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

Ohio Medicaid Program

Review of Medicaid Provider Reimbursements Made to Ohio Health Center, Inc.

A Compliance Review by the

Fraud, Waste and Abuse
Prevention Division

October 2000 ***AOS/FWAP-01-014C***

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

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Ohio Health Center, Inc.
Ralph Newman, D.O.
Provider # 0939775
1000 East Broad Street
Columbus, Ohio 43205

Dear Dr. Newman:

We have completed our review of selected medical services rendered by Ohio Health Center, Inc. to Medicaid recipients for the period January 1, 1998 through December 31, 1999. We identified findings in the amount of $6,695.61, which must be repaid to the Ohio Department of Job and Family Services. A "provider remittance form" is located at the back of this report for remitting payment. The attached report details the basis for the findings.

Please be advised that in accordance with Ohio Revised Code Section 131.02, if payment arrangements are not made with the Ohio Department of Job and Family Services within 45 days of receipt of this report, this matter will be referred to the Ohio Attorney General's office for collection.

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Johnnie L. Butts, Jr., Chief, Fraud, Waste and Abuse Prevention Division, at (614) 466-3212.

Yours truly,

JIM PETRO
Auditor of State

October 24, 2000

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ABBREVIATIONS

AOS	Auditor of State
FWAP	Fraud, Waste and Abuse Prevention (Division of)
ODJFS	Ohio Department of Job and Family Services
OAC	Ohio Administrative Code
ORC	Ohio Revised Code
SURS	Surveillance and Utilization Review Section
E&M	Evaluation and Management

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SUMMARY OF RESULTS

The Auditor of State (AOS) performed a review of Ohio Health Center, Inc, Provider #0939775, doing business at 1000 East Broad Street, Columbus, Ohio 43205. During this review, we identified findings amounting to $6,695.61, which resulted from Medicaid claims submitted by Ohio Health Center, Inc. that did not meet reimbursement rules under the Ohio Medicaid Transportation Manual and the Ohio Administrative Code (OAC).

BACKGROUND

The AOS, working with cooperation and statistical data from ODJFS, performs audits designed to assess Ohio Medicaid providers' compliance with Federal and State claims reimbursement claim rules.

Medicaid, established in 1965 under the authority of Title XIX of the Social Security Act, is a Federal/State financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. The fundamental principal underlying Medicaid is medical necessity. All services, other than those services specifically categorized as "preventative" must be considered medically necessary for the patient's well being and health. The professionals who provide services to Medicaid recipients are know as *providers*[1].

ODJFS has direct operational responsibility for Ohio's Medicaid program. As part of that responsibility, ODJFS issued the Ohio Medicaid Provider Handbook which contains the regulations that providers must follow.

Pursuant to Chapter 3334 of the Medicaid handbook and Section 5101:3-1-27 of the OAC , providers are required to keep records which will disclose the extent of services rendered and upon request must provide those records. Additionally, statistical methods may be used to audit providers and to determine any amount of overpayment, which is recoverable at the time of discovery.

Pursuant to Chapter 3334, Section IV, Subsection (B) of the Ohio Medicaid Provider Handbook and Section 5101:3-1-172 of the OAC, 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 form the date of receipt of payment or until any initiated audit is completed, whichever is longer."

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

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

[1]Ohio Medicaid Provider Handbook, Chapter 3334, Section II, Part A, Program Definition.

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

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

OBJECTIVE, SCOPE AND METHODOLOGY

The objectives of this review were to: 1) determine whether the Provider's claims for reimbursement of services rendered to Medicaid patients were in compliance with regulations, and 2) calculate the amount of any ODJFS overpayment resulting from any noncompliance.

We reviewed the Provider's history of services billed to ODJFS ("claims history") and subsequent reimbursements to determine compliance with applicable regulations. A provider's claims history is maintained in ODJFS' Medicaid Management Information System (MMIS), which captures such data elements from providers' claims as: patient name, place of service, procedure/service billed, amount billed, billing period, and amount paid.

Following our claims history review and subsequent discussions with the Provider, we focused on three issues:

the basis for psychological services billed as CPT code 90802 (Interactive psychiatric diagnostic interview using play equipment. . . .);
the support for payments made for Evaluation & Management services and psychological interview services billed for the same patient on the same day; and
instances where the Provider may have been paid twice for the same service.

To augment our claims history review, we also reviewed five haphazardly selected patient case files.

Our review was limited in scope, as it included only selected services rendered by the Provider to recipients from January 1, 1998 through December 31, 1999. Our work and review were conducted in accordance with generally accepted government auditing standards.

FINDINGS

During the review period of January 1, 1998 through December 31, 1999, the Provider was reimbursed $525,953.29 by ODJFS for 29,555 Medicaid services. We found $6,695.61 in reimbursements that resulted from erroneous and duplicate billings. The results of our review and the basis for our findings are discussed below.

ERRONEOUSLY BILLED PSYCHOLOGICAL SERVICES

During the claims history review, we discovered that the Provider billed CPT 90802, (Interactive psychiatric diagnostic interview using play equipment. . . .), and for 169 of 170 patients, this code was billed for services to adults. Through a discussion with the Provider and a review of file documentation, we determined that CPT code 90802 should not have been billed. According to the Provider and our limited sample of patient files, the Provider administered Zung Depression Scale tests, not interactive interviews of adults. The Provider acknowledged the error and agreed that an overpayment had occurred.

Therefore, we determined that a $6,485.00 recoverable overpayment was made to the Provider for 200 interactive interviews billed and reimbursed during our audit period.

PSYCHOLOGICAL INTERVIEWS BILLED IN CONJUNCTION WITH EVALUATION AND MANAGEMENT (E&M) CODES

During our review of the claims history, we discovered the Provider billed psychological interviews[2] for the same patient on the same date of service as E & M codes. This type of psychological interview involves a diagnostic interview using play equipment and physical devices, which may overlap with E & M services[3], which typically involve an office visit and three components: an examination, a patient history, and medical decision making.

We reviewed five instances where this occurred to determine if the Provider appeared to be performing both services and if the services were correctly documented in the patient files. After review of the documentation, we determined that services were correctly documented. Therefore, we did not identify overpayments in this area. However, as previously stated, the code used to identify the psychological interview was erroneously billed.

DUPLICATE PAYMENTS

During review of the claims history, we discovered that eight procedures had been paid twice for the same recipient and service on the same date. The procedures identified were established patient, outpatient office visits and urinalysis, non-automated, without microscopy.

The Provider concurred with five of the eight instances of duplicate billings, but disagreed about receiving duplicate payments for the other three because his computer records did not show that he

[2]Interactive psychological diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication.

[3] Billed as CPT codes 99201 through 99205 for new patients and CPT codes 99211 through 99215 for established patients.

had been paid twice. However, we are making a finding for all eight duplicate payments because ODJFS' paid claims history files showed that the Provider had been paid twice for all eight claims, and the Provider did submit written documentation to the contrary.

CONCLUSIONS

Our review identified findings totaling $6,695.61 from payments made to the Provider for incorrectly billed Psychological services and duplicate billings.

A draft report was mailed to the Provider on June 15, 2000 to afford the Provider an opportunity to provide additional documentation or otherwise respond in writing. The Provider responded by telephone on June 20, 2000, and acknowledged the billing error for CPT code 90802. As noted above, the Provider also concurred with five of the eight instances of duplicate payments. Our findings include all eight instances of duplicate payments because ODJFS' records show that two payments were made in all eight instances, and the Provider did not give us documentation to dispute the three instances in question.

The Provider is aware that if payment is not made to ODJFS within 45 days of the date of this report, this matter will be referred to the Ohio Attorney General of collection.

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 Unit
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider:	Ohio Health Center 1000 East Broad Street Columbus, Ohio 43205
Provider Number:	0939775
Review Period:	January 1, 1998 through December 31, 1999
AOS Finding Amount:	$6,695.61
Date Payment Mailed:	
Check Number:	

IMPORTANT: To ensure that our office properly credits your payment, please also fax this remittance form to: Charles Carle at (614) 728-7398.

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OHIO HEALTH CENTER, INC.

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
OCTOBER 24, 2000