Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Alliance Medical Specialists, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

May 27, 2004

Andres Lao Jr., M.D., President
Alliance Medical Specialists, Inc.
75 West Glamorgan, Suite 101
Alliance, Ohio 44601

Re: Audit of Alliance Medical Specialists, Inc.
Provider Number: 0720447

Dear Dr. Lao:

We have completed our audit of selected medical services rendered to Medicaid recipients by you for the period October 1, 2000 through June 30, 2003. We identified $15,164.68 in findings, which must be repaid to the Ohio Department of Job and Family Services. A "Provider Remittance Form" is included at the back of this report for remitting payment. The attached report details the bases for the findings.

Please be advised that in accordance with Ohio Rev.Code 131.02, if repayment is not made to the Ohio Department of Job and Family Services within 45 days of the date 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 contact Cynthia Callender, Director of the 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
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TABLE OF CONTENTS

ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
HCPCS	Healthcare Common Procedural Coding System
HIPAA	Health Insurance Portability and Accountability Act
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Alliance Medical Specialists, Inc. (here after called the Provider), Provider # 0720447, doing business at 75 West Glamorgan, Suite 101, Alliance, Ohio 44601. 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 findings amounting to $15,164.68, 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 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 constitutes an over utilization of Medicaid covered services and results 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 to identify any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a physician group practice.

Following a letter of notification, we held an entrance conference at the Provider's place of business on January 21, 2004 to discuss the purpose and scope of our audit. 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, 2000 through June 30, 2003. The Provider was reimbursed $462,674.11 for 12,675 services rendered on 7,465 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH 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 Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & 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. These included tests for:

- Services rendered to deceased recipients after the date of their death.
- Potentially duplicated service claims where a duplicated claim was defined as two or more paid claims with the same date of service, patient, procedure code, procedure code modifier and reimbursement amounts.
- Potential billing errors in regards to the "units of service" field in which the Provider billed multiple units of service for CPT code 93010 (electrocardiogram, routine ECG with at least 12 leads; interpretation and report only).
- Potential Evaluation and Management (E&M) visit code billing errors:

[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. 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.*

- New patient E&M codes billed for established patients who had received professional services from the Provider within the past three years.
- New patient E&M codes billed more than once for the same recipient during the audit period.
- Critical care services rendered to Medicaid recipients.
- Multiple E&M codes billed for the same recipient on the same date of service.

The results of the above tests for potentially inappropriate services or service code combinations were negative except for duplicate service claims. During our field work, we reviewed the Provider's supporting documentation for the potentially duplicate service claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's medical services, we also analyzed a statistically random sample of 165 recipient dates of service, containing a total of 591 services, not already selected for examination by the computer exception analyses. Our objective was to determine whether patient records supported claims paid by Medicaid for these services.

Our work was performed between August 2003 and April 2004 in accordance with government auditing standards.

FINDINGS

Our review of the computerized tests on the Provider's Medicaid payments for potentially duplicated service claims identified findings of $217.53. Additionally, we identified and projected findings of $14,947.15 for errors identified in our review of sample recipient dates of service. These findings were in two categories: missing documentation and unsupported level of E&M service.

Together, our computer exception testing and statistical sample identified $15,164.68 in findings that are repayable to the Ohio Department of Job and Family Services. The circumstances leading to these findings are discussed below.

Duplicate Payments

Ohio Adm.Code 5101:3-1-19.8 (F) states in pertinent part:

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

During our field review, we reviewed patient records relating to seven (7) instances identified by our computer testing as potentially duplicate claims, i.e. two or more claims filed and paid for the same procedure code, the same recipient, the same payment amount and the same date of service. As a result, we identified $217.53 in findings, which represents the total amount of the duplicated claims.

Missing Documentation

Ohio Adm.Code 5101:3-1-27(C) states:

> ***
>
> Records, documentation and information must be available regarding any services for which payment has been or will be claimed to determine that payment had been or will be made in accordance with applicable federal and state requirements. For the purposes of this rule, an invoice constitutes a business transaction but does not constitute a record which is documentation of a medical service.
>
> ***

In our review of patient medical records for 165 recipient dates of service (591 services), we found 18 services that did not meet Medicaid requirements for reimbursement. For these services, we did not find any documentation in the patients' charts to show that services occurred on the date in question.

Unsupported Level of E&M Service

Ohio Adm.Code 5101:3-4-06(A)(2) states in pertinent part:

> A "physician visit" or 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...

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.
>
> ***

The American Medical Association descriptors for levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

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

The key components[3] in selecting an appropriate level of E&M service to bill are history, examination and medical decision-making – the more complex the services involving these components, the higher the level of service billed and the more a provider is reimbursed. E&M services for new patients are billed using CPT codes 99201 through 99205; while E&M services for established patients are billed using CPT 99211 through 99215.

From our sample of patient medical records for 165 recipient dates of service (591 services), we identified one (1) service where documentation in the patient's medical record did not support that the required component(s) of the E&M level service billed had been performed. In this instance, the Provider billed the highest level E&M code (99215), which requires a comprehensive history, a comprehensive examination, and high complexity of decision making. However, the patient record did not support that a comprehensive history was taken or a comprehensive examination was performed. When calculating our finding, we reduced the level of service due the Provider to the level supported by documentation in the patient record, a 99213.

Projection of Sample Findings

We took exception with six (6) of the 165 statistically sampled recipient dates of service (19 of 591 services) from a stratified sample of the Provider's population of paid services. Based on this error rate, we calculated the Provider's correct payment amount for this population, which was $420,980.82, with a 95 percent certainty that the actual correct payment amount fell within the range of $383,962.50 to $434,661.66 (+/- 8.79 percent). We then calculated the audit findings repayable to ODJFS by subtracting the correct population payment amount ($420,980.82) from the amount paid to the Provider for this population ($435,927.97), which resulted in a finding of $14,947.15. This finding must be repaid to ODJFS.

PROVIDER'S RESPONSE

Following review of a report draft, the Provider stated that they would repay the $15,164.68 in findings. The Provider also has committed to take corrective actions. The Provider said a custom report had been designed to prevent duplicate payments and billing personnel would review current patient charges before posting additional charges. In addition, the Provider stated

> After review of your findings the information was presented to our Board of Directors. The Board of Directors then presented the information to all of our physicians at our monthly Business Meeting on April 21, 2004 to address the findings of your audit.
>
> Alliance Medical Specialists, Inc. will continue to follow the Compliance Plan we have in place and additionally perform periodic internal audits. We will follow-up with any findings resulting from our internal audits with our physicians.

[3] *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.*

Copies of the Provider's responses to our audit will be forwarded to ODJFS' Surveillance and Utilization Review Section for their review and disposition.

APPENDIX I

Summary of Sample Analysis: Alliance Medical Specialists, Inc.
Audit Period October 1, 2000 to June 30, 2003

Description	Audit Period: October 1, 2000 – June 30, 2003
Type of Examination	**Stratified Random Sample of Recipient Dates of Service**
Number of Population Services Provided	**12,272**
Number of Population Recipient Dates of Service	**7,286**
Total Medicaid Amount Paid For Population	**$435,927.97**
Number of Recipient Dates of Service Sampled	**165**
Number of Services Sampled	**591**
Amount Paid for Services Sampled	**$40,429.19**
Point Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level	**$420,980.82**
Upper Limit Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level[4]	**$434,661.66**
Lower Limit Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level	**$383,962.50**
Precision of Estimate at the 95% Confidence Level	**$37,018.32 (8.79%)**
Point Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($435,927.97) – Point Estimate of Correct Population Payment Amount of $420,980.82)	**$14,947.15**
Lower Limit Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($435,927.97) – Upper Limit Estimate of Correct Population Payment Amount of $434,661.66)	**$1,266.31**
Upper Limit Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($435,927.97) – Lower Limit Estimate of Correct Population Payment Amount of $383,962.50)	**$51,965.47**

Source: AOS review of MMIS data and Provider Medical Records

[4] *Upper limit of correct population payment set to actual amount paid less actual errors found in sample.*

APPENDIX II

Summary of Audit Findings for: Alliance Medical Specialists, Inc.
Audit Period October 1, 2000 to June 30, 2003

Description of Audit Findings	Dollar Amount of Findings
Missing Documentation **Unsupported Levels of Service** **Projection of Sample Findings**	**$14,947.15**
Duplicate Payments	**$217.53**
Total Findings	**$15,164.68**

PROVIDER REMITTANCE FORM

Make your check payable to the Treasurer of State of Ohio and mail check along with this completed form to:

Ohio Department of Job and Family Services
Accounts Receivable
Post Office Box 182367
Columbus, Ohio 43218-2367

Provider: Alliance Medical Specialists, Inc.
75 West Glamorgan, Suite 101
Alliance, Ohio 44601

Provider Number: 0720447

Audit Period: October 1, 2000 – June 30, 2003

AOS Finding Amount: $15,164.68

Date Payment Mailed: _____

Check Number: _____

IMPORTANT:
To ensure that our office properly credits your payment, please also fax a COPY of this remittance form to (614) 728-7398: ATTN: Health Care and Contract Audit Section.

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Auditor of State
Betty Montgomery

88 East Broad Street
P.O. Box 1140
Columbus, Ohio 43216-1140

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

ALLIANCE MEDICAL SPECIALISTS, INC

STARK 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
MAY 27, 2004