Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Rodney Roof, D.P.M.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

December 30, 2005

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

Re: Audit of Rodney Roof, D.P.M.
Provider Number: 2145191

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Rodney Roof, D.P.M. for the period January 1, 2001 through December 31, 2003. We identified $7,451.24 in findings that are repayable to the State of Ohio. 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 a final determinations regarding recovery of the findings and any interest accruals.

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.

Copies of this report are being sent to Rodney Roof, D.P.M., the Ohio Attorney General, and the State Medical Board of Ohio. In addition, copies are 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
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
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 Rodney Roof, D.P.M. (hereafter called the Provider), Provider #2145191, doing business at 10475 Reading Rd. Ste 306, Cincinnati, OH 45241. 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 $7,451.24 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Ohio Medicaid Provider Handbook.

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 a final determination regarding recovery of the findings[1] and any interest accruals.[2]

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 Ohio Medicaid Provider Handbook. 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 requirements for reimbursement of Medicaid covered services.[3] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

The scope of coverage for podiatrists is defined by Ohio Adm.Code 5101:3-7-02(A) which states in pertinent part: "Podiatrists may perform covered services…which consist of the medical, mechanical and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma. The podiatrist may also treat the local manifestation of systemic disease as they appear in the hand and foot, but the patient must be concurrently referred to a doctor of medicine or a doctor of osteopathic medicine and surgery for treatment of the systemic disease itself."

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

[2] *Ohio Adm.Code 5101:3-1-25(B) states: "Interest payments shall be charged on a daily basis for the period from the date the payment was made to the date upon which repayment is received by the state." Ohio Adm.Code 5101:3-1-25(C) further defines the "date payment was made," which in the Provider's case was December 31, 2003, the latest payment date in the exception reports used for analysis.*

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

Ohio Adm.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any audit initiated within the six year period is completed."

In addition, Ohio Adm.Code 5101:3-1-29(A) states in part: "…In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general."

Ohio Adm.Code 5101:3-1-29(B)(2) states: " 'Waste and abuse' are defined as practices that are incostent 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."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as an individual podiatrist. The Provider is also a member of a podiatry group practice, Podiatry of Hamilton, and billed services to Medicaid under the group's Medicaid number during the audit period.

We sent the Podiatry of Hamilton group and the Provider a notification letter on June 24, 2005 explaining that our audit of the Podiatry of Hamilton group had been expanded to include Dr. Roof. 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, 2001 through December 31, 2003. During this period (the audit period), the Provider was reimbursed $151,839.62 for 3,552 services rendered on 1,854 recipient dates of service. This payment total includes services billed under the Provider's individual Medicaid number (2145191) and the Podiatry of Hamilton group number (2207767). A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the Ohio Medicaid Providers Handbook as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's paid claims history from ODJFS' Medicaid Management Information System, which contains an electronic file of services billed to and paid by the Medicaid program. This 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).[4]

[4] 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

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:

- Billings for services to deceased recipients after their 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 code modifier, and same payment amount occurring on different claims.)
- New patient level evaluation and management services (office visits) billed for established patients.
- Debridement services performed and billed on a recipient more than once in a sixty-day period.
- Evaluation and management services billed in conjunction with surgical procedure(s) that included an evaluation and management service.
- Multiple surgeries and bilateral procedures were reimbursed appropriately.

The test for deceased recipients was negative, but all other exception tests identified potentially incorrect reimbursements. The Provider was asked to submit supporting documentation for any services they believed were appropriately billed and reimbursed.

Our work was performed between June 2005 and December 2005.

RESULTS

A total of $7,451.24 in findings repayable to ODJFS were identified by our exception tests. The circumstances leading to these findings are discussed below:

Incorrectly Billed Multiple Surgeries

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

> (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

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.

secondary procedure; and (c) Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Our computer analysis identified 290 recipient dates of service (645 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After further analysis, we determined that 51 recipient dates of service (126 services) were not properly reimbursed according to the multiple surgery rules. Therefore, we reduced the amount paid for 50 of the 126 services to what they should have been reimbursed under the multiple surgery rules. In performing our calculation, we always considered the highest paying service to be the primary service (100 percent payable); the second highest paying service to be the secondary service (50 percent payable); and all other services to be tertiary (25 percent payable). The finding amount of $1,539.08 is the difference between what was paid and what the Provider should have been paid.

Incorrectly Billed Bilateral Procedures

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

(1) "Bilateral procedures" are defined as surgical operations performed on both the right and left side of a patient's body during the same operative session requiring separate sterile fields and a separate surgical incision.

(2) Bilateral procedures should be billed to the department using the appropriate code for the procedure modified by the modifier 50 (e.g., 6943350 would mean a tympanostomy was performed on both ears. Code 69433 billed without a modifier would mean the procedure was performed on one ear).

(3) The medicaid maximum for bilateral procedures is one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally.

Our computer analysis identified 290 recipient dates of service (645 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating any services subject to the multiple surgery rules, we identified 15 recipient dates of service (30 services) where surgical services subject to the bilateral procedure rule had been improperly billed and resulted in an overpayment. These services (CPT 29580 - Strapping, Unna Boot) had been billed without a procedure code modifier (code 50, bilateral procedure). This resulted in the second CPT 29580 service being paid at 100 percent of the Medicaid maximum (200 percent for the pair), rather than the proper 50 percent (150 percent for the pair). We reduced the amount paid for 15 services by $17.95 (50 percent of price per service.) This resulted in a finding of $269.25.

E&M Service Incorrectly Billed in Conjunction with a Surgical Procedure

Ohio Adm.Code 5101:3-4-06(M)(3)(c) states:

> Visits on the same day as surgery. A provider may be reimbursed for a visit on the same day as surgery, only if the procedure is identified by an asterisk in appendix DD of rule 5101:3-1-60 of the Administrative Code and it is customary for the physician to charge a visit for all patients.

Our computer analysis identified 170 E&M services billed in combination with surgical procedures, not identified by an asterisk in appendix DD. After reviewing the medical documentation supporting these services; we determined that 143 of the 170 E&M services were overpaid. While reviewing documentation supporting the E&M services, we took exception with another 27 services (one service had two errors) where documentation was lacking to verify that the surgical procedure was performed. The findings for E&M services billed in conjunction with surgical procedures were $4,490.79, and the additional findings associated with the other services were $880.10. Thus, the total findings for this area were $5,370.89. The circumstances leading to these findings are discussed below.

E&M Services Included with Surgical Procedure

The American Medical Association's Surgical Package Definition states in pertinent part:

> In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation...subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)...

After reviewing the 170 E&M services billed in conjunction with surgical procedures, we determined that 56 E&M services were not separate and identifiable services from the surgical procedure being performed. Therefore, the E&M service was considered an "inclusive" service of the surgery and the extra charge for the E&M service was disallowed.

E&M Service Incorrectly Billed on the Same Date as a Strapping Procedure

Ohio Adm.Code 5101:3-4-22(H)(2) states:

> The casting, splinting and strapping procedures listed at the end of the musculoskeletal surgery section (codes 29000 through 29799) may be billed only when the casting, splinting or strapping is performed as a replacement procedure during or after the period of follow-up care. A visit may not be billed with any of the casting, splinting, or strapping codes.

Our review of the 170 E&M services determined that 59 E&M services were billed with a strapping or casting procedure where an E&M service should not have been billed. Therefore, we disallowed the extra charge for the E&M service.

Missing Documentation

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

> To maintain all records necessary and in such form so as to fully disclose the extent of services provided…

Our review of the 170 E&M services billed in conjunction with surgical procedures also identified 18 services where the Provider did not provide documentation to support that an E&M service had been provided. In addition, while reviewing patient medical records for the E&M services, we were unable to verify that 21 surgical, strapping, or x-ray procedures were performed. Thus, on these occasions, we took exception with the reimbursement for the surgical or strapping procedure and permitted the E&M service if it did not have any other errors. Furthermore, we recoded two of the x-ray procedures that had been reimbursed for a higher number of x-rays than the documentation supported. Therefore, we took the difference between what was reimbursed and the correct allowed amount.

E&M Billed During a Post Operative Period

Ohio Adm.Code 5101:3-4-06(M)(3)(d)(ii)(a) states:

> A physician may be reimbursed for visits provided during the minimum surgical follow-up period only if the visit was provided after the day of surgery and the visit was provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure (previously) performed.

The American Medical Association's Surgical Package Definition states in pertinent part:

> In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation...typical postoperative follow-up care.

Our review of the 170 E&M services billed in conjunction with surgical procedures also identified three services where the Provider billed for an evaluation and management visit during a surgical follow up period. We disallowed the reimbursement for these three services because patient documentation did not show the office visits involved a diagnosis, treatment, illness, and/or condition unrelated to the surgery. In addition we disallowed the reimbursement for one surgical service because the service should have been included in the typical postoperative follow-up care, and, therefore, not billed separately.

Level of Service Overstated

Ohio Adm.Code 5101:3-4-06(B) states:

> Providers must select and bill the appropriate visit (E & M service level) code in accordance with the code definitions and the CPT instructions for selecting a level of E & M service.

According to the AMA, which promulgates CPT definitions, new patient E&M services (billed as CPT codes 99201 through 99205) require the Provider's documentation to include all of the key components (history, examination, and medical decision making) and to meet or exceed the stated requirements to qualify for a particular level of E&M service. Established patient E&M services (billed as 99211 through 99215) require the Provider's documentation to include two of the three key components and to meet or exceed the stated requirements to qualify for a particular level of E&M service. In accordance with Ohio Adm.Code 5101:3-7-03, podiatrists may only bill codes 99201 through 99203 and 99211 through 99213 in this code series.

Our review of the 170 E&M services billed in conjunction with surgical procedures identified seven services where the Provider appropriately billed for an E&M visit that was separate and identifiable from the previous procedure; however, the level of service was overstated. Therefore, we reduced one service from a 99203 (a detailed new patient visit) to a 99201 (a problem focused new patient visit); five services from a 99202 (an expanded problem focused new patient visit) to a 99201; and one service from a 99222 (a comprehensive initial hospital care visit) to a 99221 (a detailed initial hospital care visit). We took the difference between what was paid and the Medicaid maximum payment allowed for the service level that should have been billed to determine the finding amount.

Non-Covered Services

Ohio Adm.Code 5101:3-7-04(B) states in pertinent part:

> In addition, the following services are noncovered, unless a recipient has a localized infection or is under the care of a doctor of medicine or a doctor of osteopathic medicine and surgery for a metabolic disease such as diabetes mellitus, or another condition which may result in a circulatory impairment or desensitization in the legs or feet:
>
> ***
>
> (2) Cutting or removal of corns and calluses;
>
> ***
>
> (6) Treatment of mycotic nails for an ambulatory and nonambulatory patient unless the physician attending the patient's mycotic condition documents that:
>
> (a) There is clinical evidence of onychomycosis of the toenail; and
>
> (b) The patient has mycosis/dystrophy of the toenail causing secondary infection and/or pain which results or would result in marked limitation of ambulation and require the professional skills of a podiatrist.

Our review of the 170 E&M services billed in conjunction with surgical procedures identified four services where the Provider billed for services that are not covered under the Medicaid program. One of the services was for the cutting or removal of corns and calluses. Three services were for debridement of mycotic nails; however, there was not proper documentation of the patient's mycotic condition in the chart to substantiate the service. Therefore, we disallowed the reimbursement for these four services because these services should have been noncovered.

Billing for E&M Services when not Customary for all Patients

Ohio Adm.Code 5101:3-4-06(M)(3)(c) states in pertinent part:

> …A provider may be reimbursed for a visit on the same day as surgery, only if…it is customary for the physician to charge a visit for all patients.

Our review of E&M services billed in conjunction with surgical procedures identified four services where the Provider billed Medicaid for an E&M service with an injection although the Provider did not customarily charge a visit for all patients. Therefore, we disallowed the reimbursement for the four E&M services.

Incorrectly Billed Debridement Services

Ohio Adm.Code 5101:3-7-03(C)(2) states in pertinent part:

> Surgeries…the following limitation applies: reimbursement for debridement of nails is limited to a maximum of one treatment within a sixty-day period.

Our computer analysis identified four occasions (total of eight services) where the Provider performed more than one debridement service within a sixty-day period. Because the maximum is limited to one treatment within sixty-days, we disallowed the four additional services. This resulted in a finding of $101.01.

Duplicate Claims

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part:

> …A provider agreement is a contract between the Ohio department of job and family services and a provider of medicaid covered services. By signing this agreement the provider agrees to comply with the terms of the provider agreement, Revised Code, Administrative Code, and federal statutes and rules; and the provider certifies and agrees:
>
> (A) To…submit claims only for service actually performed…
>
> ***

Our computer analysis identified four potential duplicate billings where the Provider charged more than once for the same procedure code, for the same recipient, on the same day, and for the same amount. We determined, by a review of the patients' medical records, that the services were billed and paid twice, but only performed once. Therefore, we disallowed the reimbursement for the second billed service. This resulted in a finding of $136.59.

Established Patients Billed as New Patients

Ohio Adm.Code 5101:3-4-06(B) states:

> Provider must select and bill the appropriate visit (E & M service level) code in accordance with the code definitions and the CPT instructions for selecting a level of E & M service.

The American Medical Association, 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 codes 99211 through 99215. Our computer analysis identified three services where the Provider billed a new patient E&M service after providing professional services within the previous three years. We took exception with one reimbursement because the Provider did not provide any additional documentation that would support recoding the service to an established level. The other two service reimbursements were taken back in other exception tests for more egregious errors. This resulted in a finding of $34.42.

Summary of Findings

In total, we identified $7,451.24 in findings for our January 1, 2001 to December 31, 2003 audit period that are repayable to ODJFS. The following table summarizes the basis for our findings.

Summary of Audit Findings for: Rodney Roof, D.P.M.
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 to December 31, 2003
Incorrectly Billed Multiple Surgeries	$1,539.08
Incorrectly Billed Bilateral Procedures	$269.25
E&M Service Incorrectly Billed in Conjunction with a Surgical Procedure	$5,370.89
Incorrectly Billed Debridement Services	$101.01
Duplicate Claims	$136.59
Established Patients Billed as New Patients	$34.42
TOTAL	**$7,451.24**

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

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on December 12, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider responded by agreeing that some payment errors had occurred. The Provider went on to state that their billing department billed all insurance carriers the same way and that only Medicaid took exception with their use of procedure modifiers for multiple surgeries and bilateral procedures. The Provider also stated that to their knowledge only Medicaid did not allow a 30 minute E&M service to be billed along with the time required to perform the surgical procedures. While Medicaid may not accept all procedure code modifiers, it does accept and in certain instances requires the use of certain modifies. Our review found that in many cases the Provider had failed to use the '50' modifier to identify bilateral procedures. In other cases, the Provider had used a '24' modifier to identify certain E&M services as being a unrelated evaluation and management service by the same physician during a postoperative period; while our review of the documentation for these services indicated that the E&M service was not separate nor distinct from the surgical procedure performed.

We advised the Provider that Medicaid reimbursement rules are the responsibility of the Office of Ohio Health Plans in the Ohio Department of Job and Family Services and recommended that the Provider's staff contact the Medicaid Provider Assistance Hotline for further guidance or clarification. A copy of the Provider's comments was also forwarded to ODJFS for their consideration in the review and formulation of Medicaid rules.

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RODNEY ROOF, D.P.M.

HAMILTON 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
DECEMBER 30, 2005