



**Auditor of State
Betty Montgomery**

Ohio Medicaid Program

*Audit of Medicaid Reimbursements Made to
Derek C. Hindman, 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 Derek C. Hindman, D.P.M.
Provider Number: 0262880

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Derek C. Hindman, D.P.M. for the period January 1, 2001 through December 31, 2003. We identified \$41,134.46 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 any final determinations regarding recovery of the findings identified herein, 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 Derek C. Hindman, D.P.M., the Ohio Attorney General, and the Ohio State Medical Board. 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,

A handwritten signature in black ink that reads "Betty Montgomery".

Betty Montgomery
Auditor of State

TABLE OF CONTENTS

SUMMARY OF RESULTS	1
BACKGROUND	1
PURPOSE, SCOPE, AND METHODOLOGY	2
RESULTS	3
Exception Test Results.....	3
Multiple Surgeries.....	3
Bilateral Procedures	4
E&M Service Incorrectly billed in Conjunction with a Surgical Procedure	5
E&M Services Part of Surgical Procedure.....	5
E&M Service Incorrectly Billed on the Same Date as a Strapping Procedure.....	6
Missing Documentation	6
E&M Billed During a Post Operative Period	6
Level of Service Overstated.....	7
Duplicate Claims.....	8
Erroneously Billed Debridement Services.....	8
Sample Results.....	8
E&M Billed During a Surgical Follow-Up Period	8
Missing Documentation	9
Sample Projection	9
PROVIDER’S RESPONSE	9
APPENDIX I	11
APPENDIX II.....	12
Copy of PROVIDER’S Response.....	13

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 Derek C. Hindman, D.P.M. (hereafter called the Provider), provider #0262880, 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 \$41,134.46 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code Ohio and the Medicaid Provider Handbook (OMPH).

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 findings¹ 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 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 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, according to Ohio Adm.Code 5101:3-7-02(A) states in 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."

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

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)

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 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, Inc.; however, the Provider did not bill any services to Medicaid under the group’s Medicaid number during the audit period.

Following a letter of notification, we held an entrance conference at the Provider’s place of business on August 31, 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 January 1, 2001 through December 31, 2003. Excluding Medicare co-payments, the Provider was reimbursed \$367,429.17 for 8,579 services rendered on 3,320 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 paid 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).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 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

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:

- Checking for services to deceased recipients for service dates after their date of death.
- Checking for 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.)
- Checking for new patient level evaluation and management services billed for established patients.
- Checking for debridement services performed and billed for a recipient more than once in a sixty-day period.
- Checking for evaluation and management services billed by the Provider in conjunction with a surgical procedure(s) that included an evaluation and management service.
- Determining whether multiple surgeries and bilateral procedures were reimbursed appropriately.

The test for deceased recipients was negative, but all other exception tests identified potentially inappropriate service code combinations. When performing our audit field work, we reviewed the Provider's supporting documentation for all claims identified by our exception analyses with potentially inappropriate service code combinations.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a stratified statistically random sample of 171 recipient dates of service, containing a total of 505 services. The statistical sample was taken from a subpopulation of the Provider's claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review.

Our work was performed between April 2004 and October 2005.

RESULTS

We identified \$29,900.46 in findings from our exception tests and \$11,234.00 in projected findings from our statistical sample. The total findings of \$41,134.46 are repayable to ODJFS. The circumstances leading to these findings are discussed below:

Exception Test Results

Multiple Surgeries

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

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.

- (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 computer analysis identified 1,577 recipient dates of service (4,123 services) where the Provider billed for more than one surgical procedure on the same date for the same recipient. After eliminating services that were subject to the bilateral procedure rule (see next section) and any services that MMIS does not list as being subject to multiple surgery charge adjustment, we identified 979 recipient dates of service (1,725 services) that were potentially overpaid. After further analysis, we determined that 286 recipient dates of service (702 services) were not properly reimbursed according to the multiple surgery rules. Therefore, we reduced the amount paid for 332 of the 702 services to the correct amount. 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 \$8,508.02 is the difference between what was paid and what the Provider should have been paid.

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 1,577 recipient dates of service (4,123 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 329 recipient dates of service (643 services) where surgical services subject to the bilateral procedure rule had been improperly billed resulting 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 329 services by \$17.95 (50 percent of price per service). We also reduced another service by \$35.90 (100 percent of price per service) since it was a duplicated third strapping billed on that date. This resulted in a finding of \$5,941.45.

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

Ohio Adm.Code 5101:3-4-06(M)(3)(c) specifies the reimbursement rules for E&M services (office visits) that occur on the same day as a surgery:

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 527 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 502 of the 527 E&M services were overpaid. The E&M service exceptions we identified included: 1) services not separate and identifiable from the surgical procedures being performed; 2) services incorrectly billed on the same date as a strapping procedure; 3) services that lacked documentation in patient medical record to support a billed service; 4) services billed during a covered post operative period; and 5) services billed at a higher level than supported by medical records. The total findings identified for E&M services billed in conjunction with surgical procedures was \$14,636.42. For those E&M services that had multiple reasons for taking an exception, we identified one monetary finding for each service.

In addition, while reviewing patient medical records for the E&M services, we were unable to verify that 21 surgical or strapping services were actually performed; therefore, we took exception with the reimbursement for the 21 services and identified an additional finding for \$670.85. The reimbursement for these 21 services was also backed out of the sampled subpopulation prior to overpayment projection to avoid double counting. The circumstances leading to these findings are discussed below.

E&M Services Part of 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 527 E&M services billed in conjunction with surgical procedures, we determined that 198 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.

After reviewing the 527 E&M services billed in conjunction with surgical procedures, we determined that 314 E&M services were billed with a strapping 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 527 E&M services billed in conjunction with surgical procedures identified 47 services where the Provider did not have documentation in the chart 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 or strapping 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.

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.

Our review of E&M services billed in conjunction with surgical procedures also identified 48 services where the Provider billed for an evaluation and management visit during a surgical follow up period. We disallowed the reimbursement for these 48 services because the services

were not provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure previously performed.

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. Furthermore, established patient E&M services (billed as CPT codes 99211 through 99215) require the Provider's documentation to include two of the three 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. 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 E&M services billed in conjunction with surgical procedures identified two 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 99202 (an expanded problem focused new patient visit) and one service from a 99213 (an expanded problem focused established patient visit) to a 99212 (a problem focused established patient visit). We took the difference between what was paid and the Medicaid maximum payable amount for the recoded level of service to determine the finding amount.

- In the first visit, the patient's progress note listed a detailed history, which covered both the surgery and the separate E&M visit; a limited examination with only a description of appearance followed by an x-ray; a diagnosis confirming the x-ray results; and a plan of treatment. Because the visit focused solely on one problem/issue and had a detailed history, the service was performed at an expanded problem focused level.
- In the second visit, the patient's progress note showed it was a follow-up visit. The note listed a chief complaint, a limited examination followed by an x-ray, a diagnosis confirming the x-ray results, and a plan of care. Because this was a follow up visit and focused solely on one problem/issue, the service was performed at a problem focused level.

Duplicate Claims

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

Overpayments are recoverable by the department at the time of discovery...

Our computer analysis identified four potential duplicates 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. Further review determined that three services had been billed and paid twice, but only performed once. Therefore, we disallowed the reimbursement for the second billed service. This resulted in a finding of \$107.64.

Erroneously 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 three occasions (total of six 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 additional three services. After adjustment for multiple surgery overpayments, this resulted in a finding of \$36.08.

Sample Results

Our sample was a stratified random sample of 171 recipient dates of service, containing a total of 505 services. This statistical sample was taken from a subpopulation of the Providers claims that excluded all Medicare co-payments and all services that were identified by our exception tests for 100 percent review. This sample identified 30 services that were overpaid resulting in projected findings of \$11,234.00. The bases for these findings are presented below.

E&M Billed During a Surgical Follow-Up 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.

We took exception with the payment for five sampled services. The five errors occurred when the Provider billed for an E&M visit during the surgical follow-up period when the service was not separate and identifiable from the surgical procedure previously performed.

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...

We also disallowed the reimbursement for 25 sampled services because of a lack of proper documentation. The patient medical records for these 25 services either did not have any documentation in the patient record for the date of service billed or the documentation listed for that date did not support that the service billed was performed.

Sample Projection

The overpayments identified for 30 of 505 services (15 of 171 recipient dates of service) from our stratified random sample were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of \$20,101 with a 95 percent certainty and a precision of plus or minus \$8,867. Since the precision range was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed lower-limit estimate (equivalent to method used in Medicare audits), and a finding was made for \$11,234.00. This allows us to say that we are 95 percent certain that the population overpayment amount is at least \$11,234.00.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on August 19, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing. The Provider submitted a response regarding the matters discussed in this report which is attached for the review and consideration of ODJFS' Surveillance and Utilization Section.

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APPENDIX I
Summary of Statistical Sample Analysis for Derek C. Hindman, D.P.M.
Audit Period: January 1, 2001 – December 31, 2003

Description	Audit Period January 1, 2001 – December 31, 2003
Type of Examination	Stratified Statistical Random Sample
Description of Population	All paid services less 100% examined exception cases
Number of Population Recipient Date of Services	3,318
Number of Population Services Provided	7,936
Total Medicaid Amount Paid For Population	\$336,749.61
Number of Recipient Date of Services Sampled	171
Number of Services Sampled	505
Amount Paid for Services Sampled	\$54,102.32
Estimated Overpayment using Point Estimate	\$20,101
Precision of Overpayment Estimate at 95% Confidence Level	\$8,867
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	\$11,234

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

APPENDIX II
Summary of Overpayment Results for:
Derek C. Hindman, D.P.M.
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 to December 31, 2003
Multiple Surgeries	\$8,508.02
Bilateral Procedures	\$5,941.45
E&M Service Billed in Conjunction with a Surgical Procedure	\$15,307.27
Duplicate Claims	\$107.64
Erroneously Billed Debridement Services	\$36.08
Projected Findings for Statistical Sample	\$11,234.00
TOTAL	\$41,134.46

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

CENTER FOR FOOTCARE
MEDICINE AND SURGERY OF THE FOOT AND ANKLE

DR. KRISTIN TITKO • DR. JERRY TITKO • DR. DEREK HINDMAN • DR. RODNEY ROOF • DR. GARRY NELTNER • DR. BRYAN FALLIS • DR. CYNTHIA MILLER



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45013

111 WELLINGTON PLACE
CLIFTON, OHIO
45219

8474 WINTON ROAD
FINNEYTOWN, OHIO
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2859 BOUDINOT AVENUE
WESTERN HILLS, OHIO
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5525 MARIE AVENUE
BRIDGETOWN, OHIO
45247

4130 DRY RIDGE ROAD
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(859) 341-0575

3215 DIXIE HIGHWAY
ERLANGER, KENTUCKY
41018

Dear Mr. Lidman:

*Re: Medicaid Audit
Dr. Kristin Titko
Dr. Derek Hindman
Dr. Rodney Roof
Dr. Bryan Fallis*

We have reviewed many of our charts following your audit. We agree that payment errors did exist in various cases.

The audit essentially is limited to Multiple Surgeries, Bilateral Procedures and E & M with a surgical procedure. We do not understand and would appreciate clarification regarding "Projected Findings for Statistical Sample".

Our billing department, which consists of 6 full time experienced employees, bills all insurance companies in almost an identical manner. We use modifiers to explain Multiple Surgeries and Bilateral Procedures. Unfortunately, for whatever reason, only Medicaid does not accept these nationally recognized modifiers.

Regarding E&M Service in conjunction with a surgical procedure. Only Medicaid, to our knowledge, does not recognize payment for the 30 minute E & M Service along with the 20-30 minutes to perform the Surgical Procedures. All other insurances pay for both codes. As I explained before, our billing department bills all insurance essentially the same. The employees of the insurance companies then determine what codes they individually pay.

We would like to ask for two things:

- 1) We would prefer to negotiate a settlement and close this matter swiftly.*

2) *We would appreciate meeting with someone from Medicaid to avoid any future audits. From our point of view, the problems seems to be Medicaid not accepting the modifiers used by all other insurance companies. We would also appreciate knowing why Medicaid does not recognize and pay for an E & M service in conjunction with a Surgical Procedure.*

Thank you.

Sincerely,



Dr. Jerry L. Titko
JLT:kr



**Auditor of State
Betty Montgomery**

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DEREK C. HINDMAN, 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**