Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Keyhan Mobasseri, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

July 12, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Keyhan Mobasseri, M.D.
Provider Number: 0215172

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Keyhan Mobasseri, M.D. for the period January 1, 2000 through December 31, 2002. We identified $42,855.86 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 potential findings identified herein. Copies of this report are also being sent to Keyhan Mobasseri, M.D., the Ohio Attorney General, and the Ohio State Medical Board. In addition, copies are also available on the Auditor's web site (www.auditor.state.oh.us).

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

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ACRONYMS

AMA	American Medical Association
CLIA	Clinical Laboratory Improvements Amendment of 1988
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCCA	Health Care and Contract Audit Section
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Keyhan Mobasseri, M.D. (hereafter called the Provider), Provider #0215172, doing business at 5162 Broadway Avenue, Suite 5, Cleveland, Ohio 44127. 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 $42,855.86, in 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 pertinent 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 result 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 regulations and, if warranted, calculate the amount of any findings due to non compliance. Within the Medicaid program, the Provider is listed as an obstetrician-gynecologist.

Following a letter of notification, we held an entrance conference at the Provider's place of business on January 28, 2004 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, for which the Provider rendered services to Medicaid patients, not involving Medicare co-payments, and received payment during the period of January 1, 2000 through December 31, 2002. The Provider was reimbursed $339,183.07 for 7,737 services rendered during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of covered 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 and 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. Potentially inappropriate services identified by our computer analysis were selected for 100 percent review. These tests checked for the following:

- 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.
- Services billed for recipients who died prior to the date of service.
- Quantitative Strep A testing being billed instead of qualitative testing.
- Preventative counseling visits billed in conjunction with other office visit services, either E&M or gynecological.
- Multiple Surgical Services performed on the same patient and date of service.
- Salpingo-oophorectomy services billed in conjunction with total hysterectomy services.

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 (AMA). 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 for duplicate billings and services billed for recipients who died prior to the date of service were negative, but the other tests identified potential inappropriate billings. When performing our audit field work, we requested the Provider's supporting documentation for all reimbursement claims with identified exceptions.

To facilitate an accurate and timely test of the Provider's remaining reimbursements, we selected a stratified statistical sample of 103 recipient dates of service (RDOS) comprising 191 services from a population of 4,081 RDOS (6,465 services). A recipient date of service is defined as all services received by a particular recipient on a specific date.

Our work was performed between March 2004 and May 2005.

RESULTS

We identified and projected findings of $30,489.67 for the services in the sampled population. Additionally, we identified findings of $242.40 for undocumented services and $12,123.79 for services in our exception testing. Together, our findings totaled $42,855.86. The bases for our results are discussed below.

Results of Sampled Services

During our review of statistically selected patients' medical records, we took exceptions with billings for (1) levels of evaluation and management (E&M) services, (2) services that lacked supporting documentation in patient medical records, and (3) an incorrectly coded service.

Unsupported Level of Evaluation and Management Service Billings

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part respectively:

> …an "evaluation and management (E&M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient…
>
> 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.

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 of an E&M service, as defined by the American Medical Association's CPT Code Book, are an examination, medical decision making, and history. For new patient E&M services, the provider must perform all three key components. For established patient E&M services, the provider must perform any two of the key components.

The Provider was paid $151,424.07 for E&M office visit services, which comprised 45 percent of the total reimbursement for the audit period.

We found that the level of service billed for 52 of 83 E&M services in our sample was not supported by the documentation in the patients' medical records, or the documentation did not contain the required components as established by the CPT code book or by ODJFS.

We determined the difference between the reimbursement for the unsupported level of E&M service and the maximum allowed reimbursement for the level of service supported by the documentation in the patients' medical records. These differences ($841.16) were used in calculating the findings of the sample population.

Undocumented Services

Ohio Adm.Code 5101:3-1-17.2(D) states 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.

We identified three (3) services that lacked documentation to support that the billed service occurred. The amount paid for these unsupported services ($917.88) was used in calculating the findings of the sample population.

Summary of Sample Findings

We took exception with 55 of 191 statistically sampled recipient services (53 of 103 RDOS) from a stratified random sample of the Provider's population of paid services (which excluded services extracted for 100 percent review). Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $213,610.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $225,624.00 to $201,596.00 (+/- 5.62 percent). We then calculated audit findings repayable to ODJFS by subtracting the projected correct population amount ($213,610.00) from the amount paid to the Provider for this population ($244,099.67), which resulted in a finding of $30,489.67. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of Exception Testing

Incorrectly Billed Laboratory Tests

Pursuant to Ohio Adm.Code 5101:3-11-03 (I):

> Billing the laboratory procedure codes:
>
> (1) The provider must assign the most appropriate code for each laboratory procedure performed. Some procedures are listed by the name of the substance

> (analyte) being measured; some are listed by methodology (e.g., RIA, EIA, TLC, Culture, etc.); some are listed by both the name and methodology; . . .
>
> (2) The provider must bill the code that describes the procedure in the most detail. Codes using the term "not elsewhere specified" in the definition for the procedure may only be used when the laboratory is performing a quantitative test for a specific analyte for which there is no specific code.
>
> ***

The Provider used a 'Clearview Strep A Test' test kit manufactured by Wampole Laboratories to perform 581 Strep A tests. We reviewed the insert in the test kit to determine:

- If the description of the test insert matched the description of the CPT code billed by the Provider and,
- If the described testing methodology matched the testing methodology of the CPT code billed by the Provider.

According to the test kit insert, the intended use of the kit is "a rapid immunoassay for the ***qualitative*** detection of a group A streptococcal antigen. . . ."

The Provider billed for Strep A testing services using CPT code 86317 (Immunoassay for infectious agent antibody, ***quantitative***, not otherwise specified). However, a **qualitative** test, such as the one used by the Provider, should have been billed using CPT code 87430 (Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A.).

Pursuant to Ohio Adm.Code 5101:3-11-03 (I), the most appropriate code (CPT 87430) for the Strep A test used by the Provider should have been billed. Since the Provider did not bill the appropriate code and billed for a higher paying, more extensive test; we took the difference in reimbursement amount for the code billed by the Provider (CPT 86317) and the Medicaid maximum allowed charge for the appropriate code (CPT 87430) as a finding. This resulted in a finding of $2,405.34 repayable to ODJFS.

Incorrectly Billed Preventative Counseling Services

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part, respectively:

> …an "evaluation and management (E&M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient…
>
> 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.

CPT code definitions are promulgated by the American Medical Association (AMA).

The Provider billed 41 preventative counseling services using CPT code 99402, which the AMA defines as "**Preventive medicine counseling** and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes." According to the AMA, CPT code 99402 is a type of evaluation and management service.

Code 99402 is further defined by the AMA's description of "Counseling and/or Risk Factor Reduction Intervention (99401-99429) New or Established Patient":

> These codes are used to report services provided to individuals at ***a separate encounter*** *[emphasis added]* for the purpose of promoting health and preventing illness or injury.
>
> Preventive medicine counseling and risk factor reduction interventions provided as a separate encounter will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health and diagnostic and laboratory test results available at the time of the encounter.
>
> These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital or consultation or other evaluation and management codes. . . .

Our analysis of the Provider's records determined these 41 preventive counseling services were not performed as a separate encounter, and were in fact billed in conjunction with services that included a counseling component. In 23 of the 41 billings for CPT 99402, the Provider had also billed for an evaluation and management office visit (codes 99201 – 99205 and codes 99211 – 99215), and in the remaining 18 instances, the Provider had also billed for a family planning service (code X1453).

According to the AMA, counseling is one of the seven recognized components included in an evaluation and management service.

During our audit period, code X1453 (family planning) was defined in Ohio Adm.Code 5101:3-4-07[3]:

> ***
>
> (B), Covered family planning services include medical, consultative, and educational services related to:
> (1) Temporary contraceptive management;
> (2) Permanent contraceptive management (sterilization);
> (3) Physical and emotional reproductive health of the patient;

[3]Effective October 1, 2003, the Ohio Administrative Code deleted X1453 as a billable code.

(4) Genetic counseling and diagnostic testing;
(5) Pregnancy determination.

***

(D) Family planning visits.
(1) A "family planning visit" is any visit performed for the purpose of providing a family planning service. The visit may be performed either by a physician and/or a health professional or social service professional qualified under the Revised Code. The visit may or may not include a physical examination.

Because the evaluation and management services and the family planning visits rendered by the Provider already included a counseling component, and the patients' medical records did not document a separately identifiable counseling service, we identified a $1,476.41 finding for the 41 reimbursements for CPT code 99402.

Incorrectly Billed Multiple Surgical Services

Ohio Adm.Code 5101:3-4-22 (D) states:

Multiple surgeries.
(1) A 'multiple surgery' is defined as two or more consecutive surgical procedures performed by a single physician at the same operative site during the same operative session.
(2) Reimbursement for multiple surgical procedures performed on the same patient by the same provider shall be the lesser of billed charges or:
(a) One hundred per cent of the medicaid maximum allowed for the primary procedure;
(b) Fifty per cent of the medicaid maximum allowed for the secondary procedure; and
(c) Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Our review of the Provider's claims showed that multiple surgical services were billed for the same date of service for the same patient. Our review also determined that the reimbursements received by the Provider did not follow the multiple surgery rules on reimbursement.

To determine if findings existed for multiple surgical services billed to the same patient on the same date of service, we adopted the following procedure:

- We verified that the multiple surgery procedures analyzed were all services where the above discount procedure was required.
- The multiple surgical service with the highest Medicaid maximum allowed charge was considered the primary surgery and was paid at 100 percent of the maximum allowed charge.

- The multiple surgical service with the 2nd highest Medicaid maximum allowed charge was considered the secondary surgery and was paid at 50 percent of the maximum allowed charge.
- The multiple surgical service with the 3rd or subsequent highest Medicaid maximum allowed charge was considered a tertiary surgery and was paid at 25 percent of the maximum allowed charge.

After performing the above calculation, we compared the amount reimbursed to the Provider to the proper payment amount calculated by our analysis. Our comparison found that for 85 patients the Provider was reimbursed more than the proper amount for multiple surgical services.

A finding of $5,806.23 was made for the difference between the amount reimbursed to the Provider and the proper discounted amount that should have been paid for the multiple surgical services performed.

While reviewing multiple surgical services, we identified three additional areas of concern which resulting in findings. These areas are described as follows:

Undocumented Multiple Surgery Services

Our review of the medical records for patients with multiple surgery services found that five (5) surgery services lacked proper documentation to verify that the services billed were performed. In accordance with Ohio Adm.Code 5101:3-1-17.2(D), we identified a finding for the $242.40 reimbursement the Provider received for these five services.

Incorrectly Coded Surgery Service

Our review of medical records for one (1) patient with multiple surgery services showed the Provider incorrectly billed CPT code 46917 [Destruction of lesion(s), anus (e.g., condyloma, papilloma, molluscum contagiosum, herpetic vesicle), simple; laser surgery] for a service documented in patient records as laser treatment of tumors on neck. According to the AMA, this service should have been billed as CPT code 17000 [Destruction (e.g. laser surgery, electrosurgery, cryosurgery, chemosurgery, and surgical curettement), all benign or pre-malignant lesions (e.g., actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion]. As the reimbursement for the incorrect code was greater than the Medicaid maximum allowed charge for the correct code, we made a finding for the $14.47 difference.

Delivery of Placenta Charged with Inclusive Procedure

The Provider billed CPT code 59414 (delivery of placenta; separate procedure) for the same patient on the same date of service as CPT code 59820 (Treatment of missed abortion, completed surgically; first trimester). According to the AMA, a CPT code 59414 service is not allowed on the same date that a CPT code 59820 is performed, since the delivery of placenta is an integral part of the treatment of a missed abortion. Therefore, the total reimbursement for CPT code 59414 was disallowed and a finding made for $51.33.

Salpingo-oophorectomy Services Billed Incorrectly with Total Hysterectomy Services

Ohio Adm.Code 5101:3-4-22 (C) states:

> For the reimbursement of surgical services, the physician must bill the appropriate code for the surgical procedure(s). Each surgical procedure billed must be a separate procedure and not a minor surgical procedure performed as an integral part of a major surgical procedure (e.g., suturing of a surgical incision).

The AMA states:

> Codes designated as "separate procedures" may not be additionally reported when the procedure/service is performed as an integral component of another procedure/service.

For 12 patients, the Provider billed a salpingo-oophorectomy (CPT code 58720) on the same date of service as a total hysterectomy (billed using either CPT code 58150 or 58200). Stedman's Medical Dictionary, 27th Edition, defines a salpingo-oophorectomy as "removal of the ovary and its fallopian tube." The AMA designates CPT code 58720 as a separate procedure.

The AMA defines CPT code 58150 as "total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)" and defines CPT code 58200 as "total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)." Since hysterectomy CPT codes 58150 and 58200 include the removal of tube(s) and/or removal of ovary(s), a CPT code 58720 should not have been billed on the same date of service. Therefore, for the 12 patients in question, we identified a finding for the $2,370.01 reimbursed to the Provider for salpingo-oophorectomy services on the same date of service as a total hysterectomy service.

Summary of Findings

Findings from our statistical sample ($30,489.67) and our exception testing ($12,366.19) resulted in total findings of $42,855.86.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on April 21, 2005 in order to afford her an opportunity to provide additional documentation or otherwise respond in writing.

A post audit conference was held with the Provider on April 28, 2005. The Provider also responded in writing on May 5, 2005. At the Provider's request, we subsequently met with the Provider on May 6, 2005 and May 26, 2005 to further review supporting documentation and

explain the basis for our findings. In addition, we consulted with ODJFS' Medicaid policy staff regarding the Provider's practice of billing laparotomies in conjunction with hysterectomies. Based on this post-audit work, we adjusted our audit findings from $58,272.93 to $42,855.86.

However, the Provider continues to disagree with our findings for levels of evaluation and management services, Strep A testing, preventative medicine counseling, multiple surgery billings, and the undocumented surgery services. The Provider also took issue with the amount that Medicaid reimburses for various services, including services she provides to Medicaid patients "free of charge". These "free of charge" services include items such as: "filling out" forms for handicap stickers; "filling out" leave of absence forms for patients who were ill or had surgery; calling the pharmacy in the evenings and during the weekend; and filling out school forms for students' medication regimens.

The Provider did not respond to our request for a corrective action plan to prevent recurrence of the matters discussed in this report. We made several recommendations to the Provider, however, to help avoid future billing problems. For example, during the audit, we discovered that the Provider was using an outdated (1999) AMA CPT Code Manual to bill for Medicaid services. This could have contributed to billing errors because AMA revises its coding manual annually. The Provider also did not have a copy of the Ohio Medicaid Provider Handbook, which describes billing procedures and covered services. We sent the Provider a copy of the January 2005 Ohio Medicaid Provider Handbook. In a follow up letter, we recommended that the Provider 1) periodically obtain current versions of ODJFS' Handbook; 2) maintain a current copy of the AMA CPT Coding Manual; 3) review office billing system reports to identify claims needing additional attention; and 4) contact ODJFS' Provider Network Management Section to take advantage of educational information and training opportunities.

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APPENDIX I

Summary of Sample Record Analysis for Keyhan Mobasseri, M.D.
Population: Paid Services[4]
For the period January 1, 2000 to December 31, 2002

Description	Audit Period January 1, 2000 – December 31, 2002
Type of Examination	**Statistical Stratified Random Sample**
Description of Population	**All paid services net of any adjustments and excluding Medicare Cross-over payments**
Number of Population Recipient Date of Services	**4,081**
Number of Population Services Provided	**6,465**
Total Medicaid Amount Paid For Population	**$244,099.67**
Number of Recipient Dates of Service Sampled	**103**
Number of Services Sampled	**191**
Amount Paid for Services Sampled	**$16,168.56**
Estimated Correct Sub-population Payment Amount	**$213.610.00**
Lower Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	**$201,596.00**
Upper Limit Estimate of Correct Sub-population Payment Amount at 95% Confidence Level.	**$225,624.00**
Precision of Correct Population Payment Estimate at 95% Confidence Level	**$12,014.00 (5.62%)**
Estimated Overpayment (Point Estimate) = Actual Amount Paid Less Estimated Correct Sub-population Payment Amount.	**$30,489.67**

[4] Excluding services separately reviewed for 100 percent by exception tests.

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KEYHAN MOBASSERI, M.D.

CUYAHOGA 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
JULY 12, 2005