examination, spine single view, specify level
72040 Radiologic examination, spine, cervical; two or three views
72050 Radiologic examination, spine; minimum for four views
72052 Radiologic examination, spine; complete, including oblique and flexion and/or extension studies
72069 Radiologic examination, spine, thoracolumbar, standing (scoliosis)
72070 Radiologic examination, spine; thoracic, two views
72072 Radiologic examination, spine; thoracic, three views
72074 Radiologic examination, spine; thoracic, minimum of four views
72080 Radiologic examination, spine; thoracolumbar, two views
72090 Radiologic examination, spine, scoliosis study, including supine and erect studies
72100 Radiologic examination, spine, lumbosacral; two or three views
72110 Radiologic examination, spine, lumbosacral; minimum of four views

We identified 85 recipients with 228 radiology services involving 278 units of service where the Provider billed codes that indicated more x-ray views were taken than were supported by documentation. For all 228 radiology services, the documentation supported billing a code for a lesser number of views. Therefore, we recoded these 228 radiology services to an appropriate radiology level.

When calculating our findings, we reduced the allowable payment for all 228 radiology services to the level supported by the CPT codes and identified a finding for the difference between the amount originally paid and the amount paid at the recoded level. This resulted in findings of $5,088.94.

Billing Erroneous Multiple Units of Radiology Services

As noted immediately above, the American Medical Association's CPT Manual Radiology Guidelines specifies the required number of x-ray views for each radiology CPT code.

We identified 466 recipients with 947 radiology services involving 1,910 units of service where the Provider billed multiple units of service for the same patient on the same date of service. A review of the Provider's billing procedures and supporting documentation showed that the Provider billed units of service according to the number of views taken, which is counter to CPT code definitions and resulted in an overpayment. Therefore, we took exception with 947 radiology services involving 963 units of service, resulting in findings of $26,015.24. The following are examples of the exceptions:

- The Provider billed four units of service for the same patient on the same date of service for CPT 72110 ~ Radiology examination, spine, lumbosacral; minimum of four views. For this billing, we reduce the four units of service to one unit of service.
- The Provider billed two units of service for the same patient on the same date of service for CPT 72070 ~ Radiology examination, spine, thoracic, two views. For this billing, we reduced the two units of service to one unit of service.
- The Provider billed four units of service for the same patient on the same date of service for CPT 72050 ~ Radiologic examination, spine, cervical; minimum of four views. For this billing, we reduced the four units of service to one unit of service.

Billing Laboratory Services Without Proper CLIA Certification

Ohio Adm.Code 5101:3-11-02(A) states:

> ***
>
> (2) Laboratory services may also be provided and billed by any medicaid provider who is certified to perform laboratory procedures under CLIA…
>
> ***
>
> (4) The type of certification required for participation is dependent on the type of tests the laboratory performs: waivered tests, PPMP tests, moderate complexity (formerly level I) tests or high complexity (formerly level II) tests. Current CLIA regulations contain the lists of covered procedures that are categorized as waivered tests or PPMP tests and the HCPCS codes that must be billed by providers only possessing a certificate of waiver or a PPMP certificate…
>
> > (a) Providers who possess only a certificate of waiver will be restricted to performing and billing for the procedures listed in the current CLIA regulations.
> >
> > ***
>
> ***

The Provider had one CLIA certificate on file with the Ohio Department of Health that allowed the Provider to perform waivered tests. We reviewed the CLIA certificate to determine if the Provider had billed in accordance with medicaid rules during the audit period.

We identified 17 recipients with 17 services, where the Provider billed for laboratory services that are not allowed under the tests granted waivered status under CLIA. For 14 services, the Provider billed CPT 86677~ Antibody; Helicobacter Pylori; and for the remaining three services the Provider billed CPT 88150 ~ Cytopathology Cervical/Vagina (Pap) Screen Int <3 Smears. Because the Provider's certification did not allow them to perform these tests, we took exception with all 17 services, resulting in findings of $309.60.

Duplicate Billings

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

We identified eight duplicate billings involving the same patient, the same procedure code, and the same date of service. Because the medical records supported that only one service was rendered, we took exception with the eight duplicative billings, which amounted to $169.91 in findings.

Summary of Exception Testing

We took exception with 13,016 of the 13,024 paid services that were segregated from the sampled population for complete examination. Table 1 summarizes the exceptions found by reason.

Table 1: Summary of Exception Services
For Services Identified by Exception Tests for 100 Percent Review
For the Period of July 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions	Amount of Overpayment
Improper Billing for Physical Therapy Services	**11,529**	**$174,505.98**
Billing Erroneous Multiple Units of Radiology Services	**947**	**$26,015.24**
Billing Radiology Services in Excess of the Allowed Two Units of Service	**287**	**$15,964.80**
Upcoded Radiology Services	**228**	**$5,088.94**
Billing Laboratory Services Without Proper CLIA Certification	**17**	**$309.60**
Duplicate Billings	**8**	**$169.91**
Total Services with Exceptions	**13,016**	**$222,054.47**

Source: AOS analysis of the Provider's MMIS claims history

Results of the Sample Analysis

Our analysis of the Provider's supporting documentation for a stratified sample of medical services (160 recipient dates of services with 278 total services) identified exceptions in the following areas:

- Evaluation and management services where the documentation in the patient medical record did not support the level of service billed.
- Services where documentation could not be found to support that the services had been performed.
- A duplicate billing where two separate chiropractic service procedure codes were billed for the same recipient on the same day.

Unsupported Levels of Evaluation and Management Services

An Evaluation and Management service is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient. 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 code definitions and the CPT instructions for selecting a level of E&M service.
>
> ***

The American Medical Association's CPT Manual Instructions for Selecting a Level of E/M Service section (page 5 of the 2004 edition) states the following: The descriptors for the 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 problem.
- Time.

***

The key components[3] 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 the provider is reimbursed. E&M services for new patients are billed using CPT 99201 through 99205 while E&M services for established patients are billed using CPT 99211 through 99215.

Of the 278 services in our sample, we found five services billed at the CPT 99215 level that were not supportable because the patient medical records did not contain the required level of service components for the CPT codes billed. For the five services, the documentation supported two levels lower (e.g. CPT 99213 instead of 99215). The following are examples of service levels we took exception with:

- The patient was in for medication refills. The medical record showed that the patient's blood pressure and pulse were taken, an expanded problem focused exam was performed, and medication refills were given. We recoded the service from CPT 99215 to 99213 because the patient record lacked evidence that at least two of three key components for CPT 99215: a comprehensive history, a comprehensive examination, or decision making of high complexity; had been performed.

[3] *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 components.*

- The patient was in for follow-up on x-ray report. The medical record showed that the patient's blood pressure and pulse were taken and an expanded problem focused exam was performed. We recorded the service from CPT 99215 to 99213 because the patient record lacked evidence that at least two of three key components for CPT 99215: a comprehensive history, a comprehensive examination, or decision making of high complexity; had been performed.

- The patient was in for review of a sleep study. The medical record showed that the patient's blood pressure and pulse were taken, an expanded problem focused exam was performed, and a review of the study occurred. We recorded the service from CPT 99215 to 99213 because the patient record lacked evidence that at least two of three key components for CPT 99215: a comprehensive history, a comprehensive examination, or decision making of high complexity; had been performed.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) 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 the services provided to medicaid consumers, and to document significant business transactions…
>
> ***

Of the 278 services in our sample of medical services, we found that three billed services that were not supportable because the patient's medical records did not contain the required documentation to support billing to ODJFS.

Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these three services.

Duplicate Chiropractic Manipulative Treatment Service Billing

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

We disallowed one chiropractic manipulative treatment service because it was duplicative of another service paid for the same patient on the same date of service. The service involved two chiropractic manipulative treatment services (CPT 98940 and 98941) billed for the same patient on the same date of service. We confirmed that only one service was rendered, and therefore, we took exception with the duplicative billing.

Projected Findings from the Sample

The findings identified for the nine services in our stratified statistical random sample were projected across the Provider's total sub-population of recipient dates of service not otherwise excluded for exception analysis. This resulted in projected findings of $7,696.00 with a 95 percent certainty that the true population fell within the range of $1,197.00 to $14,196.00, a precision of plus or minus $6,499.00 (84.4 percent). Since the precision percentage achieved was greater than our procedures require for use of a point estimate, a finding was made for $1,197.00, the lower limit overpayment estimate amount. This allows us to say we are 97.5 percent certain that the population finding amount is at least $1,197.00. See Table 2 for a summary of the services we took exception with, and Appendix I for more details concerning our projected findings.

Table 2: Summary of Findings from the Sample
For the Period of July 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions
Unsupported Levels of Evaluation and Management Services	**5**
Missing Documentation	**3**
Duplicate Chiropractic Manipulative Treatment Service Billing	**1**
Total Services with Exceptions	**9**

Source: AOS analysis of a random sample of 160 recipient dates of service.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on June 4, 2004. The Provider's legal representative responded on July 9, 2004 by agreeing with our results except for those pertaining to physical therapy services. The legal representative noted that overpayments for radiology services had been caused by computer problems that were corrected upon discovery.

Regarding physical therapy services, the legal representative stated that it was inequitable and unreasonable to disallow all of the physical therapy treatments because the services, while not performed by a licensed therapist, were directly supervised by a physician, and the Provider substantially complied with all Medicaid provider reimbursement rules and regulations. The legal representative's response included examples from patient records to support this position.

After reviewing the examples and other documentation copied from patient records, we disagree that the Provider was entitled to be reimbursed by Medicaid for physical therapy services. As noted on page 5 of our report, the documentation does not support that the requirements for reimbursement were met, namely, that services were performed incident to a referral from a qualified physician that services performed by a nonphysician were reviewed and countersigned by a physician, and that services were performed in accordance with a physician's plan of treatment. To further validate our position, we shared the representative's response with staff from the Office of Ohio Health Plans, which is charged with administering the Medicaid program in Ohio, and they concurred with our findings.

APPENDIX I

Summary of Non-Exception Service Sample Analysis
Audit Period: July 1, 2000 – June 30, 2003

Description	Audit Period July 1, 2000 – June 30, 2003
Type of Examination	**Stratified Random Sample**
Number of Sub-Population Recipient Date of Services	**11,729**
Number of Sub-Population Services Provided	**14,072**
Number of Recipient Date of Service Sampled	**160**
Number of Services Sampled	**278**
Amount Paid for Services Sampled	**$10,393.56**
Total Medicaid Amount Paid For Sub-Population	**$335,424.59**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$14,196.00**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$1,197.00**
Point Estimate of Projected Findings	**$7,696.00**
Precision of Estimated Sub-Population Overpayment Amount at the 95% Confidence Level	**$6,499.00 (+/- 84.45%)**

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

APPENDIX II

Summary of Findings for Ironton Medical Rehab, Inc.
Audit Period: July 1, 2000 – June 30, 2003

Description of Audit Findings	Dollar Amount of Findings
Billing Physical Therapy Services Without the Required Documentation	**$174,505.98**
Billing Erroneous Multiple Units of Radiology Services	**$26,015.24**
Billing Radiology Services in Excess of the Allowed Two Units of Service	**$15,964.80**
Upcoded Radiology Services	**$5,088.94**
Medicaid Services Sample Excluding Exceptions	**$1,197.00**
Billing Laboratory Services Without Proper CLIA Certification	**$309.60**
Duplicate Billings	**$169.91**
Total Audit Findings	**$223,251.47**

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

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

IRONTON MEDICAL REHAB., INC.

LAWRENCE 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 14, 2004