STATE OF OHIO
OFFICE OF THE AUDITOR

JIM PETRO, AUDITOR OF STATE

# Ohio Medicaid Program

## *Review of Medicaid Provider Reimbursements Made to John C. Marasigan, M.D.*

A Compliance Review by the

**Fraud, Waste and Abuse**
**Prevention Division**

STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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Dr. John C. Marasigan
2400 Wales Road N.W., Suite D
Massillon, Ohio 44646

Re: Medicaid Review of Provider Number #0121175

Dear Dr. Marasigan:

We have completed our review of selected medical services rendered to Medicaid recipients by you for the period October 1, 1998 through September 30, 2001. We identified findings in the amount of $50,786.72, 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.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment is not made to the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General'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 Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

April 9, 2002

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## ABBREVIATIONS

| | |
|---|---|
| CPT | Physician's Current Procedural Terminology |
| E&M | Evaluation and Management |
| FWAP | Fraud, Waste and Abuse Prevention (Division of) |
| MMIS | Medicaid Management Information System |
| ODJFS | Ohio Department of Job and Family Services |
| OAC | Ohio Administrative Code |
| ORC | Ohio Revised Code |

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## *SUMMARY OF RESULTS*

The Auditor of State performed a review of John C. Marasigan, M.D., Provider #0121175, doing business at 2400 Wales Road N.W., Massillon, Ohio 44646. We identified findings amounting to $50,786.72. The findings are recoverable as they resulted from Medicaid claims submitted by the Provider for services that did not meet reimbursement rules under the Ohio Medicaid Provider Handbook 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 federal/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.

The Auditor of State, working in cooperation with the Ohio Department of Job and Family Services, performs reviews designed to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

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].

Pursuant to the Medicaid Handbook, Chapter 3334, Section IV, Subsection B, and the Ohio Administrative Code Section 5101:3-1-172, (E), 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 initiated audit is completed, whichever is longer".

Pursuant to the Ohio Medicaid Provider Handbook, Chapter 3334, Section V, Subsection B(6), (OAC Section 5101:3-1-198), overpayments, duplicate payments or payments for services not rendered are recoverable by the department at the time of discovery.

In addition, rule 5101:3-1-29 (C) of the OAC states: "In all instances of fraud 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."

"Abuse" is defined in rule 5101:3-1-29 (B) as "...those provider practices that are inconsistent with

[1] OAC Section 5101:3-1-01

professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and result in an unnecessary cost to the medicaid program."

## *PURPOSE, SCOPE AND METHODOLOGY*

The purpose of this review 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.

Additionally, we wanted to determine if the Provider had proper documentation for Evaluation and Management (E&M) services[2] billed during the audit period. A provider is eligible to bill E&M services as long as the reimbursement requirements as outlined in the Ohio Medicaid Provider Handbook are followed.

We notified Dr. Marasigan by letter of our compliance review and an Entrance Conference was held on December 3, 2001 at his Massillon office. We performed an on-site review of medical records, equipment and required certifications.

The scope of our review was limited to claims for which the Provider rendered services to Medicaid patients during the period October 1, 1998 though September 30, 2001. Our field work was performed between December 3, 2002 and December 18, 2002 and was done in accordance with government auditing standards.

We utilized the Medicaid Provider Handbook and the OAC 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 the five (5) digit Current Procedural Terminology (CPT)[3] coding system.

The Provider was reimbursed $633,832.30 for 28,887 services rendered during the audit period. In analyzing the Provider's claims history, we identified billing patterns utilizing the highest levels of established patient E&M services. Only one (1) new patient E&M level of service code was billed by the Provider.

To facilitate an accurate and timely review of paid claims, we analyzed a statistical random sample of E&M services. T**hree (3) different levels of service comprising a total of 150 dates of service** were selected:

[2]Office visits

[3]The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

1. Fifty (50) dates of service for which CPT code 99204, new patient - comprehensive level, was billed.
2. Fifty (50) dates of service for which CPT code 99214, established patient - detailed level, was billed and
3. Fifty (50) dates of service, for which CPT code 99215, established patient - comprehensive level was billed.

## *FINDINGS*

We identified findings in all three level of services areas reviewed: CPT codes 99204, 99214 and 99215. Total findings amounted to $50,786.72. A discussion of each deficiency follows.

## Evaluation & Management Levels of Service

An Evaluation and Management (E&M) service is a face-to-face encounter between the patient and the physician for the purpose of medical evaluation or management. Pursuant to the Medicaid Provider Handbook, Section 1101.2[4], providers must select and bill the appropriate visit code (E&M service level) in accordance with the CPT code definitions and instructions.

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:

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

The **key components** in selecting a level of E/M service are history, examination and medical decision making. **Contributory factors** are counseling, coordination of care, and nature of the presenting problem. The final component, time, is not considered a key nor a contributory component.

**CPT 99214 - Established Patient - Detailed level**

Per the Current Procedural Terminology, code 99214 is an:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
> • a detailed history;
> • a detailed examination;

[4]OAC 5101:3-4-06 (B)

• medical decision making of moderate complexity.

During our review of the 50 sampled dates of service for which CPT code 99214 was billed, we found 27 (54%) dates of service, where the medical record documentation did not support the required components as established by the CPT.

Of the 27 dates of service: a) 14 of them included the Provider's notation that a lower level of service, 99213, was to be billed; b) eleven (11) did not include sufficient documentation to support the level of service as billed; c) one (1) record was not received and d) one(1) record did not contain the date of service requested in our sample.

As providers must bill the appropriate visit code in accordance with the CPT book, findings for each of the above services were calculated using the difference between the amount reimbursed for each service as billed, and the reimbursement amount for the appropriate level of service as documented by the medical records.

These amounts were projected across the total CPT code 99214 population billed and reimbursed during the review period resulting in a projected finding of $41,162.51.

**CPT 99204 - New Patient - Comprehensive level**

Per the Current Procedural Terminology code 99204 is an:

> Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:
> • a comprehensive history;
> • a comprehensive examination;
> • and medical decision making of moderate complexity.

During our review of the 50 sampled dates of service for which CPT code 99204 was billed, we found 46 (92%) dates of service, where the medical record documentation did not support the required components as established by the CPT.

Of the 46 dates of service: a) two (2) patient records were not received from the Provider; b) twelve (12) included the Provider's notations that a lower level was to be billed and c) 32 did not include sufficient documentation to support the level of service as billed.

As providers must bill the appropriate visit code in accordance with the CPT book, findings for each of the above services were calculated using the difference between the amount reimbursed for each service as billed, and the reimbursement amount for the appropriate level of service as documented by the medical records.

These amounts were projected across the total CPT code 99204 population billed and reimbursed,

during the review period, resulting in a projected overpayment of $5,225.86.

**CPT 99215 - Established Patient- Comprehensive level**

Per the Current Procedural Terminology, code 99215 is an:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
> • a comprehensive history;
> • a comprehensive examination;
> • medical decision making of high complexity.

During our review of the 50 sampled dates of service for which CPT code 99215 was billed, we found 46 (92%) dates of service, where the medical record documentation did not support the required components as established by the CPT.

Of the 46 dates of service: a) one (1) medical record was not received from the provider; b) 45 included the Provider's notation that lower levels of service were to be billed.

As providers must bill the appropriate visit code in accordance with the CPT book, findings for each of the above services were calculated using the difference between the amount reimbursed for each service as billed, and the reimbursement amount for the appropriate level of service as documented by the medical records.

These amounts were projected across the total CPT code 99215 population billed and reimbursed, during the review period. This resulted in a projected finding of $5,702.85, with a 95 percent certainty that the actual finding fell within a range of $4,398.35 to $7,007.35. Because this range is larger than we require when projecting a sample result, we are making a finding for $4,398.35 – 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 reviewed all of the Provider's claims for the audit period.

## *CONCLUSIONS*

To afford an opportunity to respond to our findings, we mailed our draft results to the Provider on January 17, 2002. On January 30th, we received additional documentation for three patients that had not been presented during the field review that ended December 18, 2001.

We subsequently discussed the basis for our findings with Dr. Marasigan at a February 6th exit conference. At that time, two additional pieces of documentation were presented to us, and at Dr. Marasigan's request, we agreed to return to his office on February 13th to discuss various patient records and services.

During our February 13th meeting with the Provider, we were presented with copies of medical records that we had already reviewed during our field work, and to which it appeared new information may have been added. Because we could not verify the validity of the records, we did not consider any information provided subsequent to our field review when determining the amount of our findings, which totaled $50,786.72.

## APPENDIX I

### Table 1: Summary of Record Analysis of CPT 99214 E&M Level of Service For the period October 1, 1998 through September 30, 2001

| Description | October 1, 1998 - September 30, 2001 |
|---|---|
| Total Medicaid E&M Office visit Services Paid | $172,868.15 |
| Number of E&M Office Visit Services | 3,476 |
| Type of Examination | A statistical sample of claims of type CPT 99214 |
| Number of CPT 99214 Services Sampled | 50 |
| Amount Paid for Services Sampled | $2,456.80 |
| Projected Correct Reimbursement for Population | $131,705.64 |
| Upper Limit of Population Estimate | $143,911.13 |
| Lower Limit of Population Estimate | $119,500.15 |
| Overpayment Amount | $41,162.51 |

### Table 2: Summary of Record Analysis of CPT 99204 E&M Level of Service For the period October 1, 1998 through September 30, 2001

| Description | October 1, 1998 - September 30, 2001 |
|---|---|
| Total Medicaid E&M Office visit Services Paid | $12,898.12 |
| Number of E&M Office Visit Services | 213 |
| Type of Examination | A statistical sample of claims of type CPT 99204 |
| Number of CPT 99204 Services Sampled | 50 |
| Amount Paid for Services Sampled | $3,099.53 |
| Projected Correct Reimbursement for Population | $7,672.26 |
| Upper Limit of Population Estimate | $8,358.66 |
| Lower Limit of Population Estimate | $6,985.86 |
| Overpayment Amount | $5,225.86 |

**Table 3:Summary of Record Analysis of CPT 99215 E&M Level of Service**
**For the period October 1, 1998 through September 30, 2001**

| Description | October 1, 1998 - September 30, 2001 |
|---|---|
| Total Medicaid E&M Office visit Services Paid | $27,120.00 |
| Number of E&M Office Visit Services | 435 |
| Type of Examination | A statistical sample of claims of type CPT 99215 |
| Number of CPT 99215 Services Sampled | 50 |
| Amount Paid for Services Sampled | $ 3,105.00 |
| Overpayment of Lower Limit Estimate | $4,398.35 |

# 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: | John C. Marasigan, M.D.<br>2400 Wales Road NW, Suite D<br>Massillon, Ohio 44646 |
| Provider Number: | 0121175 |
| Review Period: | October 1, 1998 through September 30, 2001 |
| AOS Finding Amount: | $50,786.72 |
| 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: Charles T. Carle at (614) 728-7398.

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STATE OF OHIO
OFFICE OF THE AUDITOR
JIM PETRO, AUDITOR OF STATE

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P.O. Box 1140
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Telephone 614-466-4514
800-282-0370
Facsimile 614-466-4490

**JOHN C. MARASIGAN, M.D.**

**STARK 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**
**APRIL 9, 2002**