Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Columbus Southern MS, Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

March 21, 2006

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

Re: Audit of Columbus Southern MS, Inc.
Provider # 2091230

Dear Director Riley:

Attached is our report on Medicaid reimbursement made to Columbus Southern MS, Inc. for January 1, 2001 through December 31, 2003. We identified $178,139.01 in findings that are repayable to the State of Ohio. We are also recommending that the Department consider revising the rules under which it reimburses providers for trigger point injections. Presently, Ohio Medicaid rules are less restrictive than Medicare rules, which we calculate resulted in at least $220,348.77 in additional reimbursements to this provider during our audit period.

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering Ohio's Medicaid program, the Department is responsible for making a final determination regarding recovery of the findings and any accrued interest.

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 Columbus Southern MS, Inc., the Ohio Attorney General, and the Ohio State Medical Board. 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 assist further, 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
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

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ACRONYMS

AMA	American Medical Association
BWC	Ohio Bureau of Workers' Compensation
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DO	Doctor of Osteopathy
E&M	Evaluation and Management Service
HCCA	Health Care and Contract Audit
HCPCS	Healthcare Common Procedural Coding System
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
PA	Physician Assistant
RDOS	Recipient Date of Service
TPI	Trigger Point Injection

SUMMARY OF RESULTS

The Auditor of State performed an audit of Columbus Southern MS, Inc. (hereafter called the Provider), Provider # 2091230, doing business at 2912 South High Street, Columbus, OH 43207. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Section 117.10 of the Ohio Revised Code. As a result of this audit, we identified findings amounting to $178,139.01, based on reimbursements that did not meet the rules of the Ohio Administrative Code. We are also recommending that the Department consider revising the rules under which it reimburses providers for trigger point injections. Presently, Ohio Medicaid rules are less restrictive than Medicare rules, which we calculate resulted in at least $220,348.77 in additional reimbursements to this Provider during our audit period.

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 accrued interest.[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 general principles regarding reimbursement for Medicaid covered services.[3] 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."

[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)*

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 over utilization of medicaid covered services and results in an unnecessary cost to the medicaid program."

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 identify, if appropriate, any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as an osteopathic group.

Following a letter of notification, we held an entrance conference at the Provider's place of business on July 15, 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. The Provider was reimbursed $2,035,348.37 for 62,129 services, not involving Medicare co-payments, rendered on 21,236 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 Ohio Medicaid Provider Handbook (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).[4]

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

[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 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.*

services or service code combinations. Potentially inappropriate services identified by our computer analysis were selected for 100 percent review. These tests checked for the following:

- Services billed for recipients who died prior to the billed date of service.
- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and same payment amount occurring on different claims.
- Duplicate billings for services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and same payment amount occurring on the same claim.

The test for services rendered to deceased recipients was negative, but the other exception tests identified potential erroneous billings. When performing our audit field work, we requested the Provider's supporting documentation for all reimbursement claims with identified exceptions.

Because of the multiple issues involved and to facilitate an accurate and timely audit of the Provider's medical services, we also analyzed three samples of the Provider's services rendered during the audit period.

The first sample was a census (100 percent review) of all services rendered by the Provider on the three highest Evaluation and Management (E&M) service volume days within the audit period (April 28, 2003, June 2, 2003 and June 16, 2003), which consisted of 223 recipient dates of service (RDOS) and a total of 478 services. A RDOS was defined as all services received by a particular recipient on a specific date. We requested supporting documentation for the three high service volume days as a check on how the Provider was able to perform E&M office visits for 100 or more patients on 81 separate occasions during the audit period. The high service volume days were identified by merging billed service data from regular Medicaid, the Ohio Bureau of Worker's Compensation (BWC), and CareSource (Medicaid HMO insurer for Ohio). Our review was limited to just regular Medicaid, but auditors from BWC were present and performed the review of medical records related to workers compensation benefits.

The remaining two samples were both statistically random samples drawn from the subpopulation of claims not already identified for 100 percent review. The second sample of 70 recipient dates of service (comprising 229 services) was drawn from dates of service in which the Provider billed both Medicaid and BWC for an E&M service on the same day for the same recipient. We drew the final sample of 100 recipient dates of service (comprising 284 services) from all other Medicaid services not already selected for review.

During the course of our field review and sample record analysis of patient medical records, questions arose concerning the Provider's methods of administering and documenting trigger point injections (CPTs 20550, 20552, and 20553). Since trigger point injections made up $415,957.17 (20.46 percent) of the Provider's total Medicaid reimbursement, we broke out these services for separate review and analysis.

Our work was performed between February 2004 and December 2005.

RESULTS

We identified $7,414.00 in findings from our exception tests and $170,725.01 in findings from our statistical samples. We are also recommending that the Department consider revising the rules under which it reimburses providers for trigger point injections. Presently, Ohio Medicaid rules are less restrictive than Medicare rules, which we calculate resulted in at least $220,348.77 in additional reimbursements to the Provider during our audit period.

The circumstances leading to the findings and our concerns about trigger point injections are discussed below:

Results of Exception Tests

While reviewing patient medical records for potential duplicate services, we identified the following issues: (1) instances where the Provider billed twice for an identical services to the same patient on the same date, but documentation in the patient medical record showed only one service was performed; (2) instances where documentation for both potential duplicate services was missing from the patient medical record; (3) instances where physician assistants billed for established patient services without the required modifier; and (4) instances where a physician assistant performed services not approved in their utilization plan by the state medical board. The following presents the results of our exception tests.

Duplicate Billings

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…
>
> ***

We identified 290 duplicate billings involving the same patient, the same procedure code, and the same date of service. Our examination of the medical records supported that only one service was rendered; therefore, we took exception with the 290 duplicate billings resulting in findings totaling $7,187.90.

Billings for Services with Missing Supporting Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

> "…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 level of the services provided to medicaid consumers, and to document significant business transactions…"
>
> ***

While analyzing the potential duplicate billings, we identified three services where the patients' medical records did not contain the required documentation to support billing for the original services. Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we took exception with the three services lacking supporting documentation. This resulted in additional findings of $60.42.

Physician Assistant Services Erroneously Billed as Physician Services

According to Ohio Rev.Code 4730.01(A), " 'Physician assistant' means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance."

The Provider had one standard physician assistant utilization plan on file with the State Medical Board of Ohio and submitted notice when bringing new physician assistants (PAs) on staff. We audited the Medicaid services performed by the PAs during our audit period to determine if they had been billed in accordance with Medicaid rules and the utilization plan filed with the Medical Board.

Ohio Adm.Code 5101:3-4-03(C) states:

> (1) With the exception of services defined in paragraph (C)(2) of this rule, reimbursement for services described in paragraph (B) of this rule will be the provider billed charge or eighty-five per cent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit code followed by the UD modifier…
>
> ***
>
> (2) The following services will be considered physician services and will be paid for at one hundred per cent of the medicaid maximum.
>
> ***
>
> (b) Procedures/services performed by a physician assistant and the employing physician/group also provides direct and identified services, including a face-to-face encounter with the patient;…
>
> ***

While analyzing the potential duplicate billings, we identified three physician assistant services that had been billed without the required UD modifier and without direct and identifiable physician services required by Ohio Adm.Code 5101:3-4-03(C)(2)(b). Specifically, patient records lacked evidence that a physician saw the patient. Thus, the services had been erroneously reimbursed at 100 percent of the Medicaid maximum, instead of 85 percent of the maximum. We reduced the amount paid for the three services by 15% to adjust for the billing error. This resulted in findings totaling $18.19.

Billings for Physician Assistant Services Not Approved by the State Medical Board

Ohio Adm.Code 4731-4-01(A) states in pertinent part:

> The physician assistant shall perform only in the manner and to the extent set forth in the standard utilization plan and any supplemental plans of the supervising physician as approved by the state medical board…
>
> ***

Ohio Adm.Code 5101:3-4-03(B)(1) states in pertinent part:

> (a) The services are listed as standard functions for a physician assistant approved by the state medical board as described in rule 4731-4-01 of the Administrative Code with the exceptions of the services listed in paragraph (C)(4) of this rule; or
>
> (b) The services have been approved by the state medical board as supplemental functions for that physician assistant as descried in rule 4731-4-02 of the Administrative Code;
>
> ***

We identified reimbursements for four services performed by a physician assistant that were not approved by the state medical board as a standard or supplemental function of their utilization plan. These services were for CPT 20550 ~ Injection Tendon Sheath Ligament or Trigger Point and CPT 20552 ~ Single or multiple trigger point(s), one or two muscle(s). Based on the supporting documentation for these services, we believe the service provided would have been more appropriately billed as a lidocaine injection (CPT J2000), which was within the PA's utilization plan. We reduced the amount paid for these four services to CPT J2000 and took the difference as a finding totaling $147.49.

Summary of Exception Tests

Of the 578 services segregated from the sample population for special examination, we took exception with 300 services. Table 1 summarizes the exceptions found by reason and overpayment amount.

Table 1: Summary of Service Billing Exceptions Found During Analysis of Duplicate Billings

Basis for Exceptions	Number of Services with Exceptions	Repayable Finding
Duplicate Billings	**290**	**$7,187.90**
Billing for Services with Missing Supporting Documentation	**3**	**$60.42**
Physician Assistant Services Erroneously Billed as Physician Services	**3**	**$18.19**
Billing for Physician Assistant Services Not Approved by the State Medical Board	**4**	**$147.49**
Total Services with Exceptions	**300**	**$7,414.00**

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

Results of High Three Volume Days Census Analysis

We reviewed 100 percent of the services rendered by the Provider on the top three E&M high volume service days (April 28, 2003, June 2, 2003 and June 16, 2003), which comprised 223 recipient dates of service and 478 services. We identified $2,909.14 in findings for 133 of the 478 services. The findings resulted from deficiencies listed below:

Physician Assistant Services Erroneously Billed as Physician Services

Ohio Adm.Code 5101:3-4-03(C) states:

> (1) With the exception of services defined in paragraph (C)(2) of this rule, reimbursement for services described in paragraph (B) of this rule will be the provider billed charge or eighty-five per cent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit code followed by the UD modifier…
>
> ***
>
> (2) The following services will be considered physician services and will be paid for at one hundred per cent of the medicaid maximum.
>
> ***
>
> (b) Procedures/services performed by a physician assistant and the employing physician/group also provides direct and identifiable services, including a face-to-face encounter with the patient;…
>
> ***

We identified 51 physician assistant services that had been billed without the required UD modifier and without direct and identifiable physician services required by Ohio Adm.Code 5101:3-4-03(C)(2)(b). Specifically, patient records lacked evidence that a physician saw the patient. Thus, the services had been erroneously reimbursed at 100 percent of the Medicaid maximum, instead of 85 percent of the maximum. We reduced the amount paid for the 51 services by 15% to adjust for the billing error. This resulted in findings totaling $290.05.

Billings for Physician Assistant Services Not Approved by the State Medical Board

Ohio Adm.Code 4731-4-01(A) states in pertinent part:

> The physician assistant shall perform only in the manner and to the extent set forth in the standard utilization plan and any supplemental plans of the supervising physician as approved by the state medical board…
>
> ***

Ohio Adm.Code 5101:3-4-03(B)(1) states in pertinent part, "Services/procedures provided by a physician assistant…are covered if:

> (a) The services are listed as standard functions for a physician assistant approved by the state medical board as described in rule 4731-4-01 of the Administrative Code with the exceptions of the service listed in paragraph (C)(4) of this rule; or
>
> (b) The services have been approved by the state medical board as supplemental functions for that physician assistant as descried in rule 4731-4-02 of the Administrative Code;
>
> ***

We identified reimbursements for 51 services performed by a physician assistant that were not approved by the state medical board as standard or supplemental functions. These services included CPT 20552 ~ Single or multiple trigger point(s), one or two muscle(s); CPT 98925 ~ Osteopathic manipulative treatment (OMT); and CPT 97124 ~ Therapeutic massage, each 15 minutes, which require a physician or therapist to perform. Based on the supporting documentation for CPT 20552, we believe the service provided would have been more appropriately billed as a lidocaine injection (CPT J2000). We reduced the amount paid for the trigger point services to CPT J2000, which a physician assistant is approved by the state medical board to administer. For CPT 98925 and CPT 97124, there was no documentation to support billing an alternative procedure allowed to be performed by a PA. Therefore, we disallowed all PA performed services for CPTs 98925 and 97124, and took the difference between CPT 20552 and J2000, which resulted in findings totaling $1,657.67.

Physician Assistant Services Erroneously Billed for New Patients

Ohio Adm.Code 5101:3-4-03(B)(4) states:

> A patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.

Ohio Adm.Code 5101:3-4-03(B)(7) states:

> In each situation described in paragraphs (B)(4) to (B)(6) of this rule, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant.

We identified 15 services provided to new patients by a physician assistant. The documentation in the patient medical records did not support that a supervising physician was physically present, saw and evaluated the patient, and discussed patient management with the physician assistant. Therefore, we took exception with the payments for these 15 services, resulting in findings totaling $431.43.

Billings for Services with Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

> "…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 level of the services provided to medicaid consumers, and to document significant business transactions…"
>
> ***

We identified 14 services that were not supportable because the patients' medical records did not contain the required documentation to support billing to ODJFS. Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these 14 services resulting in findings totaling $448.95.

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

- History
- Examination

- Medical decision-making
- Counseling
- Coordination of care
- Nature of Presenting problem
- Time

The key components[5] in selecting a level of E&M service to bill are history, examination, and medical decision-making – the more complex the service 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 CPR 99211 through 99215.

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

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

As a result of our census review, we reduced the allowable payment for one evaluation and management service to the level supported by documentation in the patient's medical record. The following is the service we took exception with:

- The patient was in for a routine pap smear. The patient record showed that patient vitals had been taken (blood pressure, pulse rate, weight), and an expanded problem focused examination occurred. We recoded the service from 99215 to 99213 because the patient record lacked evidence of the key components for a 99215: a comprehensive history, a comprehensive examination, and a medical decision-making of high complexity.

When calculating our finding, we reduced the allowable payment for the one evaluation and management service to the level supported by documentation in the patient's record. A finding was then made for the difference between the amounts originally paid and the Medicaid maximum amount payable at the recoded level of service. This resulted in findings amounting to $46.69.

Multiple Procedure Codes Incorrectly Billed Together

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:

[5] Other contributory factors are counseling, coordination of a care, and nature of the presenting problem. The final component, time, is not considered a key or contributory component.

> (A) To…submit claims only for services actually performed…
>
> ***

According to the American Medical Association Guidelines for Pulmonary:

> Items 94010 – 94799 include laboratory procedure(s) and interpretation of test results. If a separate identifiable Evaluation and Management service is performed, the appropriate E/M service code should be reported in addition to 94010 – 94799.

We disallowed one of the 478 services in our sample because it duplicated another service paid for the same patient on the same date of service. The services involved CPT 94060 ~ Bronchospasm evaluation: spirometry before and after bronchodilator and CPT 99213 ~ Expanded history and examination, office or other outpatient visit. Because the patient's medical record did not indicate that a separate identifiable E&M service was performed in addition to CPT 94060, we took exception with the E&M service, which resulted in a finding of $34.35.

Findings from High Three Volume Days Census

Overall, we identified 133 exceptions in our sample of 478 services. Table 2 summarizes the bases for our exceptions.

Table 2: Summary of Findings from High Three Volume Days Census
For the Period of January 1, 2001 – December 31, 2003

Basis for Exception	Number of Services with Exceptions	Repayable Findings
Physician Assistant Services Erroneously Billed as Physician Services	**51**	**$290.05**
Billing for Physician Assistant Services Not Approved by the State Medical Board	**51**	**$1,657.67**
Physician Assistant Services Erroneously Billed for New Patients	**15**	**$431.43**
Billing for Services with Missing Documentation	**14**	**$448.95**
Unsupported Level of Evaluation and Management Service	**1**	**$46.69**
Multiple Procedure Codes Incorrectly Billed Together	**1**	**$34.35**
Total Services with Exceptions	**133**	**$2,909.14**

Source: AOS analysis of the Provider's high three volume days 478 services.

Analysis of Overlapping Medicaid and BWC Services

Overlapping Medicaid and BWC Evaluation and Management Services

Ohio Adm.Code 5101:3-1-08 states in pertinent part:

> (A) The medicaid program reimburses for covered services only after all available third-party benefits are exhausted. Payments for services provided under the

> medicaid program must be reduced to the extent that they are offset by an insurance policy, workers' compensation, or other third-party resource. The provider may not bill the medicaid consumer for any difference between the medicaid payment and the provider's charge, or request the consumer to share in the cost through a co-payment or other similar charge.
>
> (B) Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party. In such instances, the department will not reimburse for the cost of services which are or would be covered by a third-party payer. If the provider receives a third-party payment after having received a medicaid payment for the same items and services, the department must be reimbursed the overpayment. Under no circumstances may the provider refund any money received from a third party resource to a consumer.
>
> > (1) …After receipt of the third-party resource, the department may be billed for the balance, however, the total reimbursement shall not exceed the department's medicaid maximum amount. When the existence of third-party resources is known to the department and a claim is submitted that does not indicate collection of the third-party payment, the claim will be rejected pending determination of third-party coverage. Providers should complete their investigation of available resources before submitting the claim to the department for payment.

When claims involving multiple insurers are submitted for Medicaid reimbursement, ODJFS requires providers to indicate on their claims when another insurance carrier is involved. We reviewed the Provider's claims data submitted to ODJFS to determine if the Provider was coding for the existence of another insurer, (i.e., BWC.) We did not find any claims that were coded to show the existence of another insurer. Thus, ODJFS' claims processing system was not aware that a third-party payer was involved.

The Provider justified the dual billings on the basis that patients were being seen for different conditions, (e.g., a back injury as a result of an industrial injury and a common cold), and documentation in patient records generally supported this assertion. We question, however, whether a Provider should be entitled to reimbursement for two office visits during a single patient encounter. Office visit reimbursement rates, particularly for higher levels of service are based in part on taking a patient's vitals and performing a general examination – two things that generally would not be performed twice in a single patient encounter. Thus, to bill and be reimbursed twice for one office visit includes at least a degree of duplication.

When we discussed our results with ODJFS' Bureau of Health Plan Policy, which is responsible for writing Medicaid reimbursement rules, a spokesperson stated that regardless of the number of medical problems or conditions evaluated or treated during a medical visit and the number of payers responsible for the payment of a medical claim, only one visit code should be billed and paid. When more than one payer is involved, the principles of coordination of benefits should be followed. The primary payer should be billed first. Once payment is made by the primary payer,

the claim should be billed to the secondary payer and the billing provider should report the amount collected from the primary payer. This would enable the secondary payer to offset the payment by the amount previously collected.

The ODJFS spokesperson added that for workers' compensation claims specifically, the Provider would need to bill BWC for the level of the visit code appropriate for the workers' compensation portion of the claim. However, when billing Medicaid as the secondary payer, it would be appropriate for the Provider to bill the level of visit code appropriate for the entire visit, including the workers' compensation condition, as well as any additional medical condition(s). This would mean that the code billed to Medicaid may be at a higher level since it describes the entire service. Then, the third party liability process would offset the Medicaid maximum rate by the amount paid by BWC, and both departments would have paid the appropriate amount.

For example, assume a provider treated an ill Medicaid-eligible recipient who also had an approved workers' compensation claim. Then, assume the provider billed BWC for a 99212 office visit (a $43.94 reimbursement in 2003) to cover treatment for the workers' compensation claim. Following ODJFS' guidance, the provider might then bill Medicaid for a 99214 visit, representing the total services rendered to the patient during the visit and which had a $52.57 Medicaid maximum rate in 2003. In this example, the provider would have received a Medicaid reimbursement of $8.63 ($52.57 less the $43.94 already reimbursed by BWC).

To determine if the Provider properly billed for patients who were dually eligible for Medicaid and BWC services, we performed a computer match of Medicaid and BWC claims billed by and reimbursed to the Provider during our audit period. This match determined that the Provider supplied services to 2,338 unique Medicaid recipients and 1,043 unique BWC claimants during our audit period. Included were 788 overlapping claims, where an E&M service was billed to both agencies for the same patient on the same date of service. The Medicaid reimbursement for these services was $29,891.06.

To facilitate an accurate and timely analysis of the Provider's billings to Medicaid and BWC, we reviewed supporting documentation for a statistical sample of 70 of the 788 overlapping claims. The sample consisted of 70 patient dates of service, each of which contained both a Medicaid and BWC E&M service (CPT 99203 through 99245). These 70 patient dates also included reimbursements for 159 other non-E&M Medicaid services. Our review of the supporting documentation for the E&M services confirmed that only one office visit had occurred and, in accordance with ODJFS' guidance, we determined that a one level increase (e.g., 99213 to 99214) in the level billed to Medicaid was sufficient to cover the additional services for the BWC component of the office visit.

To determine the Medicaid amount that should have been reimbursed to the Provider, we subtracted the actual amount paid by BWC for the workers' compensation related E&M service from the Medicaid maximum allowed for the adjusted E&M service. Usually this resulted in an overpayment because for a given level of service, BWC pays more than Medicaid.

Following the logic used in analyzing our sample, we then performed an across-the-board calculation for all 788 overlapping claims. In 781 of the 788 claims, the amount paid by BWC

was greater than the adjusted amount payable by Medicaid, resulting in a net $29,235.87 overpayment by Medicaid.

Billings for Services with Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

> "…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 level of the services provided to medicaid consumers, and to document significant business transactions…"
>
> ***

Of the 159 other non-E&M services in our overlapping Medicaid and BWC service sample (which equated to 56 recipient dates for service after removal on dates of service that only involved an evaluation and management office visit), we found 14 billed services that were not supportable because the patients' records did not contain the required documentation to support billing to ODJFS. These included services for such items as CPT 20550 ~ Injection tendon sheath ligament or trigger point; CPT 93000 ~ Electrocardiogram with interpretation and report; CPT 71020 ~ Radiologic examination, chest, two views; CPT 94010 ~Spirometry, including graphic record; CPT 94375 ~ Respiratory flow volume loop, CPT 97012 ~Application of mechanical traction; and CPT 98925 ~ Osteopathic manipulative treatment.

Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we took exception with the payments for these 14 services.

Physician Assistant Services Erroneously Billed for New Patients

Ohio Adm.Code 5101:3-4-03(B)(4) states

> A patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.

Ohio Adm.Code 5101:3-4-03(B)(7) states

> In each situation described in paragraph (B)(4) to (B)(6) of this rule, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant.

Of the 159 non-E&M services in our sample of concurrent Medicaid and BWC medical services, we identified 12 services that had been provided to new patients by a physician assistant. The documentation in the patient medical records did not support that the supervising physician was

physically present, saw and evaluated the patient, and discussed patient management with the physician assistant. Therefore, we took exception with the payments for these 12 services.

Billings for Physician Assistant Services Not Approved by the State Medical Board

Ohio Adm.Code 4731-4-01(A) states in pertinent part:

> The physician assistant shall perform only in the manner and to the extent set forth in the standard utilization plan and supplemental plans of the supervising physician as approved by the state medical board…
>
> ***

Ohio Adm.Code 5101:3-4-03(B)(1) states in pertinent part, "Services/procedures provided by a physician assistant…are covered if:

> (a) The services are listed as standard functions for a physician assistant approved by the state medical board as described in rule 4731-4-01 of the Administrative Code with the exceptions of the service listed in paragraph (C)(4) of this rule; or
>
> (b) The services have been approved by the state medical board as supplemental functions for that physician assistant as described in rule 4731-4-02 of the Administrative Code;
>
> ***

Of the 159 non-E&M services in our sample of medical services, we identified 15 services that were performed by a physician assistant that were not listed as an approved standard or supplemental function of the PA utilization plan approved by the state medical board. The services billed were for CPT 20552 ~ Single or multiple trigger point(s), one or two muscle(s); and CPT 98925 ~ Osteopathic manipulation treatment (OMT) which is a manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders to one or two body regions. Based on the supporting documentation for CPT 20552, we believe that the service provided would more appropriately have been billed as a lidocaine injection (CPT J2000), which is within the scope of the PA's utilization plan. We reduced the amount paid for the trigger point services to CPT J2000 and took the difference in Medicaid maximum allowable payment as a finding. The documentation present did not allow the recoding of the OMT services to a service allowed to be performed by a PA; therefore, these services were disallowed in their entirety.

Findings for Non-E&M Services in Overlapping Sample

Overall, we identified 41 exceptions out of the 159 non-E&M services from our sample of concurrent E&M services billed to both Medicaid and BWC. Table 3 summarizes the bases for our exceptions.

Table 3: Summary of Findings from the Overlapping Medicaid & BWC Services For the Period of January 1, 2001 – December 31, 2003

Basis for Exception	Number of Services with Exceptions
Billing for Services with Missing Documentation	**14**
Physician Assistant Services Erroneously Billed for New Patients	**12**
Billing for Physician Assistant Services Not Approved by the State Medical Board	**15**
Total Services with Exceptions	**41**

Source: AOS analysis of a sample of 229 overlapping Medicaid & BWC services.

The overpayments identified for 23 of 56 statistically sampled RDOS (41 of 159 services) from our simple random sample of the Provider's subpopulation of Medicaid non-E&M paid services involved with overlapping services with BWC (which excluded services associated with Medicare co-payments, services extracted for 100 percent review) were projected across the Provider's total sub-population of paid recipient dates of service. This resulted in a projected overpayment amount of $13,451 with a 95 percent certainty that the true subpopulation overpayment fell within the confidence interval of $7,951 to $18,952. Since the confidence interval was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say we are 95 percent certain that the population overpayment amount is at least $8,859. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of All Other Medicaid Services Sample Analyses

Our sample of services not included in other analyses consisted of 100 recipient dates of services and 284 services. Our analysis of the supporting documentation for these services identified the following issues.

Billings for Services with Missing Documentation

Ohio Adm.Code 5101:3-1-27(A) states in pertinent part:

> …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 level of the services provided to medicaid consumers, and to document significant business transactions…
>
> ***

Within our sample of all services not included in other analyses (100 RDOS, 284 services), we found 18 billed services that were not supportable because the patients' records did not contain the required documentation to support billings to ODJFS. This included such services as CPT 20550 ~ Injection tendon sheath ligament or trigger point; CPT 71020 ~ Radiologic examination, chest, two views; CPT 93000 ~ Electrocardiogram with interpretation and report; CPT 95004 ~

Percutaneous tests; CPT 97124 ~ Therapeutic massage, each 15 minutes; and CPT 98926 ~ Osteopathic manipulation treatment.

Because the Provider did not maintain the required documentation, we were unable to confirm that the services were actually rendered. Consequently, we disallowed the payments received for these 18 services.

Physician Assistant Services Erroneously Billed as Physician Services

Ohio Adm.Code 5101:3-4-03(C) states:

> (1) With the exception of services defined in paragraph (C)(2) of this rule, reimbursement for services described in paragraph (B) of this rule will be the provider's billed charge or eighty-five per cent of the medicaid maximum, whichever is less. For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit code followed by the UD modifier…
>
> ***
>
> (2) The following services will be considered physician services and will be paid at one hundred per cent of the medicaid maximum.
>
> ***
>
> (b) Procedures/services performed by a physician assistant and the employing physician/group also provides direct and identifiable services, including a face-to-face encounter with the patient;…
>
> ***

Our sample of other services (100 RDOS, 284 services) also identified 16 services that had been billed without the required UD modifier and without direct and identifiable physician services required by Ohio Adm.Code 5101:3-4-03(C)(2)(b). Specifically, patient records lacked evidence that a physician saw the patient. Thus, the services had been erroneously reimbursed at 100 percent of the Medicaid maximum, instead of 85 percent of the maximum. We reduced the amount paid for the 16 services by 15% to adjust for the billing error.

Physician Assistant Services Erroneously Billed for New Patients

Ohio Adm.Code 5101:3-4-03(B)(4) states

> A patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant.

Ohio Adm.Code 5101:3-4-03(B)(7) states

> In each situation described in paragraph (B)(4) to (B)(6) of this rule, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant.

Our sample of other services (100 RDOS, 284 services) identified one service that had been provided to a new patient by a physician assistant. The documentation in the patient's medical record did not support that the supervising physician was physically present, saw and evaluated the patient, and discussed patient management with the physician assistant. Therefore, we took exception with the one service.

Billings for Physician Assistant Services Not Approved by the State Medical Board

Ohio Adm.Code 4731-4-01(A) states in pertinent part:

> The physician assistant shall perform only in the manner and to the extent set forth in the standard utilization plan and any supplemental plans of the supervising physician as approved by the state medical board…
>
> ***

Ohio Adm.Code 5101:3-4-03(B)(1) states in pertinent part, "Services/procedures provided by a physician assistant…are covered if:

> (a) The services are listed as standard functions for a physician assistant approved by the state medical board as described in rule 4731-4-01 of the Administrative Code with the exceptions of the service listed in paragraph (C)(4) of this rule; or
>
> (b) The services have been approved by the state medical board as supplemental functions for that physician assistant as described in rule 4731-4-02 of the Administrative Code;
>
> ***

Our sample of other services (100 RDOS, 284 services) also identified 16 services that were performed by a physician assistant, where the services were not listed as a standard or supplemental function in the PA utilization plan approved by the state medical board. The services billed were for CPT 20552 ~ Single or multiple trigger point(s), one or two muscle(s); and CPT 98925 ~ Osteopathic manipulation treatment (OMT) which is a manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders to one or two body regions. Based on the supporting documentation for CPT 20552, we believe that the service provided would more appropriately have been billed as a lidocaine injection (CPT J2000), which is within the scope of the PA's utilization plan. We reduced the amount paid for the trigger point services to CPT J2000 and took the difference in Medicaid maximum allowable payment as a finding. The documentation present did not allow the recoding of the OMT

services to a service allowed to be performed by a PA; therefore, these 16 services were disallowed in their entirety.

Projected Findings from the Sample

Overall, we identified 51 exceptions in our random sample of 100 RDOS and 284 services. Table 4 summarizes the bases for our exceptions.

Table 4: Summary of Findings from the All Other Services Sampled For the Period of January 1, 2001 – December 31, 2003

Basis for Exception	Number of Services with Exceptions
Billing for Services with Missing or Insufficient Documentation	**18**
Physician Assistant Services Erroneously Billed as Physician Services	**16**
Physician Assistant Services Erroneously Billed for New Patient Service	**1**
Billing for Physician Assistant Services Not Approved by the State Medical Board	**16**
Total Services with Exceptions	**51**

Source: AOS analysis of a sample of 284 medical services.

The overpayments identified for 23 of 100 statistically sampled RDOS (51 of 284 services) from our simple random sample of the Provider's subpopulation of paid services (which excluded services associated with Medicare co-payments, services extracted for 100 percent review, and overlapping services with Medicaid and BWC) were projected across the Provider's total sub-population of paid recipient dates of service. This resulted in a projected overpayment amount of $268,041 with a 95 percent certainty that the true subpopulation overpayment fell within a confidence interval of $102,744 to $433,338. Since the confidence interval was greater than our procedures require for use of a point estimate, the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment amount is at least $129,721. A detailed summary of our statistical sample and projection results is presented in Appendix II.

Questionable Billings for Trigger Point Injections

During the audit period, the Provider billed and was reimbursed $415,957.17 for 9,777 trigger point injection services (billed as CPT codes 20550, 20552 and 20553), accounting for 20.46 percent of the Provider's total Medicaid reimbursements. About 45 percent of the Medicaid recipients treated by the Provider during our audit period (1,043 of 2,338 patients) received trigger point injections.

According to the Neurology Channel, a medical information website of Healthcommunities.com[6], a trigger point injection (TPI) is a procedure used to treat extremely

[6] Healthcommunities.com is a leading provider of physician developed and monitored medical information, continuing medical education, and resources for the empowerment of health care consumers and medical professionals.

painful areas of muscle. Normal muscle contracts and relaxes when it is active. A trigger point is a knot or tight, ropy band of muscle that forms when muscles fail to relax. In the TPI procedure, a physician inserts a small needle into a patient's trigger point. The injection contains a local anesthetic that sometimes includes a corticosteroid.

The Centers of Medicare & Medicaid Services (CMS) state injections of trigger point or the tender areas associated with fibromyalgia syndrome, or for secondary manifestations of joint disorders such as osteoarthritis, may occasionally be medically necessary as a temporary measure during an acute episode, but should not be the mainstay of treatment of chronic pain syndrome. Chronic pain syndrome requires individual multidiscipline programs aimed at specific treatment goals.

As noted earlier, providers are required to bill for Medicaid services using HCPCS codes, which include descriptive CPT codes promulgated by the American Medical Association (AMA). The Provider billed the following trigger point injection codes during our audit period: CPT 20550[7] [an injection(s); single tendon sheath, or ligament], CPT 20552 [an injection(s) single or multiple trigger point(s), one or two muscle(s)], and CPT 20553 [an injection(s) or multiple trigger point(s), three or more muscles]. During our audit period, Ohio Medicaid paid $37.90 for CPT 20550 and $44.53 for trigger point injections billed as either CPT 20552 or CPT 20553.

Medicare guidance issued for services performed on or after June 30, 2002, states that documentation must be available in the patient's medical record to support the medical necessity of frequent or prolonged injection regimens. While Ohio Medicaid guidance is less specific, and the Medicare guidance was issued after the start of our audit period, the guidance indicates the expectations surrounding this type of treatment.

Ohio Medicaid rules regarding trigger point injections are general and contained in Ohio Adm.Code 5101:3-4-13, which states:

> (A) Therapeutic injections or other pharmaceuticals administered during an office visit.
>
> ***
>
> (3) A physician may be reimbursed, in addition to the office visit, for covered injections/drugs provided by and administered in the physician's office, clinic, in a patient's home, or in a long-term care facility (LTCF) when the physician purchased the injectable.
>
> (a) Conditions of reimbursement.
>
> (i) Reimbursement will be limited to only those injections/drugs:
>
> *(a)* That have an FDA approved indication; or

[7,] Effective January 1, 2002, the AMA created two CPT codes (20552 and 20553) for trigger point injections and modified its definition of CPT 20550 such that it no longer encompassed trigger point injections.

> *(b)* Considered by accepted standards of medical practice as specific or effective treatment for the particular condition for which given.
>
> *(ii)* Reimbursement will not be made for injections/drugs administered beyond the frequency or duration indicated by accepted standards of medical practice as an appropriate level of care for that condition.
>
> ***

In a "Notice of Operational Deficiency" issued to the Provider on March 29, 2004, ODJFS' Surveillance and Utilization Section, which also performs reviews of Medicaid provider reimbursement claims, stated "Frequent Trigger Point Injections were administered with inadequate history or exam to support the medical necessity; also the name and amount of medication administered was either not documented or illegible." The Provider was advised to correct this and other deficiencies immediately or face the possibility of further administrative sanctions.

The Provider gave us the following standard protocol for trigger point injection when we asked about the above deficiencies:

> …unless otherwise noted/documented, a trigger point injection will be done as follows: the trigger point lesion will be identified and the procedure will be explained to the patient along with the patient being placed in appropriate position for the injection to be given. Then under aseptic technique, approximately 1.5 cc of 1% lidocaine HCL without epinephrine will be administered/injected into the trigger point lesion muscle utilizing a 1.5 inch 27 gauge needle. Bandages, post care instructions, alternate medications or deviations from the above will be additionally documented as appropriate.

However, our review of documentation supporting 206 trigger point injection services billed by the Provider during our audit period continued to raise questions about these services. For example, the patient documentation did not specify the muscle group being treated or the reason for selecting this therapeutic option, nor were there any indications that the treatments were part of an overall treatment plan. Also, we noted that the Provider's trigger point injections were often not temporary in nature, as described by CMS. Of the 1,043 unique recipients receiving trigger point injections, 393 recipients received eight or more injections, 155 recipients received more than 20 injections, and one recipient received 88 injections during the audit period.

Based on the supporting documentation for the Provider's trigger point injections, we believe the injections could have been more appropriately billed as lidocaine injections (CPT J2000). As such, the Provider would have been paid between $2.16 and $2.86 per injection, instead of $37.90 to $44.53 per injection. We estimate billing for trigger point injections in lieu of lidocane injections increased Medicaid expenditures by at least $220,348.77 during our audit period. Our

estimate[8] represents the amount remaining after subtracting the recoverable findings for trigger points inappropriately administered by a physician assistant, not supported by documentation in patient records, and duplicate billed.

We do not believe the Provider's billings for trigger point injections would qualify for reimbursement under Medicare rules because patient documentation lacked evidence of a treatment plan or a reason for selecting this therapeutic option. However, because Ohio Medicaid rules as stated in Ohio Adm.Code 5101:3-4-13(A)(3)(a)(i)*(b* are less specific, we are not asserting findings in this matter. Nonetheless, because we believe there are questions as to whether the Provider's use of trigger point injections meets accepted standards of medical practice, we have referred this matter to the Ohio Medical Board for their consideration. And, because ODJFS is responsible for administrating the Medicaid program in Ohio, we are also recommending that the Department consider revising the rules under which it reimburses providers for trigger point injections. By adopting rules more akin to Medicare rules for trigger point injections, we calculate that the Department could have avoided at least $220,348.77 during our audit period.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider's legal representative on December 6, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing.

In a response letter dated January 6, 2006, the Provider's legal representative disagreed with our audits findings relating to (1) duplicate payments; (2) physician assistant services erroneously billed as physician's services; (3) billings for physician services not approved by the state medical board; (4) physician assistant services erroneously billed for new patients; (5) unsupported level of evaluation and management service; and (6) overlapping Medicaid and BWC evaluation and management services. The Provider's response is included in its entirety at the end of this report.

With regards to duplicate payments, no additional documentation was provided to verify that some of the duplicates were in fact separate and distinct services and thus reimbursable. In the absence of supporting documentation, we did not change our findings for services identified as duplicates.

With regards to the other areas of disagreement, we coordinated the positions taken in our report with representatives of the Ohio Department of Job and Family Services, the Ohio Bureau of Workers' Compensation, the Ohio State Medical Board, and the Ohio Attorney General during the performance of our audit. As such, we believe the rules forming the bases for our findings have been interpreted correctly.

[8] A one-tailed estimate that has a 95 percent degree of confidence that the amount in question is at least $220,348.77.

APPENDIX I

Summary Table of Sample Record Analysis for Columbus Southern MS, Inc.
Subpopulation of Medicaid Non Evaluation & Management Services Involved with BWC Overlapping Dates of Service Excluding Exception Tests and Non Medicare Co-payment Services
For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 – December 31, 2003
Type of Examination	**Statistical Simple Random Sample**
Description of Population	**Non E&M Medicaid paid services from Overlapping BWC and Medicaid Services**
Number of Population Recipient Date of Services	**611**
Number of Population Services Provided	**1,697**
Total Medicaid Amount Paid For Population	**$60,018.15**
Number of Recipient Date of Services Sampled	**56**
Number of Services Sampled	**159**
Amount Paid for Services Sampled	**$5,421.14**
Estimated Overpayment using Point Estimate	**$13,451**
Lower Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$7,951**
Upper Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$18,952**
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	**$8,859**

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

APPENDIX II

Summary Table of Sample Record Analysis for Columbus Southern MS, Inc. Subpopulation of Non Exception, Non BWC Overlap, and Non Medicare Co-payment Services For the period January 1, 2001 to December 31, 2003

Description	Audit Period January 1, 2001 – December 31, 2003
Type of Examination	**Statistical Simple Random Sample**
Description of Population	**All paid services net of adjustments and excluding Medicare Co-payments, 100% Exception tests, and Overlapping BWC and Medicaid Services**
Number of Population Recipient Date of Services	**20,201**
Number of Population Services Provided	**59,046**
Total Medicaid Amount Paid For Population	**$1,924,816.26**
Number of Recipient Date of Services Sampled	**100**
Number of Services Sampled	**284**
Amount Paid for Services Sampled	**$9,552.03**
Estimated Overpayment using Point Estimate	**$268,041**
Lower Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$102,744**
Upper Limit Overpayment Estimate at 95% Confidence Level (two-tailed).	**$433,338**
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	**$129,721**

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

APPENDIX III

Summary of Audit Findings for Columbus Southern MS, Inc.
Audit Period: January 1, 2001 to December 31, 2003

Basis for Exception	Amount of Overpayment
Duplicate Billings	**$7,187.90**
Billing for Services with Missing Documentation	**$60.42**
Physician Assistant Services Erroneously Billed as Physician Services	**$18.19**
Billing for Physician Assistant Services Not Approved by the State Medical Board	**$147.49**
High Three Volume Days Census	**$2,909.14**
Estimated Overpayment for Overlapping Medicaid and BWC Evaluation and Management Services	**$29,235.87**
Projected Overpayment from Non-E&M Services in Overlapping Medicaid & BWC Services	**$8,859.00**
Projected Overpayment from All Other Services Sampled	**$129,721.00**
Total Services with Exceptions	**$178,139.01**

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

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J. RANDALL RICHARDS
Attorney at Law
An Associate of Geoffrey E. Webster

Two Miranova Place, Suite 310
Columbus, Ohio 43215
614 / 461-1156
FAX #614 / 461-7168
jrresq@yahoo.com

January 6, 2006

Robert I. Lidman
Healthcare and Contract Audit Section
35 North Fourth Street, 1st Floor
Columbus, Ohio 43215

Re: Columbus Southern MS, Inc.

Dear Mr. Lidman:

On behalf of Columbus Southern Ms, Inc., I am submitting the provider's response to your draft audit report issued December 6, 2005.

A. Exception Test Results

1. Duplicate Billings

The provider contests the Auditor's findings made in regard to duplicate billings. The Auditor made finding of duplicate billings involving the same patient, and the same procedure performed on the same date of service. Upon review of these records, it is clear these are not duplicate billings but separate and distinct billings. Each and every instance identified includes treatment for multiple body locations. Specifically, the same procedure and therefore the same procedure code was performed to the left hand and the right hand of the patient with the same date of service. Thus, when treatment is provided on two separate body parts but for the same condition to those separate body parts, the codes, date of service, and patient will obviously remain the same. For example, x-rays taken of the right hand and x-rays taken of the left hand will be billed to the same patient, with the same procedure code and with the same date of service. This is not duplicate billing. This is the proper billing for separate and distinct services to the same patient.

2. Physician Assistant Services Erroneously Billed As Physician's Services

The provider strenuously contests the Auditor's finding that the physician assistant services were erroneously billed as physician's services. To make this finding, the Auditor has misconstrued the definition of direct and identified services pursuant to Ohio Administrative Code 5101:3-4-03(C)(1)(b). Subsection (b) states that reimbursement for physician assistant services will be billed at 85% of the Medicaid maximum with the exception of services such as "procedures/services performed by a

physician assistant and the employing physician/group also provides direct and identifiable services including a face to face encounter with the patient; …" The Auditor has misconstrued this section to require a face to face encounter by the physician in order for the physician assistant services to be billed at a 100% of the Medicaid maximum. Such an interpretation is inconsistent with the commonly used definition of the word "including." Including means to contain within as part of the whole. See, Webster's Dictionary. Thus, a face to face encounter with the patient is contained as a part of the whole definition of direct and identifiable services. Therefore, a face to face encounter is not the only direct and identifiable service. As such, a physician assistant may provide a service during which the employing physician provides direct and identifiable services without a face to face encounter with the patient. The most common example of this would be a full and thorough examination by the physician assistant with a change in medication ordered by the physician based upon that examination, but without a face to face encounter with the patient.

All services provided by the physician assistant were provided in conjunction with direct and identifiable services performed by the physician. Therefore, reduction to 85% is inappropriate.

3. Billings For Physician Assistant Services Not Approved By The State Medical Board

The provider strenuously contests the Auditor's findings related to billing for physician assistant services not approved by the State Medical Board. At no time and under no circumstances has a physician assistant ever performed services that were not approved by the State Medical Board. The Auditor contends that services provided that are not approved by the State Medical Board include: 1. single or multiple trigger point(s), one or two muscles, 2. osteopathic manipulative treatment, 3. therapeutic massage.

This is another example of misinterpretation of the Ohio Administrative Code. The Auditor correctly points out that Ohio Administrative Code 4731-4-01(A) states in pertinent part;

> "The physician assistant shall perform only in the manner and to the extent set forth a standard utilization plan and any supplemental plans of the supervising physician as approved by the State Medical Board."

The Auditor also correctly points out that the Ohio Administrative Code 5101:3-4-03(B)(1) states in pertinent part;

> "Services/procedures provided by a physician assistant…are covered if: (a) the services are listed as standard functions for a physician assistant approved by the State Medical Board as described in Rule 4731-4-01 of

> the Administrative Code with the exceptions of the services listed in paragraph (C)(4) of this rule…"

However, the sections cited by the Auditor do not support its contention that the physician assistant provided services not approved by the State Medical Board.

Ohio Administrative Code 4731-4-01 defines the standard functions for a physician assistant. Under subsection (B), a supervising physician may authorize a physician assistant to perform the following functions: (1) under "off site supervision, on site supervision, or direct supervision" as defined by Rule 4731-4-03 of the Administrative Code: (g) implementing treatment plans that have been reviewed and approved by the supervising physician, subject to the supervision requirement of Rule 4731-4-03(D).

This Code section defines all of the functions a physician assistant is authorized to perform. The functions with which the Auditor has taken exception fall within subsection (g) implementing treatment plans. So long as the trigger point injections, osteopathic manipulative treatment, and therapeutic massage had been reviewed and approved by the supervising physician, the physician assistant is authorized to implement those treatments. Again, such treatment only requires on site supervision, which only requires the physical presence of the supervising physician in the same location (e.g., the physician's office suite) as the physician assistant, but does not require his physical presence in the same room. 4731-4-03(B)(2).

The allegation that a trigger point is not a service approved by the State Medical Board is particularly troubling as it is simply an injection, nothing more. It is customary for injections to be performed by nurses as well as other medical staff not as well trained as a physician assistant. To preclude a physician assistant from administering an injection places their level of skill below that of a medical assistant with far less training and education. Further, had the physician assistant actually been engaging in providing services not approved by the State Medical Board, the Medical Board would have taken administrative action against both the physician and the physician assistant. See, Royder v. State Medical Board of Ohio, 2002 WL31867888. No such action has been taken by the State Medical Board.

Further, the Administrative Code specifically lists those services or acts that physician assistants are prohibited from performing. See, OAC 4731-4-04. A thorough examination of this Code section makes it clear that a physician assistant is not prohibited from administering trigger point injections, manipulative treatment, or therapeutic massage. None of those treatments are enumerated in the prohibition section. Therefore, the physician assistant is permitted to administer such procedures in accordance with the treatment plan reviewed and approved by the supervising physician.

4. Physician Assistant Services Erroneously Billed For New Patients

The provider strenuously objects to the Auditor's finding related to physician assistants allegedly billing for new patients. Again, all services provided by the physician assistants are performed in accordance with law and the physician assistant utilization plan. Pursuant to Ohio Administrative Code 4731-4-01 a physician assistant may obtain comprehensive patient histories, perform physical examinations, initiate requests and/or perform routine laboratory radiologic and diagnostic studies, identify normal and abnormal findings on histories, assess patients and screen patients to aide the supervising physician and determine the need for further medical attention provided all of these are performed under the supervision of the on site supervising physician. Pursuant to the physician assistant utilization plan, there is no prohibition against the physician assistant making preliminary findings regarding new patients, much as many nurses do as well. 5101:3-4-03 merely requires that the supervising physician evaluate the patient during the visit. While a physician assistant may perform a significant role in the initial evaluation, the supervising physician always sees and evaluates the patient independently. At all times, the supervising physician also discusses patient management with the physician assistant as is protocol.

Again had this been an issue outside the scope of practice for a physician assistant, the Medical Board of Ohio would have taken appropriate action. No such action has taken place because no such violation has occurred.

5. Unsupported Level Of Evaluation And Management Service

The provider contests the Auditor's findings related to unsupported level of evaluation and management service. The Auditor takes issue with one patient record. The Auditor alleges that an incorrect code was used for a visit during which a patient was administered a pap smear. The Auditor further claims a lack of comprehensive history, comprehensive examination, and medical decision making of a high complexity. The provider objects to the Auditor making a medical determination as to what constitutes a medical decision of high complexity. That is purely a decision for a medical professional. As even the Auditor admits, that an expanded examination had occurred, it is unreasonable to believe that a comprehensive history and comprehensive examination did not take place. Further, as this was coded for an existing patient, routine protocol would be to elicit history in change in circumstance in an examination related to the same. Therefore, it is the provider's position the proper level of E & M service was billed.

B. Findings from High Three Days Census

1. Overlapping Medicaid And BWC Evaluation and Management Services

The provider adamantly and strenuously objects to the Auditor's analysis of overlapping Medicaid and BWC services. The manner in which the Auditor suggests billing should take place under these circumstances is tantamount to both Workers' Compensation fraud and Medicaid fraud. The Auditor suggests that when a patient is

treated for both workers' compensation injuries and unrelated healthcare issues during the same visit, the Bureau of Workers' Compensation should be billed for the visit as the "primary insurer." The Auditor then suggests that whatever the Bureau of Workers' Compensation does not pay for could then be resubmitted to Medicaid for reimbursement. Such a suggestion demonstrates a profound misunderstanding of the workers' compensation system.

The Bureau of Workers' Compensation and/or the managed care organization responsible for payment of workers' compensation medical bills would certainly reject any bill that includes services for any condition that is not a recognized allowed condition in the patient's workers' compensation claim. The BWC or MCO would not simply bifurcate the bill as the Auditor suggests. The bill would be rejected outright for treatment of non-allowed conditions. That is the nature of the workers' compensation system.

Should a provider submit a bill to the Bureau of Workers' Compensation listing only treatment to the allowed conditions in the claim, but when non-allowed conditions were actually treated as well, that would be Workers' Compensation fraud as the provider is submitting payment for services to non-allowed conditions. To suggest the provider should bill in this manner is akin to suggesting that a BWC claim can be treated just the same as medical insurance. So long as there is nominal treatment to the allowed workers' compensation conditions, the physician may provide any other medical treatment the patient may need as the office visit will be covered by workers' compensation. For example, patient A has a workers' compensation claim allowed for a lumbosacral sprain. Patient A presents to provider B because Patient A believes he has the flu. Provider B examines patient A regarding the flu-like symptoms, develops a treatment plan, and implements the treatment plan to address the flu-like condition. Provider B also performs range-of-motion testing on patient A's lower back. No further treatment is provided to the lower back. Under the Auditor's scenario, this visit should be submitted solely to the Bureau of Workers' Compensation to determine how much of that claim will be reimbursed under the workers' compensation system. As the Bureau will only reimburse for treatment to allowed conditions, the ICD-9 code for lumbosacral sprain would be the code billed for this visit. Obviously, should there be an audit of the files or even a submission of the doctor's office note, it would be clear that this office visit included treatment for non-allowed conditions. The physician would be billing treatment for non-allowed conditions to the BWC, i.e., workers' compensation fraud. This is the exact scenario likely to result from the Auditor's suggested billing practice.

Conversely, such a billing practice would have a negative effect on the Medicaid system as well. As state above, the BWC would certainly reject any bill that included treatment to non-allowed conditions. Thus, once that bill has been rejected in its entirety by the BWC, the provider would then turn to Medicaid for reimbursement. Medicaid would then be required to reimburse for the entire visit including for the allowed conditions in the workers' compensation claim. Again upon audit or review of medical records, it would appear clear that those conditions should have been paid for by the

Bureau of Workers' Compensation first and should have been billed accordingly. Since the entire visit was then billed to Medicaid, the provider engages in Medicaid fraud for failure to have treatment to lumbosacral sprain paid by the other insurer.

To avoid these very likely contingencies, the current provider has maintained separate and distinct charts and billings for workers' compensation conditions and all others which are properly billed to Medicaid.

2. Physician Assistant Services Erroneously Billed For New Patients

See same heading above.

3. Billings For Physician Assistant Services Not Approved By The State Medical Board

See same heading above.

4. Findings For Non E&M Services in Overlapping Sample

See same heading above.

C. Results Of All Other Medicaid Services Sample Analyses

For each subheading, see the same heading above.

CONCLUSION

Columbus Southern MS, Inc. asserts that its billing practices are in compliance with both federal and state law. At no time has a physician assistant affiliated with the company ever performed any service outside those are permitted by law and/or the physician assistant utilization plan approved by the Medical Board of Ohio. Finally, it is the provider's position that its bifurcation of BWC claims and Medicaid claims actually prevents waste, fraud, and abuse rather than results in it.

Sincerely,

J. Randall Richards
Attorney at Law

JRR/mt

cc: Client
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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

COLUMBUS SOUTHERN MS, 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
MARCH 21, 2006