Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Marion General Hospital Emergency Room

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

July 6, 2004

Mr. Jerry Feyh, Vice President of Finance
Marion General Hospital Emergency Room
1000 McKinley Park Drive
Marion, OH 43302

Re: Audit of Marion General Hospital Emergency Room
Provider Number: 0753555

Dear Mr. Feyh:

We have completed our audit of selected medical services rendered to Medicaid recipients by your facility for the period October 1, 2000 through June 30, 2003. We identified $77,108.00 in findings, which must be repaid to the Ohio Department of Job and Family Services. A "Provider Remittance Form" is included at the back of this report for remitting payment. The attached report details the bases for the findings.

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

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

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
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ACRONYMS

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

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Marion General Hospital Emergency Room (hereafter called the Provider), Provider #0753555, doing business at 1000 McKinley Park Dr, Marion, OH 43302. 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 $77,108.00, based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Administrative Code.

BACKGROUND

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

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

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

In addition, Ohio Adm.Code 5101:3-1-29(A) states in part: "…In all instances of fraud, waste, and abuse, any amount in excess of that legitimately due to the provider will be recouped by the department through its surveillance and utilization review section, the state auditor, or the office of the attorney general…"

Ohio Adm.Code 5101:3-1-29(B)(2) states " 'Waste and abuse' are defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that 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 physician group practice providing emergency medicine services.

Following a letter of notification, we held an entrance conference with the Provider on December 16, 2003 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, not involving Medicare co-payments, for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 2000 through June 30, 2003. The Provider was reimbursed $749,076.39 for 15,960 services rendered on 15,761 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

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

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

- Duplicate billings for emergency department services involving the same recipient, the same date of service, the same procedure code and procedure code modifier; and the same payment amount.
- Billing for emergency department services for recipient after they have expired.

The above tests did not identify any exceptions.

To facilitate an accurate and timely audit of the Provider's medical services, we analyzed a statistically random sample of 174 recipient dates of services, containing a total of 219 services. Our objective was to determine whether documentation in patient files supported the services that were billed.

[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.*

Our work was performed between September 2003 and December 2003 in accordance with government auditing standards.

FINDINGS

We identified findings of $77,108.00 from the projected results of our statistical sample. The circumstances leading to the findings are discussed below:

Results of the Sample Analysis

Our analysis of the Provider's supporting documentation for the stratified sample of services (174 recipient dates of service with 219 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.
- Surgery services where the levels of service billed were not supported by the documentation in the patients' medical records.
- Services where documentation or patient medical record could not be found to support that the services had been performed.
- Surgical codes billed in combination with emergency department codes, for the same recipient, where one of the services was inclusive of the other.

Unsupported Level of Service Billings for the Emergency Department

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

> 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 patient. Evaluation and Management codes for emergency department services are billed using CPT 99281 through 99285.

Of the 219 services in our sample, we found 18 services billed at 99282, 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 14 services, the documentation supported two levels lower (e.g. 99283 instead of 99285). For the remaining four services, the documentation supported the next lowest level of service (e.g. 99283 instead of 99284). The following are examples of the services we took exception with:

- The patient arrived at the emergency room at 10:36, complaining of runny nose and a cough productive of green phlegm for approximately one week. An upper respiratory tract infection and bronchitis was diagnosed and the attending physician prescribed an antibiotic and antihistamine. The patient was discharged to home at 11:27. We recoded the service from 99284 to 99282 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 problem(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 the presenting problem(s) are of moderate severity.

- The patient arrived at the emergency room requesting to have a burn on the palm of the right hand re-bandaged. The physician re-bandaged the burn with Silvadene 1 percent ointment dressing and the patient was discharged. We recoded the service from 99282 to 99281 because the patient record lacked evidence of the three key components for 99282: an expanded problem focused history, an expanded problem focused examination, and a low complexity of decision making when the presenting problem(s) are of low to moderate severity. The patient record more closely supported criteria for billing CPT code 99281: a problem focused history, a problem focused examination, and a straightforward medical decision making when the presenting problem(s) are self limited or minor.

- The patient arrived at the emergency room at 14:24, complaining of an earache for the past few days. An inflammation of the middle ear was diagnosed and the attending physician prescribed an antibiotic. The patient was discharged to home at 16:00. We recoded the service from 99284 to 99282 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 problem(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 the presenting problem(s) are of moderate severity.

When calculating our findings, we reduced the allowable payment for the 18 emergency department evaluation and management 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.

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 services provided to medicaid consumers, and to document significant business transactions…

Of the 219 services in our sample, we found that nine services billed were not supportable because patient medical records did not contain the required documentation to support billing to ODJFS. The following are the exceptions noted:

- For two of the services, the patient medical record did not state that the services in question were provided, although other services were shown on the service dates.
- For the remaining seven services, no patient medical records were provided.

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

Surgical and Emergency Department Procedure Codes Incorrectly Billed Together

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 Surgery Guidelines section (page 43 of the 2004 edition) states the following:

> ***
> In defining the specific services 'included' in a given CPT surgical code, the following services are always included in addition to the operation per se:
>
> - local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
> - subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
>
> ***

Of the 219 services in our sample, we found two services where the Provider billed a surgical service and an emergency department service for the same recipient, on the same date of service, and by same provider. The following are the services we took exception with:

- The Provider billed CPT 12001 (Wound repair, simple, trunk, neck, and/or extremities less than 2.5 cm) and 12011 (Wound repair, simple, face, ears, nose, lip less than 2.5 cm), in conjunction with 99283 (Emergency department evaluation and management of a patient). A review of the patient medical record confirmed two separate surgical services were performed. However, we took exception with billing 99283 because the evaluation and management service is included in the surgical services.

- The Provider billed CPT 11760 (Excision with repair of nail bed) in conjunction with 64450 (Injection of anesthetic agent). A review of the patient's medical record showed a surgical repair of the nail bed was performed. Therefore, we took exception with billing 64450 because the injection of an anesthetic agent is included in the surgical service.

Unsupported Level of Surgical Service

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

> "For the reimbursement of surgical services, the physician must bill the appropriate code for the surgical procedure(s)..."

Of the 219 services in our sample, we took exception with one surgical service where the Provider billed CPT 11750 (Excision of nail and nail matrix, partial or complete, [e.g., ingrown or deformed nail] for permanent removal), which pays $102.43, instead of CPT 11765 (Wedge excision of skin of nail fold, [e.g., for ingrown toenail]), which pays $34.26. In this instance, the patient arrived at the hospital emergency room complaining of a red and swollen right great toe. The physician examined the patient and performed a wedge resection using electrocautery and forceps to remove the nail. We recoded the surgical service from 11750 to 11765 because the service did not include permanent removal of the nail.

Projected Findings from the Sample

Over all, we identified 30 exceptions in our sample of 219 services. Table 1 summarizes the bases for our exceptions.

Table 1: Summary of Exceptions from Sample of Audit of Provider Records For the Period of October 1, 2000 – June 30, 2003

Basis for Exception	Number of Services with Exceptions
Unsupported Level of Service Billings for the Emergency Department	18
Missing Documentation	9
Surgical and Emergency Department Procedure Codes Incorrectly Billed Together	2
Unsupported Level of Surgical Service	1
Total Services with Exceptions	30

Source: AOS analysis of a sample of 174 recipients dates of service.

We took exception with 30 of 219 statistically sampled services (29 of 174 recipient dates of service) from a stratified sample of the Provider's population of paid services. We then calculated potential audit findings by projecting the error rate to the Provider's population of paid recipient dates of service. This resulted in a projected finding of $144,727.00, with a 95 percent certainty that the true population overpayment fell within the range of $77,108.00 to $212,346.00, a precision of plus or minus 46.7 percent. However, since the precision percentage achieved was greater than our procedures require for use of a point estimate, the audit findings determined to be repayable to ODJFS was set at $77,108.00, the lower limit overpayment estimate. This allows us to say that we are 97.5 percent certain that the population overpayment amount is at least $77,108.00.

PROVIDER'S RESPONSE

To afford an opportunity to respond to our findings, we mailed a draft report to the Provider on April 26, 2004. The Provider sent us a written response on May 13, 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 $77,602.00 to $77,108.00. These findings are repayable to the Ohio Department of Job and Family Services.

In a subsequent response received June 2, 2004, the Provider committed to the following actions to avoid future billing errors.

> Hospital Management plans to share the results of this audit, as appropriate, with Emergency Department Physicians, Medical Records Department staff members, Billing Department staff members, and other supportive personnel, in order to improve future billing practices. Hospital Management will also periodically

perform billing audits for the exceptions identified above to insure compliance with Medicaid regulations.

A copy of the Provider's full response is being forwarded to ODJFS' Surveillance and Utilization and Review Section for their review and disposition.

APPENDIX I

Summary of Sample Analysis for Marion General Hospital Emergency Room
Audit Period: October 1, 2000 – June 30, 2003

Description	Audit Period October 1, 2000 – June 30, 2003
Type of Examination	**Statistical Random Sample of 174 Recipient Dates of Service**
Number of Population Recipient Date of Services	**15,761**
Number of Population Services Provided	**15,959**
Number of Recipient Date of Service Sampled	**174**
Number of Services Sampled	**219**
Amount Paid for Services Sampled	**$13,147.27**
Total Medicaid Amount Paid During Audit Period	**$749,076.39**
Upper Limit Overpayment Estimate at 95% Confidence Level	**$212,346.00**
Lower Limit Overpayment Estimate at 95% Confidence Level	**$77,108.00**
Point Estimate of Projected Findings at 95% Confidence Level	**$144,727.00**
Precision of Estimated Correct Population Payment Amount at the 95% Confidence Level	**$67,619.00 (46.72%)**

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: Marion General Hospital Emergency Room
1000 McKinley Park Dr.
Marion, OH 43302

Provider Number: 0753555

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

AOS Finding Amount: $77,108.00

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

MARION GENERAL HOSPITAL EMERGENCY ROOM

MARION 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
JULY 6, 2004