Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Belmont Community Hospital

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

April 15, 2004

Belmont Community Hospital
James N. Holden, Chief Financial Officer
4697 Harrison St.
Bellaire, OH 43906

Re: Audit of Belmont Community Hospital
Provider Number: 1514276

Dear Mr. Holden:

We have completed our audit of selected medical services rendered to Medicaid recipients by Belmont Community Hospital for the period January 1, 2000 through December 31, 2002. We identified $49,580.61 in findings, which must be repaid to the Ohio Department of Job and Family Services. A "Provider Remittance Form" is located at the back of this report for remitting payment. The attached report details the basis for the findings.

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

As a matter of courtesy, a copy of this report is being sent to the Ohio Department of Job and Family Services, the Ohio Attorney General, and the Ohio State Medical Board. If you have any questions, please feel free to contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

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ACRONYMS

AMA	American Medical Association
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management Services
MMIS	Medicaid Management Information System
Ohio Adm.Code	Ohio Administrative Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
Ohio Rev.Code	Ohio Revised Code

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Belmont Community Hospital (hereafter called the Provider), Provider #1514276, doing business at 4697 Harrison St.; Bellaire, OH 43906. We performed our audit at the request of the Ohio Department of Job and Family Services (ODJFS) in accordance with Ohio Rev.Code 117.10. As a result of this audit, we identified findings amounting to $49,580.61, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

BACKGROUND

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. Medicaid provides health coverage to families with low incomes, children, pregnant women, and people who are aged, blind, or who have disabilities. In Ohio, the Medicaid program is administered by ODJFS.

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet general principles regarding reimbursement for Medicaid covered services.[1] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

Ohio Adm.Code 5101:3-1-17.2(D) states that providers are required: "To maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions. The provider will maintain such records for a period of six years from the date of receipt of payment based upon those records or until any initiated audit 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."

[1] *See Ohio Adm.Code 5101:3-1-01 (A) and (A)(6)*

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's claims to Medicaid for reimbursement of medical services were in compliance with regulations and to identify any findings resulting from non-compliance. Within the Medicaid program, the Provider is listed as a general hospital providing emergency medicine services.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's claims history from ODJFS' Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, service rendered, and the amount paid. Services are billed using the Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[2]

Following a letter of notification, we held an entrance conference with the Provider on October 15, 2003 to discuss the audit scope. The scope of our audit was limited to services billed using CPT codes (predominantly physician services), not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of January 1, 2000 through December 31, 2002. The Provider was reimbursed $1,210,872.20 for 44,169 of these services rendered on 34,147 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.

Prior to beginning our field work, we performed a series of computerized tests on the Provider's Medicaid payments to determine if reimbursements were made for potentially inappropriate services or service code combinations. These included tests for:

- HealthChek services where more than one visit was billed within the same calendar year for recipients between the age of two and twenty.
- Non-covered services, of a preventive nature, billed for patients over the age of twenty-one.
- Multiple billings for evaluation and management (E&M) services involving the same recipient, the same date of service, and different procedure code.
- Duplicate billings for E&M services involving the same recipient, the same date of service, the same procedure code and procedure code modifier, and the same payment amount.

[2] *These codes have been adopted for use as the Health Insurance Portability and Accountability Act (HIPAA) transaction data set and are required to be used by states in administering Medicaid. There are three levels to the HCPCS. The first level is the five (5) digit Current Procedural Terminology (CPT) coding system for physician and non physician services promulgated by the American Medical Association. The second level entails alpha-numeric codes for physician and non physician services not included in the CPT codes and are maintained jointly by CMS and other medical and insurance carrier associations. The third level is made up of local level codes needed by contractors and state agencies in processing Medicare and Medicaid claims. Under HIPAA, the level three codes are being phased out but may have been in use during our audit period.*

- New patient E&M codes billed for established patients within three years of prior services rendered by Provider.
- Family planning visit services billed in conjunction with E&M services.

The above exception tests identified potentially inappropriate service code combinations. Therefore, when performing our audit field work, we reviewed the Provider's supporting documentation for all potentially inappropriate service code combinations claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services; we also analyzed two statistically random samples from the population of services after removal of those with identified potential exceptions.

- The first statistical sample was a stratified random selection of 127 recipient dates of services containing a total of 178 services, where at least one service provided on each day was an inpatient hospital, emergency room or critical care E&M service. A recipient date of service was defined as all services occurring for a specific recipient on a given date. Our objective was to determine whether documentation in the patient files supported the services that were billed.

- The second statistical sample was a stratified random selection drawn from the population of services not included in our first sample, which included outpatient E&M services, outpatient surgical services, diagnostic tests, and discharge examinations. This sample consisted of 165 recipient dates of services containing a total of 262 services. Our objective was to determine whether documentation in patient files supported the services that were billed.

Our work was performed between March 2003 and November 2003 and in accordance with government auditing standards.

FINDINGS

We identified findings of $6,935.41 from our exception tests and projected findings of $42,645.20 from the results of our two statistical samples. The circumstances leading to our total findings of $49,580.61 are discussed below by overpayment category.

Results of Exception Tests

The following presents the results of our exception tests.

Exceptions with HealthChek (EPSDT) Services

Ohio Adm.Code 5101:3-14-01 states:

> (A) "HealthChek" is Ohio's early and periodic screening, diagnosis and treatment program (EPSDT) which is a federally-mandated program of comprehensive preventive health services available to medicaid-eligible persons from birth through twenty years of age. The program is designed to maintain health by providing early intervention to discover and treat health problems.

> (B) The scope of the services provided to an individual depends on the age of the patient, gender, family medical history, ethnic background, and abnormalities encountered during a "HealthChek" (EPSDT) services.
>
> ***

Ohio Adm.Code 5101:3-14-04(B)(3) states[3]:

> One screening service per calendar year may be provided from the individual's second birthday through the day before the individual's twenty-first birthday. If any of the screenings described in paragraph (B)(1) of this rule are given in the calendar year in which the child reaches his or her second birthday, another screening may be given in that same calendar year on or after the child's second birthday. The next screening may not be given until the following calendar year.

We identified 154 recipients over the age of two, with 328 HealthChek screening services, where more than one service was billed within the same calendar year. We requested documentation to support the HealthChek screening services provided. We took exception with 170 of the 328 HealthChek services because more than one service was provided within the same calendar year. We recoded these 170 HealthChek screening services to an appropriate level E&M code depending on the services provided to the patient. Recoding these services resulted in findings of $3,187.63.

Billing Non-Covered Services

Ohio Adm.Code 5101:3-4-28 states in pertinent part:

> The following physician services are non-covered:
>
> ***
>
> (C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups with the following exceptions:
>
> (1) All HealthChek (EPSDT) services;
>
> ***
>
> (10) Required physicals for employment or for participation in job training programs, when the employer (or other available funds) does not provide a physical free of charge. Documentation to support that the physical was performed for employment must be in the patient's medical records.
>
> ***

[3] *This rule was in effect during our audit period. Effective July 1, 2003, ODJFS revised its requirements for the frequency of HealthChek screening services to coincide with those followed by the American Academy of Pediatrics.*

We identified 19 recipients with 25 services who were over the age of twenty-one that the Provider billed for routine physical examination. We requested documentation that these physicals were performed for employment or for participation in a job training program. Because the recipients were over age 21 and the Provider could only verify that two of the physicals were for employment purposes, we took exception with the remaining 23 services, resulting in findings of $691.18.

Multiple E&M Codes Billed Together

Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We identified 84 recipients and 214 services that were potentially duplicative of another service paid for the same patient on the same date of service. For 12 services, the Provider billed two different Evaluation & Management (E&M) services for the same patient on the same date of service. For the remaining 202 services, the Provider billed the same E&M service for the same patient on the same date of service.

We requested documentation from the Provider to validate the billing of multiple E&M codes. For 83 services, the Provider was unable to provide documentation to verify that an additional service had been provided on that date. Therefore, we took exception with the 83 services that could not be verified, resulting in findings of $2,197.10.

New Patient E&M Codes Billed for Established Patients

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 CPT code definitions and the CPT instructions for selecting a level of E&M service.
>
> ***

The American Medical Association's CPT Manual gives the following guidance on Evaluation and Management (E&M) services:

> Solely for the purpose of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

We found 24 billed new patient CPT code services for patients where the Provider had rendered professional services within the previous three years. We took exception with these services and

reduced them to the corresponding established patient CPT codes. The reduction of these 24 services resulted in findings of $265.50.

Family Planning Codes Incorrectly Billed with Office Visit Codes

Ohio Adm.Code 5101:3-4-07(D)(1) states:

> A "family planning visit" is any visit performed for the purpose of providing a family planning service. The visit may be performed either by a physician and/or a health professional or social services professional qualified under the Revised Code. The visit may or may not include a physical examination.

Ohio Adm.Code 5101:3-4-07(D)(2) defines CPT code X1453 as follows:

> X1453 Gynecological examination performed by a physician is a visit in which a physical examination including, at a minimum, a review of the medical history, pelvic examination, height, weight, and blood pressure, is performed in conjunction with family planning services. The visit also includes, when appropriate, all or a combination of the following services: breast examination, collection of a pap smear, collection of vaginal smears or cultures, evaluation and interpretation of laboratory procedures, checking an IUD, contraceptive counseling, generic counseling, and the prescription of contraceptive pharmaceuticals and supplies.

We identified 29 services for family planning office visits (procedure code X1453) that were billed concurrently with E&M office visits, but the documentation in the patients' medical records did not support that both types of services occurred. Since the claim for the E&M office visit more appropriately covered the service provided, we took exception with the 29 X1453 family planning visits resulting in findings of $594.00.

Summary of Exception Testing

We took exception with 329 of the 685 paid services that were segregated from the sampled population for complete examination. Table 1 summarizes the exceptions found by reason.

Table 1: Summary of Exceptions Found by Reason
For Services Identified by Exception Tests for 100 Percent Review
For the Period of January 1, 2000 – December 31, 2002

Basis for Exception	Number of Services with Exceptions	Amount of Overpayment
Exceptions with HealthChek (EPSDT) Services	**170**	**$3,187.63**
Multiple E&M Codes Billed Together	**83**	**$2,197.10**
Family Planning Codes Incorrectly Billed with Office Visit Codes	**29**	**$594.00**
New Patient E&M Codes Billed for Established Patients	**24**	**$265.50**
Billing Non-Covered Services	**23**	**$691.18**
Total Services with Exceptions	**329**	**$6,935.41**

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

Results of Hospital and Emergency Department Services Sample

Our analysis of the Providers' supporting documentation for a stratified sample of emergency department and related hospital services (127 recipient dates of services with 178 total services) identified exceptions in the following areas:

- Evaluation and management emergency department services where the documentation in the patient medical record did not support the level of service billed.
- A hospital inpatient service where the documentation in the patient medical record did not support the level of service billed.
- Multiple hospital and emergency department evaluation and management services billed for the same recipient when one service was inclusive of the other.
- No documentation or no patient medical record found to support that certain services in our sample were performed.
- A duplicate billing because the same emergency department service procedure was billed twice for the same recipient on the same day.

Unsupported Level of Service Billings for the Emergency Department

An emergency department (sometimes referred to as a hospital emergency room or ER) is defined as an organized twenty-four-hour, hospital-based facility for the provision of unscheduled episodic services to patients who seek or are in need of immediate medical attention.

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

> Whether or not the provider normally practices in the emergency department setting, evaluation and management services provided in an emergency department must be billed using:
>
> (a) One of the codes listed in the CPT under emergency department services;
>
> ***

When ER services are billed using emergency department E&M codes there is no distinction between new and established patients. Evaluation and Management codes for emergency department services are billed using CPT 99281 through 99285.

Of the 178 services in our sample, we found 10 services billed at 99283, 99284, and 99285 levels that were not supportable because the patients' medical records did not contain the required level of service components for the CPT codes billed. For one service, the documentation supported three levels lower (e.g. 99281 instead of 99284), for seven services, the documentation supported two levels lower (e.g. 99283 instead of 99285). For the remaining two services, the

documentation supported the next lowest level of service (e.g., 99283 instead of 99284). The following are examples of the service levels we took exception with:

- The patient arrived at the emergency room at 1:15, complaining of a headache onset one and half-hours ago. The patient record indicated prior treatment for the same condition; the attending physician's diagnosis was "headache"; and a Toradol shot was given. The patient was discharged to home at 1:50. We recoded the service from the 99283 level to the 99281 level because the patient record lacked evidence of the three required components for 99283: an expanded problem focused history, an expanded problem focused examination, and a moderate complexity of decision making. The patient record more closely supported criteria for billing CPT code 99281: a problem focused history, problem-focused examination, and straightforward decision-making.

- The patient arrived at the emergency room at 18:15, complaining of sleeping a lot, sore throat, lumps on neck, and fever for three to four days. An unspecified upper respiratory infection was diagnosed and the attending physician prescribed an antibiotic. The patient was discharged to home at 18:30. We recoded the service from 99284 to 99281 because the patient record lacked evidence of the three key components for 99284: a detailed history, a detailed examination, and a moderate complexity of decision making when the presenting problems(s) are not life threatening but usually of high severity that require urgent evaluation. The patient record more closely supported criteria for billing CPT code 99281: a problem focused history, a problem focused examination, and straightforward decision-making.

- The patient arrived at the emergency room complaining of ear pain, and the medical diagnosis resulted in the removal of a superficial foreign body (earring back) from the patient's earlobe. We recoded the services from 99284 to 99282 because the patient record lacked the evidence of the three key components for 99284: a detailed history, a detailed examination, and a moderate complexity of decision making when the presenting problems(s) are not life threatening but usually of high severity that require urgent evaluation. The patient record more closely supported criteria for billing CPT code 99282: an expanded problem focused history, an expanded problem focused examination, and medical decision making of low complexity.

When calculating our findings, we reduced the allowable payment for the 10 emergency department services to the level supported by documentation in the patients' records. A finding was then made for the difference between the amounts originally paid and the amount paid at the recoded level of service.

Unsupported Level of Hospital Inpatient Service

Ohio Adm.Code 5101:3-4-06(D)(1) states:

> For reimbursement of visits provided to hospital inpatients, the provider must bill the appropriate code listed in the CPT under hospital inpatient services in accordance with the instructions and definitions in the CPT.

To report initial hospital care for the evaluation and management of a patient, providers are to bill CPT codes 99221 through 99223 for the first hospital encounter. For subsequent hospital care per day, for the evaluation and management of the patient, providers are to bill CPT codes 99231 through 99233.

We found one service in our sample of 178 services where the Provider billed CPT code 99223-Initial Hospital Care, per day, for the comprehensive evaluation and management of a patient; when in fact the service was for CPT 99233-Subsequent Hospital Care, per day, for the detail evaluation and management of a patient. Therefore, we recoded the service to the level supported in the patient medical records (i.e. 99233 instead of 99223).

Hospital and Emergency Department Procedure Codes Incorrectly Billed Together

Ohio Adm.Code 5101:3-4-06(L)(3) states:

> If patient care results in a hospital admission and the physician who provided the initial observation care continues to be the patient's attending physician after admission, the physician must bill the inpatient hospital E&M codes in lieu of the initial observation codes.

The American Medical Association's CPT Manual gives guidance on Evaluation and Management (E&M) services which includes the following:

> When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of services (e.g., hospital emergency department, observation status in a hospital, physician's office) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.

Of the 178 services in our sample, we found six services where the Provider billed an office/outpatient E&M visit, emergency department visit, observation discharge service visit, initial hospital care visit, initial observation care visit, and/or critical care service for the same recipient, same date of service, and same provider. The following are the services we took exception with:

- The Provider billed CPT 99285 (Emergency department evaluation and management of a patient) in conjunction with CPT 99223 (Initial hospital care, per day, for the evaluation and management of a patient). Both of these procedures require the three key components of (1) a comprehensive history; (2) a comprehensive examination; and (3) medical decision making of high complexity. A review of the patient record showed the physician performing the 99285 service was the admitting physician of record. Therefore, we took exception with billing 99285 because the evaluation and management

service provided in the emergency department is considered part of the initial hospital care service when provided by the same physician.

- The Provider billed CPT 99213 (Office or outpatient evaluation and management visit for an established patient) in conjunction with CPT 99222 (Initial hospital care, per day, for the evaluation and management of a patient). A review of the patient record showed that the physician performing the office/outpatient service was the admitting physician of record. Therefore, we took exception with the billing of CPT 99213 because the office/outpatient evaluation and management service provided is considered part of the initial hospital care service when provided by the same physician.

- The Provider billed CPT 99223 (Initial hospital care, per day, for the evaluation and management of a patient) in conjunction with CPT 99238 (Hospital discharge day management; 30 minutes or less). A review of the patient record showed that the patient was not discharged on that date, and therefore, we took exception with the billing of CPT 99238 hospital discharge day management service.

- The Provider billed CPT 99283 (Emergency room visit for the evaluation and management of a patient) in conjunction with CPT 99219 (Initial observation care, per day, for the evaluation & management of a patient. A review of the patient record revealed that the patient was admitted to observation care from the emergency department. Therefore, we took exception with the billing of CPT 99283 because the emergency department service provided is considered part of the initial observation care service.

- The Provider billed CPT 99295 (Initial Neonatal Care, Per Day, for the Evaluation & Management of a Critically Ill Infant) in conjunction with CPT 99291 (Critical Care Evaluation & Management First 30-74 Minutes) and CPT 99238 (Hospital Discharge; Day Treatment). A review of the patient record showed that neonatal care for a critically ill infant (CPT 99295) was performed. Therefore, we took exception with the billing of CPT 99291 and CPT 99238 because those service are included in the per day billing of CPT 99295.

Missing Documentation

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

> …all medicaid providers are required to keep such records as are necessary to establish medical necessity, and to fully disclose the basis for the type, extent, and level of services provided to medicaid consumers, and to document significant business transactions. Medicaid providers are required to provide such records and documentation to the Ohio department of job and family services, the secretary of the federal department of health and human services, or the state medicaid fraud control unit upon request.

Of the 178 services in our sample of hospital and emergency department services, we found that three services billed were not supportable because the patients' medical records did not contain

the required documentation to support billing to ODJFS. The following are the exceptions we noted:

- The patient medical records did not indicate that two of the services were provided.
- No patient medical record was provided for one service.

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 three services.

Duplicate Emergency Department Service Billing

Ohio Adm.Code 5101:3-1-19.8(F) states in pertinent part: "Overpayments are recoverable by the department at the time of discovery…"

We disallowed one emergency department service because it was duplicative of another service paid for the same patient on the same date of service. The service involved two emergency department visits (CPT 99284) billed for the same patient on the same date of service. We confirmed that only one service was rendered, and therefore, we took exception with the duplicative billing

Projected Findings from Hospital and Emergency Department Service Sample

We identified 21 exceptions in our sample of 178 services. Table 2 summaries the basis for our exceptions.

Table 2: Summary of Exceptions from Hospital and Emergency Department Sample For the Period January 1, 2000 – December 31, 2002

Basis for Exception	Number of Services with Exceptions
Unsupported Level of Service Billings for the Emergency Department	10
Hospital and Emergency Department Procedure Codes Incorrectly Billed Together	6
Missing Documentation	3
Duplicate Emergency Department Service Billing	1
Unsupported Level of Hospital Inpatient Service	1
Total Services with Exceptions	21

Source: AOS analysis of a sample of 127 recipient dates of service not included in previous tests.

We took exception with 21 of 178 statistically sampled recipient services (20 of 127 recipient dates of service) from a stratified sample of the Provider's population of paid emergency department and related hospital services. Based on this error rate, we projected the Provider's correct payment amount for this population, which was $222,393.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $232,715.29 to $199,540.00 (+/-

10.28 percent). We then calculated audit findings repayable to ODJFS by subtracting the projected correct population amount ($222,393.00) from the amount paid to the Provider for this population ($233,643.96), which resulted in a finding of $11,250.96. See Appendix I for more details concerning our projections.

Results of Other Services Sample

Our analysis of the supporting documentation for a stratified sample of 165 recipient dates of services (262 total services) from the Provider's population of outpatient services not related to the emergency department identified exceptions in the following areas:

- Evaluation and management services where the level of service billed was not supported by the documentation in the patient's medical record.
- Surgery services where the level of services billed was not supported by the documentation in the patients' medical records.
- Electrocardiogram codes billed in combination with tracing services, for the same recipient, where one of the services was inclusive of the other.

Unsupported Level of E&M Services

An Evaluation and Management service is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient. Ohio Adm.Code 5101:3-4-06(B) states:

> The Providers must select and bill the appropriate visit (E&M service level) code in accordance with the CPT code definitions and the CPT instruction for selecting a level of E&M services.
>
> ***

The American Medical Association's CPT Manual gives guidance on Evaluation and Management (E&M) services and uses the following seven components to determine a level of E&M service:

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

The key components[4] in selecting a level of E&M service to bill are history, examination, and medical decision making – the more complex the services involving these components, the

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

higher the level of service billed, and the more the provider is reimbursed. E&M services for established patients are billed using CPT 99211 through 99215; while E&M services for preventive medicine for established patients are billed using CPT 99391 through 99397.

Of the 262 services in our sample, we found 11 services billed at the CPT 99204, 99213, 99214, and 99393 levels that were not supportable because the patient medical records did not contain the required level of service components for the CPT codes billed. For one service, the documentation supported two levels lower (e.g. CPT 99212 instead of 99214), for eight services, the documentation supported the next lowest level of service (e.g. CPT 99212 instead of 99213). For the remaining two services, the documentation supported billing CPT codes 99212 and 99214 instead of 99393 and 99204. The following are examples of service levels we took exception with:

- The patient was in for an office recheck. The medical record showed that patient's temperature was taken, a focused exam was performed, and a return to school approval slip was written. We recoded the service from CPT 99213 to 99212 because the patient record lacked evidence that at least two of three key components for CPT 99213: an expanded problem focused history, an expanded problem focused exam, or decision making of low complexity; had been performed.

- The patient was seen for a behavior problem and bedwetting. The medical record showed that the patient's temperature was taken and a problem focused exam occurred. We recoded the services from a CPT 99393 (preventive visit, established patient, 5-11 years of age) to a CPT 99212 because eight key components are required to bill CPT 99393, and the patient record lacked evidence that they were performed.[5]

- The patient was seen for a re-check on cold symptoms. The medical record showed that the patient's vitals were taken (blood pressure, temperature and weight), and a focused exam was performed. We recoded the services from the CPT 99213 level to the 99212 level because the patient record lacked evidence that at least two of three key components for CPT 99213: an expanded problem focused history, an expanded problem focused exam, or decision making of low complexity; had been performed.

Unsupported Level of Surgical Services

Ohio Adm.Code 5101:3-4-22(C) states: "For the reimbursement of surgical services, the physician must bill the CPT code for the surgical procedure(s)..."

The surgery guidelines contained in American Medical Association's CPT Manual state in part that:

[5] *The eight key components for a HealthChek screening are 1) comprehensive unclothed physical examination, 2) developmental and nutritional assessment, 3) vision assessment, 4) hearing assessment, 5) immunization assessment, 6) lead toxicity screening, 7) dental assessment, and 8) health education and counseling. The examination was missing a development and nutritional assessment, hearing assessment, dental assessment, and health education and counseling.*

> The repair of wounds may be classified as Simple, Intermediate, or Complex. ***Simple repair*** is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed. ***Intermediate repair*** includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

Of the 262 services in our sample, we found four surgical services billed at the intermediate level that were not supportable because the patient's medical records indicated a simple surgical level service was performed. For the four surgical services, the documentation supported the next lower level of surgical services (e.g. 12002 instead of 12032). The following are examples of the surgical services we took exception with:

- The patient arrived at the hospital emergency room with a chief complaint of a cut to the left foot while at play. The physician examined the patient and noted a minor surgery-laceration repair, simple repair of 5 cm laceration of the extremity/trunk/scalp. We recoded the surgical service from the 12032 level to the 12002 level because the patient record indicated a simple repair was performed.

- The patient arrived at the hospital emergency room with a chief complaint of a laceration to the left hand and abrasions to back of the left hand caused during the transferring of a car transmission. The physician examined the patient and noted a minor laceration repair, simple repair of 2.6 cm laceration of the extremity/trunk/scalp. We recoded the surgical service from the 12032 level to the 12002 level because the patient record indicated a simple repair was performed.

Electrocardiogram Procedure Codes Incorrectly Billed Together

Pursuant to Ohio Adm.Code 5101:3-4-16(E) states in pertinent part:

> All D & T cardiovascular services which are divided into professional component, technical component(s) and total service by unique procedure codes must be billed using the CPT codes corresponding to the components actually performed by the provider.

In our sample of 262 services, we found one service where the Provider billed CPT 93000 (Electrocardiogram, with interpretation and report) in conjunction with CPT 93005 (Electrocardiogram tracing only without interpretation and report). A review of the patient medical record showed that the total electrocardiogram service was actually provided. Therefore, we are taking exception with the billing of CPT 93005 because this service is included in the billing of CPT 93000.

Projected Findings from Other Services Sample

Overall, we identified 16 exceptions in our sample of 262 services. Table 3 summaries the basis for our exceptions.

Table 3: Summary of Exceptions from Sample Audit of Provider Records For the Period of January 1, 2000 – December 31, 2002

Basis for Exception	Number of Services with Exceptions
Unsupported Level of E&M Services	11
Unsupported Level of Surgical Services	4
Electrocardiogram Procedure Codes Incorrectly Billed Together	1
Total Services with Exceptions	16

Source: AOS analysis of a sample of 165 recipient dates of service not included in previous tests.

We took exception with 16 of 262 statistically sampled services (16 of 165 recipient dates of service) from a stratified sample of the Provider's population of paid outpatient services not related to the emergency department. Based on this error rate, we projected the Provider's correct payment amount for this population, which was $916,995.00, with a 95 percent certainty that the actual correct payment amount fell within the range of $948,134.49 to $868,496.00 (+/- 5.29 percent). We then calculated audit findings repayable to ODJFS by subtracting the estimated correct population payment amount ($916,995.00) from the amount paid to the Provider for this population ($948,389.24), which resulted in a finding of $31,394.24. See Appendix II for more details concerning our projection.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on February 3, 2004. The Provider sent us a written response on February 20, 2004, along with additional documentation to support some of the claims for services we had taken exception with. As a result of additional supporting information supplied by the Provider, we reduced our findings from $92,003.61 to $49,580.61. These findings are repayable to the Ohio Department of Job and Family Services.

The Provider also committed to correcting the deficiencies identified by our audit. In a February 20, 2004 letter, the Provider outlined a series of educational initiatives, process changes, and computer edits planned to address our audit results. We reviewed the Provider's corrective action plan and believe, if properly implemented, it is responsive to the deficiencies we identified.

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APPENDIX I

Summary of Hospital and Emergency Department Service Sample Analysis
Audit Period: January 1, 2000 – December 31, 2002

Description	
Type of Examination	**Stratified Random Sample**
Number of Population Recipient Date of Services	**7,624**
Number of Population Services Provided	**7,774**
Number of Recipient Date of Service Sampled	**127**
Number of Services Sampled	**178**
Amount Paid for Services Sampled	**$10,309.34**
Total Medicaid Amount Paid During Audit Period	**$233,643.96**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$199,540.00**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$34,103.96**
Upper Limit Correct Population Payment Amount at 95% Confidence Level[6]	**$232,715.29**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	**$928.67**
Point Estimate of Correct Population Payment Amount	**$222,393.00**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$22,853.00 (10.28%)**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$11,250.96**

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

[6] *Upper limit correct population payment set to actual population amount paid less actual errors found in sample because projected upper limit would exceed actual amount paid.*

APPENDIX II

Summary of Other Services Sample Analysis
Audit Period: January 1, 2000 – December 31, 2002

Description	
Type of Examination	**Stratified Random Sample**
Number of Population Recipient Date of Services	**26,911**
Number of Population Services Provided	**35,761**
Number of Recipient Date of Service Sampled	**165**
Number of Services Sampled	**262**
Amount Paid for Services Sampled	**$11,840.37**
Total Medicaid Amount Paid During Audit Period	**$948,389.24**
Lower Limit Correct Population Payment Amount at 95% Confidence Level	**$868,496.00**
Upper Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Lower Limit Correct Population Payment Amount)	**$79,893.24**
Upper Limit Correct Population Payment Amount at 95% Confidence Level[7]	**$948,134.49**
Lower Limit Overpayment Estimate at 95% Confidence Level (Total Medicaid Amount Paid – Upper Limit Correct Population Payment Amount)	**$254.75**
Point Estimate of Correct Population Payment Amount	**$916,995.00**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$48,499.00 (5.29%)**
Point Estimate of Projected Findings (Total Medicaid Amount Paid – Point Estimate of Correct Population Payment Amount)	**$31,394.24**

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

[7] *Upper limit correct population payment set to actual population amount paid less actual errors found in sample because projected upper limit would exceed actual amount paid.*

APPENDIX III

Summary of Findings for Belmont Community Hospital
Audit Period: January 1, 2000 – December 31, 2002

Description of Audit Findings	Dollar Amount of Findings
All Other Services Sample	$31,394.24
Hospital and Emergency Department Services Sample	$11,250.96
Exceptions with HealthChek (EPSDT) Services	$3,187.63
Multiple E&M Codes Billed Together	$2,197.10
Billing Non-Covered Services	$691.18
Family Planning Codes Incorrectly Billed with Office Visit Codes	$594.00
New Patient E&M Codes Billed for Established Patients	$265.50
Total Audit Findings	$49,580.61

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

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PROVIDER REMITTANCE FORM

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

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

Provider:	Belmont Community Hospital
	4697 Harrison St.
	Bellaire, OH 43906
Provider Number:	1514276
Audit Period:	January 1, 2000 through December 31, 2002
AOS Finding Amount:	$49,580.61
Date Payment Mailed:	
Check Number:	

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

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Auditor of State
Betty Montgomery

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

Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

BELMONT COMMUNITY HOSPITAL

BELMONT 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
APRIL 15, 2004