Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursement Made to Dona Dunkin Alba, D.O.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care Contract Audit Section

Auditor of State
Betty Montgomery

December 30, 2003

Dona Dunkin Alba, D.O.
525 E. Front Street
Logan, OH 43138

Re: Medicaid Audit of Dona Dunkin Alba, D.O.
Provider Number: 0312594

Dear Dr. Alba:

We have completed our audit of selected medical services rendered by you to Medicaid recipients for the period October 1, 1999 through September 30, 2002. We identified findings in the amount of $4,571.28, 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 is not made to 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 Cynthia Callender, Director, Fraud and Investigative Audit Group at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
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ABBREVIATIONS

AOS	Auditor of State
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
HCCA	Health Care/Contract Audit Section
MMIS	Medicaid Management Information System
OAC	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
ORC	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed a audit of Dona Dunkin Alba, D.O., Provider #0312594, doing business at 525 E. Front Street, Logan, OH 43138. Our audit was performed at the request of the Ohio Department of Job and Family Services in accordance with 117.10 of the Ohio Revised Code (ORC). As a result of this audit, we identified findings amounting to $4,571.28, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code (OAC).

BACKGROUND

Medicaid was established in 1965 under the authority of Title XIX of the Social Security Act and is a federal/state financed program which provides assistance to low income persons, families with dependent children, the aged, the blind, and the disabled. A Provider renders medical, dental, laboratory, or other services to Medicaid recipients. The Ohio Department of Job and Family Services (ODJFS) administers Ohio's Medicaid program, and issues the rules and regulations that providers must follow. The fundamental concept of the Medicaid program is medical necessity of services: 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 in cooperation with the Ohio Department of Job and Family Services, performs audits to assess Medicaid providers' compliance with federal and state claims reimbursement rules.

Section 5101:3-1-17.2 (D) of the OAC 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.

Section 5101:3-1-29(A) of the OAC states:

> 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.

In addition, Section 5101:3-1-29(B)(2) of the OAC 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 over utilization of medicaid covered services and result in an unnecessary cost to the medicaid program.

[1] See OAC Section 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 to calculate the amount of any finding resulting from non-compliance.

Following a letter of notification, we held an entrance conference with the Provider on May 14, 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 October 1, 1999 through September 30, 2002. The Provider was reimbursed $254,758.16 for 6,185 services rendered on 4,655 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. Within the Medicaid program, this provider is listed as an individual physician in general practice.

We used the Medicaid Provider Handbook, OAC, and ORC as guidance in determining the extent of 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 the five digit Current Procedural Terminology (CPT)[2] coding system or ODJFS local level codes[3].

While analyzing the Provider data prior to beginning our fieldwork and drawing statistically random samples, we extracted the following types of claims for further exception testing at the Provider's place of business:

- urinalysis services billed in conjunction with antepartum visits;
- antepartum visits billed after delivery and postpartum services;
- duplicate antepartum billings involving the same recipient, the same date of service, and the same procedure codes;
- new patient E&M codes billed for established patients within a three-year period of time;
- HealthChek services where more than one visit was billed within the same calendar year for recipients between the age of two and twenty.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed two statistically random samples.

- The first sample was a simple random sample of 25 delivery services billed as CPT code 59410 (Vaginal delivery and routine postpartum provided by same provider). Our objective was to determine whether postpartum services were provided.

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

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

- The second statistical sample was a stratified selection of 175 recipient dates of service containing a total of 272 services. To avoid double counting, this sample was drawn from service claims not already included in the exception tests identified above and our first sample. Our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between December 2002 and November 2003 and was done in accordance with government auditing standards.

FINDINGS

We identified findings of $4,571.28 from our exception tests and our analysis of the two samples. The circumstances leading to the findings are discussed below:

Exceptions with Antepartum Services

Section 1103.2 (A) (1) of the Medicaid Provider Handbook defines antepartum care as

> …all obstetrical care provided from the confirmation of the pregnancy and ending at the onset of established labor, induction, or cesarean section. The antepartum visit is inclusive of:
>
> > (a) Instruction, education and counseling on a variety of topics related to pregnancy, nutrition, infant care and family;
> >
> > (b) Routine urinalysis screening tests using reagent strips ("dipstick") to measure pH and/or to detect the presence of sugar, protein, or other components;
> >
> > (c) A physical examination which includes recording of weight, blood pressure, and fetal heart tones or similar routine services;
> >
> > (d) Coordination of the patient's medical care including at a minimum a planned hospital delivery at a designated hospital(s), arrangements for medical care and/or consultation (by telephone) in case of an emergency, and referrals to appropriate medical services (i.e., ultrasounds, etc.).

Furthermore, Section 1103.2 (A) (4) (a) states: "For services provided prior to July 1, 2003, antepartum visits must be billed to the department on a per-visit basis using the original code for antepartum care, 59420."

Our analysis of the Provider's claims history identified several exceptions with the Provider's billing for antepartum services.

Antepartum Services Billed After Delivery

We identified 23 services where the Provider erroneously billed the antepartem care CPT code 59420, when in fact the services were actually post delivery evaluation and management services. Because the Provider had billed CPT code 59410, which includes vaginal delivery and

routine postpartum care, we took exception with all 23 services, amounting to $1,113.20 in findings.

Urinalysis Services Billed in Conjunction with Antepartum Visits

We found six services where the Provider erroneously billed CPT code 59420 (antepartum care) in conjunction with CPT code 81002 (urinalysis service). Routine urinalysis screening tests are included in the reimbursement for antepartum care. Therefore, we took exception with the billing for the six urinalysis services, amounting to $19.56 in findings.

Duplicate Antepartum Service Billings

We disallowed four antepartum services because they were duplicative of another service paid for the same patient on the same date of service. These four services involved multiple antepartum visits (CPT 59420) billed for the same patient on the same date of service. We confirmed that only one service was rendered. We took exception with these four services, amounting to $193.60 in findings.

Multiple HealthChek (EPSDT) Screenings in a Calendar Year

Under Ohio's early and periodic screening, diagnosis and treatment program (EPSDT), a preventative "HealthChek" visit is a federally-mandated program of comprehensive preventive health services available to Medicaid-eligible persons from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems. The scope of the services provided to an individual depends on the age, gender, family medical history, and ethnic background of the patient; and any abnormalities encountered during a "HealthChek" (EPSDT) service.

Section 5101:3-14-04(B)(3) of the Administrative Code 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. If any of the screenings described in paragraph (B)(1) of this rule are given in the calendar year in which the child reaches his/her second birthday, another screening may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year.

From the Provider's MMIS claims history data, we identified 13 recipients over the age of two with a total of 29 HealthChek screening services within the same calendar year. We audited the patient records and found that 15 of the 29 HealthChek screening were multiple services provided in the same calendar year to the same recipient. These 15 services were down-coded to the appropriate E&M visit level of service provided to the patient. Our exceptions with the 15 HealthChek services resulted in $258.04 in findings.

New Patient Evaluation and Management Codes Billed for Established Patients

The Evaluation and Management (E & M) Service Guidelines state 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 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 five services where the Provider billed new patient CPT codes for established patients who were rendered professional services within the past three years. We took exception with these five services and reduced the services to established patient CPT codes. The difference between the amount payable for established patient services versus a new patient services amounted to findings of $52.04.

Summary of Exception Testing

Of the 98 services segregated from the sampled population for exception testing, we took exception with 53 services. Table 1 shows the basis for these exceptions.

Table 1: Summary of Exception Tests
For the Period October 1, 1999 – September 30, 2002

Basis for Exception	Number of Services with Exceptions
Antepartum Services Exceptions	33
Multiple HealthChek (EPSDT) Screenings in a Calendar Year	15
New Patient E&M Codes Billed for Established Patients	5
Total Services with Exceptions	53

Source: AOS analysis of the Provider's MMIS claims history

Postpartum Care Not Provided in Delivery Services Sample

OAC section 5101:3-4-08 (E) (1) (2) defines Delivery and Postpartum care as follows:

- "Delivery Services" include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without forceps and/or episiotomy), or Cesarean section delivery.

- "Postpartum Care" includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.

OAC Section 5101:3-4-08 (E) (3) states that the following codes should be billed for delivery and postpartum services provided to patients for which a vaginal delivery after a previous Cesarean delivery (VBAC) was not attempted:

59409 -Vaginal delivery, postpartum care provided by another provider
59410 -Vaginal delivery and routine postpartum provided by same provider
59514 -Cesarean section, postpartum care provided by another provider
59515 -Cesarean section and routine postpartum care provided by same provider

OAC section 5101:3-4-08 (E) (4) states in pertinent part: "For the reimbursement of CPT codes 59410, 59515…the provider must render, at a minimum, an evaluation and management service four to six weeks post delivery."

Of the 25 services billed as CPT code 59410 in our sample, we found that the Provider's records did not support that post delivery care services had been rendered for three of the services. Therefore, we reduced the allowable charge for the three services to CPT code 59409 (see above), with the difference repayable to ODJFS.

Projected Findings from Delivery Services Sample

We calculated the amount of overpayment by projecting the correct payment amount for the sample of 25 delivery services across the population of 50 delivery services paid to the Provider and subtracted the estimated correct population payment amount from the actual amount paid to the Provider. The projected correct population payment amount was $33,491.00, with a 95 % certainty that the actual correct payment amount fell within the range of $33,786.00 to $33,196.00 (+/- 0.88 %). Our projected finding of $366.00 resulted from subtracting the projected correct population amount ($33,491.00) from the actual amount paid to the Provider for these services during our audit period ($33,857.00). See Appendix I for more details concerning our projection.

Results of Second Sample Analysis

Our analysis of the Provider's supporting documentation for a stratified sample of 175 recipient dates of services (272 total services) identified exceptions in three areas: Unsupported Level of Evaluation and Management Service, Missing Documentation, and Multiple E & M Codes Billed Together.

Unsupported Level of Evaluation and Management Service

An Evaluation and Management service is a face-to-face encounter with a patient by the physician for the purpose of medically evaluating or managing the patient. Pursuant to the Medicaid Provider Handbook, Section 1101.2, "providers must select and bill the appropriate visit E&M service level code in accordance with the CPT code definitions and the CPT instruction for selecting a level of E&M services."

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

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

The key components[4] in selecting a level of E&M service to bill are history, examination, and medical decision making – the more complex the services involving these components, the higher the level of service billed, and the more a provider is reimbursed. E&M services for established patients are billed using CPT 99211 through 99215; while E&M services for preventive medicine for established patients are billed using CPT 99391 through 99397.

Section 5101:3-4-06(B) of the OAC states:

> "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."

Of the 272 services in our sample, we found eight services billed at the 99214 and 99391 levels that were not supportable because the patients' medical records did not contain the required level of service components for the CPT codes billed. For one service, the documentation supported two levels lower (e.g. 99212 instead of 99214). For five services, the documentation supported the next lowest level of service (e.g. 99213 instead of 99214). For the remaining two services, the documentation supported billing the CPT code 99212 instead of 99391. The following are examples of service levels we took exception with:

- In response to a mother's request during a prior visit, the physician obtained a consent form for local anesthesia, circumcised an infant, and answered the mother's questions about after care. We re-coded the service from the 99391 level to the 99212 level because the patient record lacked evidence of the eight key components necessary to bill 99391[5].
- The patient needed physician approval for surgery and patient records showed that patient vitals were taken (pulse rate, blood pressure, weight, and height). The physician contacted the surgeon to discuss the patient's diabetic control but did no further work up or exam. We re-coded the services from 99214 to 99212 because the patient record lacked evidence of two of three key components for 99214: a detailed history, a detailed exam, and a moderate complexity of decision making

When calculating our findings, we reduced the allowable payment for the eight services to a level supported by documentation in the patient record.

Missing Documentation

Section 5101:3-1-27(A) of the OAC states:

> All medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and

[4] 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.

[5] The 8 components are: 1) Comprehensive health and developmental history, 2) Comprehensive unclothed physical examination, 3) Developmental assessment (including physical and mental health development, 4) Nutritional assessment, 5) Vision assessment, 6) Hearing assessment, 7) Immunization assessment, and 8) Lead toxicity screening (all children must receive a blood lead screening test at 12-months and 24-months).

> level of services provided to medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services, the secretary of the federal department of health and human services, or the state medicaid fraud control unit upon request.

We found that three of the 272 services in our audit were missing documentation to support billing to ODJFS. Because the Provider did not maintain the required documents, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these three services.

Multiple Evaluation and Management Codes Billed Together

Section 5101:3-1-19.8 (F) of the OAC states in pertinent part:

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

We disallowed one of the 272 services in our audit sample because it duplicated another service paid for the same patient on the same date of service. The service involved two different Evaluation and Management services that were billed together. The Provider billed CPT code 99214 (an established patient office visit) in conjunction with CPT code 99382 (Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnosis) for the same patient on the same day. The patient's medical record supported that only the 99382 service was performed. Therefore, we disallowed the payments made for the 99214 service.

Projected Findings from Second Sample

Overall, we took exception with 12 of the 272 services in our sample of 175 recipient dates of services. Table 2 summarizes the basis for our exceptions.

Table 2: Summary of Exceptions from Sample Audit of Provider Records For the Period October 1, 1999 - September 30, 2002

Basis for Exception	Number of Services with Exceptions
Unsupported Level of (E&M) Service Billings	8
Missing Documentation	3
Multiple (E&M) Codes Billed Together	1
Total Services with Exceptions	12

Source: AOS analysis of a sample of 175 recipient dates of service not included in previous tests.

We calculated the amount of overpayment by projecting the correct payment amount for the sample 175 recipient dates of service across the total population of 4,546 recipient dates of service paid to the Provider using the ratio of correct payment amount to actual payment amount in our sample, and then subtracting the estimated correct population payment amount from the

actual amount paid to the Provider. The projected correct population payment amount was $203,582.97, with a 95 percent certainty that the actual correct payment amount fell within the range of $204,367.41 to $202,798.53 (+/- 0.39 percent). Our projected finding of $2,568.84 resulted from subtracting the projected correct population amount ($203,582.97) from the actual amount paid to the Provider for these services during our audit period ($206,151.81). See Appendix II for more details concerning our projection.

Provider's Response to our Findings

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on October 23, 2003. The Provider sent us a written response on November 6, 2003, along with additional documentation to support some of the claims for services we took exception with. As a result of the additional information supplied by the Provider, we reduced our findings from $8,633.58 to $4,571.28. These findings are repayable to the Ohio Department of Job and Family Services.

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APPENDIX I

Summary of Delivery Service Sample Analysis
Audit Period: October 1, 1999 – September 30, 2002

Description	
Type of Examination	**Statistical Simple Random Sample of 25 Delivery Services**
Number of Population Delivery Services	**50**
Number of Delivery Services Sampled	**25**
Total Medicaid Amount Paid During Audit Period	**$33,857.00**
Amount Paid for Services Sampled	**$16,928.50**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$33,196.00**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$661.00**
Upper Limit Correct Population Payment Amount at 95% Confidence Level	**$33,786.00**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	**$71.00**
Point Estimate of Correct Population Payment Amount	**$33,491.00**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$366.00**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$295.00 (0.88%)**

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

APPENDIX II

Summary of "All Other" Sample Analysis
Audit Period: October 1, 1999 – September 30, 2002

Description	
Type of Examination	**Statistical Stratified Random Sample of 175 Recipient Dates of Service**
Number of Population Recipient Date of Services	**4,546**
Number of Population Services Provided	**6.036**
Total Population Medicaid Amount Paid During Audit Period	**$206,151.81**
Number of Recipient Date of Service Sampled	**175**
Number of Services Sampled	**272**
Amount Paid for Services Sampled	**$15,518.42**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$202,798.53**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$3,353.28**
Upper Limit Correct Population Payment Amount at 95% Confidence Level	**$204,367.41**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	**$1,784.40**
Point Estimate of Correct Population Payment Amount	**$203,582.97**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$2,568.84**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$784.44 (0.39%)**

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

APPENDIX III

Summary of Audit Findings for Dona Dunkin Alba
Audit Period: October 1, 1999 to September 30, 2002

Description of Audit Finding	Dollar Amount of Finding
Medicaid Services Sample Excluding Other Samples and Exceptions	$2,568.84
Antepartum Visits Billed After Delivery and Postpartum Services Exceptions	$1,113.20
Delivery Services Sample	$366.00
Multiple HealthChek (EPSDT) Screenings in a Calendar Year Exceptions	$258.04
Duplicate Antepartum Billings Exceptions	$193.60
New Patient E&M Codes Billed for Established Patients Exceptions	$52.04
Urinalysis Services Billed in Conjunction with Antepartum Visits Exceptions	$19.56
Total Audit Findings	**$4,571.28**

Source: AOS analysis of MMIS information and the 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
Post Office Box 182367
Columbus, OH 43218-2367

Provider : Dona Dunkin Alba, D.O.
525 E. Front Street
Logan, OH 43138

Provider Number: #0312594

Audit Period: October 1, 1999 through September 30, 2002

AOS Finding Amount: $4,571.28

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: Thomas M. Tedeschi at (614) 728-7398.

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Betty Montgomery

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800-282-0370

Facsimile 614-466-4490

DONNA DUNKIN ALBA, DO

HOCKING 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, 2003