Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Charles James Kistler, D.O. D.B.A. Midtowne Family Practice Center

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

January 20, 2004

Charles James Kistler, D.O.
D.B.A. Midtowne Family Practice Center
1519 W. Broad Street
Columbus, OH 43222

Re: Medicaid Audit of Charles James Kistler, D.O.
Provider Number: 0411067

Dear Dr. Kistler:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period January 1, 2000 through December 31, 2002. We identified $16,017.03 in findings, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "Provider Remittance Form" is included at the back of this report for remitting payment. The attached report details the basis for our findings.

Please be advised that in accordance with Ohio Rev.Code 117.28 and 131.02, if payment is not made to ODJFS 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 ODJFS, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Ohio Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
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ACRONYMS

BHPP	Bureau of Health Plan Policy
BWC	(Ohio) Bureau of Workers' Compensation
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
D.B.A	Doing Business As
D.O.	Doctor of Osteopathic Medicine
E&M	Evaluation and Management Services
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 Ohio Auditor of State performed an audit of Charles James Kistler, D.O., D.B.A., MidTowne Family Practice Center (hereafter called the "Provider"), Provider #0411067, at 1519 W Broad Street, Columbus OH 43222. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with 117.10 of the Ohio Rev.Code. As a result of this audit, we identified findings amounting to $16,017.03 that did not meet reimbursement rules in the Ohio Adm.Code and Ohio Medicaid Provider Handbook (OMPH).

A significant portion of these findings ($15,642.02) resulted from erroneous billings for services when patients were seen for both a Medicaid and a workers' compensation condition. Because other Medicaid providers may also be billing for these services erroneously, we are recommending that the Ohio Department of Job and Family Services (ODJFS) send an advisory letter to providers covering proper billing procedures in this situation.

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 Adm.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 initiated audit 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) defines waste and abuse as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical

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

practices; and that constitute an overutilization of medicaid covered services and result in an unnecessary cost to the medicaid program.

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of our audit was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and to calculate the amount of any finding resulting from non-compliance. Within the Medicaid program, the Provider is listed as a Doctor of Osteopathic Medicine and in general practice as an individual physician.

Following a letter of notification, we held an entrance conference with the Provider on April 21, 2003 to discuss the audit objectives. 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 January 1, 2000 through December 31, 2002. The Provider was reimbursed $475,767.47 for 11,890 services rendered on 11,643 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 Medicaid Provider Handbook, Ohio Adm.Code and Ohio Rev.Code as guidance in determining the extent of services and applicable reimbursement rules. 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)[2] coding system or ODJFS local level codes[3].

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 rendered to deceased recipients after the date of death.
- New patient Evaluation and Management codes (office visits, also called E&M visits) billed for patients who had received professional services from the Provider within the past three years.
- Preventative HealthChek services billed more than once per calendar year for the same recipient where the recipient was between 2-20 years of age.
- Potentially duplicated service claims where a duplicate claim was defined as two or more paid claims with the same date of service, patient, procedure code, procedure code modifier and reimbursement amounts.

The test for services rendered to deceased recipients was negative, but the other three exception analyses identified potentially inappropriate service code combinations.

[2] *The CPT is published by the American Medical Association for the purpose of providing a uniform language to describe medical services.*

[3] *Local level codes are published in the Ohio Medicaid Providers Handbook.*

We then reviewed patient records relating to all of the potentially inappropriate service code combinations identified by our computer analyses. We also reviewed three stratified statistically random sample of the Provider's patient records for 199 medical services not already selected for examination by the computer exception analyses. Our objective was to determine whether the patient records supported claims paid by Medicaid for these services. Results from our review of potentially inappropriate service code combinations are discussed in the findings section below. In general, the patient records in our sample of 199 medical services supported the claims made to and reimbursed by Medicaid.

During our record reviews, we found several notations in patient records regarding services provided for workers' compensation claims. The Provider explained some patients had also been treated for workers' compensation injuries and that the charts for workers' compensation claims, which are billed to and paid by the Ohio Bureau of Workers' Compensation (BWC), were kept separate from the charts for Medicaid patient claims. This caused us to perform additional testing for duplicate claims to Medicaid and BWC for the same or similar services.

Our audit work was performed between February 2003 and October 2003 in accordance with government auditing standards.

FINDINGS

We identified findings of $16,017.03 for the services from the three 100 percent exception analyses and from our matching of Medicaid and BWC claims for services. Our findings were in these four categories:

(1) Overlapping claims to Medicaid and BWC for the same recipient on the same date of service.

(2) New patient E&M codes billed for patients who received professional services from the Provider within the prior three years.

(3) Multiple preventative HealthChek services billed for patients age 2-20 in the same calendar year.

(4) One case of a duplicate billed and paid Medicaid claim.

Overlapping BWC and Medicaid Claims

Ohio Adm.Code 5101:3-1-08 states in part:

> (A) The medicaid program reimburses for covered services only after all available third-party benefits are exhausted. Payments for services provided under the medicaid program must be reduced to the extent that they are offset by an insurance policy, workers' compensation, or other third-party resource. The provider may not bill the medicaid consumer for any difference between the

> medicaid payment and the provider's charge, or request the consumer to share in the cost through a co-payment or other similar charge.
>
> (B) Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party. In such instances, the department will not reimburse for the cost of services which are or would be covered by a third-party payer. If the provider receives a third-party payment after having received a medicaid payment for the same items and services, the department must be reimbursed the overpayment. Under no circumstances may the provider refund any money received from a third party resource to a consumer.
>
> > (1) …After receipt of the third-party resource, the department may be billed for the balance; however, the total reimbursement shall not exceed the department's medicaid maximum amount. When the existence of third-party resources is known to the department and a claim is submitted that does not indicate collection of the third-party payment, the claim will be rejected pending determination of third-party coverage. Providers should complete their investigation of available resources before submitting the claim to the department for payment.

To determine if the Provider billed properly when patients were dually eligible for BWC and Medicaid services, we performed a computer match of BWC and Medicaid claims billed by and reimbursed to the Provider during our audit period. This match determined that the Provider supplied services to 1,018 unique BWC claimants and 1,751 unique Medicaid recipients during our audit period. Seventy three (73) of these individuals were eligible for both Medicaid and workers' compensation services. Of the 73 individuals, 61 (83.6 percent) had potentially duplicate payments for 1,357 services (same person, same date of service), including 542 services in which the Provider was reimbursed by both Medicaid and BWC for the same or similar procedure codes. In all but one instance[4], the reimbursements were for office visits.[5]

When claims involving multiple insurers are submitted for Medicaid reimbursement, ODJFS requires providers to indicate on their claims when another insurance carrier is involved. We reviewed the Provider's claims data submitted to ODJFS to determine if the Provider was coding for the existence of another insurer, i.e. BWC, for those services we identified as potentially duplicate. We only found one claim that was coded to show the existence of another insurer, and that claim was coded erroneously. Thus, ODJFS' claims processing system was not aware a second insurer was involved.

We subsequently reviewed patient records for the 542 services and asked the Provider to explain his billing procedures in these circumstances. The Provider justified the dual billings on the

[4] *The one exception was two billings for x-ray services in which the x-ray appeared to be for the same view and diagnosis (shoulder strain).*

[5] *The rest of the 1,357 services billed for the same patient on the same day were for ancillary services such as injections, lab services and x-rays. We opted not to take issue with these services because we could not easily determine whether or not they were for essentially the same service.*

basis that patients were being seen for different conditions, e.g. a back injury and an illness, and documentation in patient records generally supported this assertion. A billing consultant representing the Provider also told us that other providers bill for two office visits in these situations. We question, however, whether a Provider should be entitled to reimbursement for two office visits during a single patient encounter. Office visit reimbursement rates, particularly for higher levels of service[6] are based in part on taking a patient's vitals and performing a general examination – two things that generally would not be performed twice in a single patient encounter. Thus, to bill and be reimbursed twice for one office visit includes at least a degree of duplication.

When we discussed our results with ODJFS' Bureau of Health Plan Policy, which is responsible for writing Medicaid reimbursement rules, a spokesperson stated that regardless of the number of medical problems or conditions evaluated or treated during a medical visit and the number of payers responsible for the payment of a medical claim, only one visit code should be billed and paid. When more than one payer is involved, the principles of coordination of benefits should be followed. The primary payer should be billed first. Once payment is made by the primary payer, the claim should be billed to the secondary payer and the billing provider should report the amount collected from the primary payer. This would enable the secondary payer to offset the payment by the amount previously collected.

The ODJFS spokesperson added that for workers' compensation claims specifically, the Provider would need to bill BWC for the level of the visit code appropriate for the workers' compensation portion of the claim. However, when billing Medicaid as the secondary payer, it would be appropriate for the Provider to bill the level of visit code appropriate for the entire visit, including the workers' compensation condition, as well as any additional medical condition(s). This would mean that the code billed to Medicaid may be a higher level since it describes the entire service. Then, the third party liability process would offset the Medicaid maximum rate by the amount paid by BWC, and both departments would have been paid the appropriate amount.

For example, assume a provider treated an ill Medicaid-eligible recipient who also had an approved workers' compensation claim. Then, assume the provider billed BWC for a 99212 office visit (a $42.01 reimbursement in 2002) to cover treatment for the workers' compensation claim. Following ODJFS' guidance, the provider might then bill Medicaid for a 99214 visit, representing the total services rendered to the patient during the visit and which had a $52.57 Medicaid maximum rate in 2002. In this example, the provider would have received a Medicaid reimbursement of $10.56 ($52.57 less the $42.01 already reimbursed by BWC).

Following ODJFS' guidance, we offset the amount paid by Medicaid for the 542 services in question by the amount paid by BWC. In 527 cases, the amount paid by BWC was greater than the amount paid by Medicaid, resulting in an overpayment for the entire amount paid by Medicaid. In the other 15 cases, the Medicaid amount was higher, resulting in an overpayment equaling the amount paid by BWC. This resulted in a total overpayment of $18,101.94.

6 The next section explains how different levels of office visits, called Evaluation and Management services, are billed.

In recognition that the Provider might have been entitled to bill a higher level of service to Medicaid if the overlapping BWC and Medicaid services had been billed in accordance with Ohio Adm.Code 5101:3-1-08 and ODJFS' guidance, we recalculated the overpayment based on the assumption that the Provider billed office visits at a higher level of service, i.e. billed at the CPT code 99214 level instead of at the CPT code 999211, 99212 or 99213 level. These services accounted for 99 percent of the 542 services in question. (The other services had already been billed at the 99214 or 99215 level). This recalculation reduced the overpayment to $15,642.02, which is a finding repayable to ODJFS.

While we believe Ohio Adm.Code 5101:3-1-08 is clear in these situations, we are also concerned about the possibility that other Medicaid providers may be billing for two separate office visits erroneously. Therefore, we are recommending that ODJFS notify its other Medicaid providers about proper billing procedures in these situations.

Established Patients Billed as New Patients

An Evaluation and Management (E&M) 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 that providers must select and bill the appropriate visit (E&M service level) code in accordance with the CPT code definitions and the CPT instructions for selecting a level of E&M service.

The description used to determine levels of E&M services involve seven components:

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

The key components[7] in selecting an appropriate level of E&M service to bill are history, examination and medical decision-making – the more complex the services involving these components, the higher the level of service billed and the more a provider is reimbursed. 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 Evaluation and Management (E&M) Service Guidelines of the American Medical Association states that "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

[7] *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 component.*

professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years."

We identified and took exception with 14 new patient services where the recipient had received professional services from the Provider within the past three years. These exceptions were initially identified by computer analysis, but then confirmed during our field review of patient medical records. For 12 services, we recoded to the new patient claim to the corresponding established patient CPT code and made a finding for the difference. For the two remaining services, the patient record did not support that the service had occurred, so we made a finding for the entire amount paid. These two conditions resulted in a finding for $273.58.

Preventative HealthChek Services Billed More than Once per Calendar Year

Ohio Adm.Code 5101:3-14-04(B)(3) states…

> One screening service per calendar year may be provided from the individual's second birthday through the day before the individual's twenty-first birthday.

Our computer analysis identified four instances where more than one HealthChek service was billed in the same calendar year for a recipient between the ages of 2 and 20. Because the Provider rendered a service, we reduced the second service to an established E&M (99213) visit and made a total finding for $67.08, which is the difference in the allowed amount between a HealthChek and a 99213 E&M service.

Duplicate Payment

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

Our computer exception analyses identified one set of potentially duplicate paid claims where the same procedure code was billed for the same recipient on the same date of service and for the same amount. During our field audit, we confirmed that the claims were in fact duplicates for the same service and made a finding of $34.35 for the duplicate claim.

AUDITEE RESPONSE

A draft report was mailed to the Provider on November 7, 2003 to afford an opportunity to submit additional documentation or otherwise respond in writing. The Provider responded on November 14, 2003. The Provider agreed with our findings for established patients billed as new patients, HealthChek services billed more than once a year, and the duplicate payment, but disagreed with our findings regarding overlapping BWC and Medicaid claims. As noted above, we adjusted our findings to recognize that the Provider may have been entitled to bill a higher level of service to Medicaid, if the overlapping BWC and Medicaid services had been billed correctly and in accordance with ODJFS guidance. This adjustment reduced the total findings repayable to the ODJFS from $18,476.95 to $16,017.03.

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APPENDIX I

Summary of Findings Results for: Charles James Kistler, D.O.
For the period January 1, 2000 to December 31, 2002

Description	Audit Period: January 1, 2000 to December 31, 2002
Overlapping BWC and Medicaid Claims	$15,642.02
Established Patients Billed as New Patients	$273.58
Preventative HealthChek Services Billed More than Once Per Calendar Year	$67.08
Duplicate Payment	$34.35
TOTAL FINDINGS	**$16,017.03**

Source: AOS review of Provider's Medical Records

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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
Accounts Receivable
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	**Charles James Kistler, D.O.** **D.B.A. Midtowne Family Practice Center** **1519 W Broad Street** **Columbus, OH 43222**
Provider Number:	**0411067**
Audit Period:	**01/01/00 through 12/31/02**
AOS Finding Amount:	**$16,017.03**
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 (614) 728-7398, Attn: Health Care and Contract Audit Section.

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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

CHARLES JAMES KISTLER, DO

FRANKLIN 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
JANUARY 20, 2004