Auditor of State
Betty Montgomery

Ohio Medicaid Program

Report on Medicaid Reimbursements Made to Kyle L. Howard, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

November 23, 2004

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

Re: Kyle L. Howard, M.D.
Provider Number: 0887652

Dear Director Hayes:

Attached is our report on Medicaid reimbursements made to Kyle L. Howard, M.D., for the period January 1, 2001 through December 31, 2003. Our work was performed in cooperation with the Warren-Clinton Drug and Strategic Operations Task Force and in accordance with our interagency agreement to perform audits of Medicaid providers. We are issuing this report to you because the Ohio Department of Job and Family Services is charged with administering the Medicaid program in Ohio.

Our audit results and other information gathered by the Task Force led to the conviction of Dr. Howard. On September 2, 2004, the Provider pled guilty to one count of Medicaid fraud before the Warren County Common Pleas Court and agreed to (1) make $215,003.71 in restitution, (2) surrender his Ohio medical license, (3) surrender his Drug Enforcement Agency license to prescribe controlled substances, and (4) forfeit $400,000 in assets. The restitution includes repaying $142,761.50 in Medicaid audit findings to the Department.

Copies of this report are being sent to Dr. Howard, the Task Force, the Ohio Attorney General, the Ohio State Medical Board and other interested parties. Copies are also available on the Auditor's web site (www.auditor.state.oh.us). We appreciate the assistance provided the Department's Surveillance and Utilization Review Section during the course of our audit. 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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ABBREVIATIONS

AG	(Ohio) Attorney General
AMA	American Medical Association
AOS	(Ohio) Auditor of State
BWC	(Ohio) Bureau of Workers' Compensation
CPT	Current Procedural Terminology
FIAG	Fraud and Investigative Audit Group
HCCA	Health Care and Contract Audit
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 Kyle L. Howard, M.D. (hereafter called the Provider), Provider #0887652, doing business at 777 Columbus Avenue, Lebanon, Ohio 45036. 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 $142,761.50 in recoverable dollars, 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."

Ohio Adm.Code 5101:3-1-27(C) states in pertinent part: "Records, documentation, and information must be available regarding any services for which payment has been or will be claimed to determine that payment had been or will be made in accordance with applicable federal and state requirements…"

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

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

medical practices; and that constitute an over-utilization of medicaid covered services and results in an unnecessary cost to the medicaid program."

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 identify any overpayments resulting from non-compliance. Within the Medicaid program, the Provider is listed as an individual physician in general practice.

During an April meeting of the Ohio Healthcare Investigators Organization, AOS staff learned that the Provider was also under investigation by the Warren-Clinton Drug and Strategic Operations Task Force. As a result of the meeting, we joined a collaborative effort with other agencies that had a vested interest in the outcome of the investigation: the Ohio Bureau of Workers' Compensation, the Ohio Attorney General, the Ohio Medical Board, AdvanceMed (the Medicare program safeguard contractor), three private insurers, and the Warren-Clinton Drug Task Force. On June 8, 2004, a search warrant was served to seize records and computer equipment from the Provider's office, residence, temporary residence and personal vehicle. Over 600 patient records were seized, of which 330 were used to perform the Medicaid audit.

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 (January 1, 2001 through December 31, 2003). The Provider was reimbursed $341,920.17 by Medicaid for 7,379 services rendered during the audit period.

To perform our audit, we relied upon the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining Medicaid service requirements and 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]

[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.

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:

- Services for deceased recipients billed to Medicaid for dates of service after the date of death.
- Potentially duplicate billed and paid services. Defined as more than one bill for the same recipient, same date of service, same procedure, same procedure modifier, and same payment amount occurring on different claims.
- Services billed as new patient Evaluation and Management (E&M) visits when the patient had been seen by the Provider within the prior three years.
- Multiple, potentially duplicate, billed and paid E&M visits on the same date of service for the same recipient.
- Services billed to and paid by Medicaid that overlapped with claims paid by the Bureau of Workers' Compensation (BWC).
- Dates of service on which the Provider had billed for seeing a combined total of 40 plus unique patients across Medicaid, Medicare, BWC, and the three private insurers.

The test for services rendered to recipients after the date of death was negative. The other five exception analyses identified potentially inappropriate service code combinations. When performing our audit work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations claims for each exception analyses.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed a statistically random sample of 87 recipient dates of service comprising a total of 88 services. For the purpose of our review, a recipient date of service was defined as all services occurring for a specific recipient on a unique date of service.

Our work was performed between March and August 2004.

FINDINGS

We identified $142,761.50 in recoverable findings as a result of a 100 percent review of selected records identified by our exception testing, and a review of a statistical sample of remaining records. The bases for our findings are discussed below.

Exception Test Results

We identified $48,616.38 in recoverable findings from our exception tests. These tests focused on reimbursement claims initially identified as (1) duplicate claims for services, (2) claims for established patients billed as new patient services, (3) Medicaid claims that overlapped with BWC claims, and (4) claims for services to 40 or more patients in a single day.

Duplicate Claims for Services

Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part:

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

In addition, 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 definition and the CPT instructions for selecting a level of E&M service...

Our computer analyses identified 46 potential duplicate billings, involving 93 total services, where the Provider billed more than once for a service (predominately E&M office visits) on the same day for the same patient. After further review, we took exception with 88 of 93 services, including:

- 52 services that were duplicate billings or otherwise unallowable because documentation did not support that a service had been performed,
- 35 evaluation and management services where the level of service was billed and reimbursed at a higher level than supported by patient records, and
- One E&M service that was erroneously billed as a new patient visit instead of an established patient visit (see below).

We disallowed the undocumented services and recoded the evaluation and management visits to the level supported by documentation in the patient records. These changes resulted in findings of $3,801.07.

Established Patients Billed as New Patients

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

The American Medical Association, which promulgates CPT code definitions, states:

> Solely for the purpose of distinguishing between new and established patients, *professional services* are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

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. The key components 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.

Our computer analyses identified 153 dates of service (involving 157 services) for 17 recipients, who were established patients, where the Provider had incorrectly billed for a new patient service. After further review, we identified 130 services that lacked supporting documentation and/or had one or more billing errors, including:

- 83 evaluation and management services where the level of service was billed and reimbursed at a higher level than supported by patient records,
- 41 services where we could not find a patient chart to support the service,
- 13 E&M services that were erroneously billed as new patient visits instead of established patient visits, and
- 6 services where documentation for the particular service was missing from patient charts.

We disallowed the undocumented services and recoded the evaluation and management visits to the level supported by documentation in the patient records. These changes resulted in findings of $4,667.79.

Other Documentation-Related Issues

In general, Ohio Adm.Code 5101:3-1-08 requires that providers offset reimbursement claims made to Medicaid with reimbursements received from third party insurers, including workers' compensation. In these situations, the Medicaid program is the payer of last resort.

To determine if the Provider billed properly for patients dually eligible for Medicaid services and workers' compensation, we performed a computer match of Ohio Bureau of Workers' Compensation (BWC) and Medicaid claims billed by and reimbursed to the Provider during our audit period. Our computer match determined that the Provider billed and was paid for 28 potentially overlapping Medicaid and BWC services, involving five individuals. In each instance, both Medicaid and BWC paid for an office visit (E&M service) for the same person on the same date of service. Since we had already taken exception with 14 of the 28 overlapping services for other reasons, we limited further analysis to the 14 unique matches.

Other problems with the remaining 14 services resulted in us not taking issue with the overlap in reimbursements. Our review of patient records identified the following issues with 12 of the 14 services:

- 11 E&M services were billed and reimbursed at a higher level than supported by patient records.
- One service could not be verified from documentation in the patient record.

The billing errors resulted in findings of $245.87.

Dates of Service with Billings for 40 or More Patient Visits

Ohio Adm.Code 5101:3-1-27(C) states in pertinent part:

> Records, documentation, and information must be available regarding any services for which payment has been or will be claimed to determine that payment had been or will be made in accordance with applicable federal and state requirements...

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 definition and the CPT instructions for selecting a level of E&M service...

Our computer analyses identified 1,432 services on the dates of service where the Provider billed for seeing 40 or more patients on a single day. Because the Provider's daily office hours were normally 6 hours and he billed for office visits that typically require 25 to 40 minutes each, we questioned whether 40 or more patients could have been seen and treated in accordance with what was billed to insurers. After further review, we identified 1,316 services that lacked supporting documentation and/or had one or more billing errors, including:

- 1,028 services where patient records supported a level of E&M service less than that billed by the Provider,
- 180 services where patient records were missing documentation for the date of service in question,
- 81 services where no patient chart could be found to support that services were provided, and
- 27 services where information in the patient record did not support the CPT code that was billed.

We disallowed services not documented and recoded the evaluation and management visits to the level supported by documentation in the patient records. The combined errors found for services on dates of service where the Provider billed for seeing 40 or more patients resulted in total Medicaid findings of $39,901.65.

Sample Results

We identified and projected $94,145.12 for erroneously billed services from the results of our statistical sample. The potentially recoverable dollars resulted from three areas of deficiency:

- Unsupportive level of evaluation and management service.
- Missing or nonsupportive documentation for a specific date of service.

- Missing patient charts.

Unsupportive Level of Evaluation and Management Service

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 definition and the CPT instructions for selecting a level of E&M service...

From our sample of 88 services, 38 lacked adequate documentation in the patient medical records to support the required components for the evaluation and management code billed. The 38 E&M office visits we took exception with included services billed at the CPT code 99203 (one service), 99204 (two services), 99213 (two services), 99214 (32 services), and 99215 (one service) levels. When calculating our findings, we reduced the allowable payment for the 38 services to the level supported by documentation in the patient record.

The following are examples of services we took exception with:

- The Provider saw the patient for a follow-up visit for anxiety and depression. The patient chart included vitals (temperature, blood pressure, pulse, weight, and height). In addition, the Provider reviewed the patients past medical history, medications, and social history. A one region examination was performed. We reduced the service from 99214 to 99213 because the patient record lacked the required components for a 99214: a detailed history / exam and a medical decision of moderate complexity. However, the documentation supported the billing of a 99213: an expanded problem focused history exam and a medical decision of low complexity.

- The Provider saw the patient for a follow-up for shortness of breath (SOB). The chart lacked vitals, medical history, and evidence of an examination; it included an impression of condition (SOB, Asthma, COPD, and L-S pain) with a medication prescription for V5's. We reduced the service from 99214 to 99211 because the patient record lacked evidence of 2 of the 3 components for an evaluation and management office visit: a medical history and examination.

Missing Charts and Documentation for Date Of Service

Ohio Adm.Code 5101:3-1-27(C) states:

> Records, documentation, and information must be available regarding any services for which payment has been or will be claimed to determine that payment had been or will be made in accordance with applicable federal and state requirements. For the purposes of this rule, an invoice constitutes a business transaction, but does not constitute a record which is documentation of a medical service.

In our review of patient medical records for 87 recipient dates of service (88 services), we found:

- 14 services where the patient record did not support that the service had been performed;
- 4 services where there was no documentation in the medical chart for the date billed, and
- 3 services where medical charts could not be found for review.

Therefore, we disallowed the payments for these 21 services.

Sample Projection

We took exception with 59 of 88 statistically sampled recipient services (59 of 87 recipient dates of service) from a stratified random sample of the Provider's population of paid services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $149,054.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $ 76,540.12 to $ 111,750.12 (+/-11.81 percent). We then calculated audit findings repayable to ODJFS by subtracting the correct population amount ($149,054.00) from the amount paid to the Provider for this population ($243,199.12), which resulted in total Medicaid findings of $94,145.12.

Overall Summary of Findings

Table 1 summarizes the bases for the $142,761.50 in audit findings that are repayable to the Ohio Department of Job and Family Services.

Table 1: Summary of Overall Findings
By Exception Test and Statistical Sample

Reason for Finding	Subtotal	Findings
Exception Tests (100 percent review):		
Dates of Service with 40+ Patients	**$39,901.65**	
Established Patients Billed as New Patients	**$4,667.79**	
Other Documentation-Related Issues	**$245.87**	
Duplicate Claims for services	**$3,801.07**	
Total Exception Test Findings		**$48,616.38**
Sample Results:		
Unsupported Level of Service	**NA**	
Missing Documentation	**NA**	
Projected Sample Findings:		**$94,145.12**
Total Findings from 100% Review and Sample:		**$142,761.50**

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

We forwarded our audit findings to the Warren-Clinton Drug and Strategic Operations Task Force on July 16, 2004. These findings, when coupled with the results from other

participants in the joint investigation, resulted in Dr. Howard being indicted on August 16, 2004 for Medicaid fraud by the Grand Jury of Warren County. On September 2, 2004, in the Warren County Common Pleas Court, Dr. Howard pleaded guilty to one count of Medicaid Fraud, a fourth degree felony, and agreed to: (1) surrender his Ohio medical license, (2) surrender his DEA license to prescribe controlled substances, (3) pay $215,000 in restitution to both public and private health care insurers (including $142,761.50 to the Medicaid program), and (4) forfeit $400,000 in assets.

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APPENDIX I

Summary of Potentially Recoverable Dollars for: Kyle L. Howard, M.D.
For the period January 1, 2001 to December 31, 2003

Description	Audit Period: January 1, 2001 to December 31, 2003
Duplicate Claims Services	$ 3,801.07
Established Patients Billed as New Patients	$ 4,667.79
Other Documentation – Related Issues	$ 245.87
Dates of Service with 40+ Patients	$39,901.65
Subtotal of 100% Examined Service Findings:	$48,616.38
Projected Sample Results:	$94,145.12
Total Findings:	**$142,761.50**

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

APPENDIX II

Summary of Sample Record Analysis for: Kyle L. Howard, M.D.
All Other Services
For the period January 1, 2001 to December 31, 2003

Description	Audit Period July 1, 2000 – June 30, 2003
Type of Examination	**Statistical Stratified Random Sample of 87 Services**
Description of Population Sample	Sub-population of Other Recipient Dates of Service excluding services selected for exception tests
Number of Recipient Dates of Service in Sub-Population	4,408
Number of Services in Sub-Population	4,528
Total Medicaid Amount Paid for Sub-population of Other Recipient Services	$243,199.12
Number of Recipient Dates of Service Sampled	87
Number of Services Sampled	88
Amount Paid for Services Sampled	$6,944.42
Estimated Overpayment (Point Estimate)	$94,145.12
Upper Limit Overpayment Estimate at 95% Confidence Level	$111,750.12
Lower Limit Overpayment Estimate at 95% Confidence Level	$76,540.12
Precision of Correct Population Payment Estimate at 95% Confidence Level	$17,605.00 (11.81%)

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

Auditor of State
Betty Montgomery

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KYLE L. HOWARD, M.D.

WARREN 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
NOVEMBER 23, 2004