Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Renu Soni, M.D.

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 Street, 32nd Floor
Columbus, Ohio 43266-0423

Re: Audit of Renu Soni, M.D.
Provider Number: 0947033

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Renu Soni, M.D. for the period April 1, 2001 through March 31, 2004. We identified $38,317.17 in findings that are repayable to the State of Ohio. We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make a final determination regarding recovery of the findings and any interest accruals.

Our work was performed in accordance with our interagency agreement to perform audits of Medicaid providers and Section 117.10 of the Ohio Revised Code. The specific procedures employed during this audit are described in the scope and methodology section of this report.

Copies of this report are being sent to Renu Soni, M.D., the Ohio Attorney General, and the Ohio State Medical Board. Copies are also available on the Auditor's web site (www.auditor.state.oh.us).

If you have questions regarding our results, or if we can provide further assistance, please contact Cynthia Callender, Director of the Fraud and Investigative Audit Group, at (614) 466-4858.

Sincerely,

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
HCPCS	Healthcare Common Procedural Coding System
MMIS	Medicaid Management Information System
ODJFS	Ohio Department of Job and Family Services
Ohio Adm.Code	Ohio Administrative Code
Ohio Rev.Code	Ohio Revised Code
OMPH	Ohio Medicaid Provider Handbook

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SUMMARY OF RESULTS

The Auditor of State performed an audit of Renu Soni, M.D. (hereafter called the Provider), Provider Number 0947033, doing business at 439 West Market Street in Tiffin, Ohio, 44883. 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 $38,317.17 in repayable findings, based on reimbursements that did not meet the rules of the Ohio Administrative Code and the Medicaid Provider Handbook (OMPH).

We are issuing this report to the Ohio Department of Job and Family Services because, as the state agency charged with administering the Medicaid program in Ohio, it is the Department's responsibility to make a final determination regarding recovery of the findings[1] and any interest accruals.[2]

BACKGROUND

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

Hospitals, long term care facilities, managed care organizations, individual practitioners, laboratories, medical equipment suppliers, and others (all called "providers") render medical, dental, laboratory, and other services to Medicaid recipients. The rules and regulations that providers must follow are specified by ODJFS in the Ohio Administrative Code and the OMPH. The fundamental concept of the Medicaid program is medical necessity of services: defined as services which are necessary for the diagnosis or treatment of disease, illness, or injury, and which, among other things, meet requirements for reimbursement of Medicaid covered services.[3] The Auditor of State, working with ODJFS, performs audits to assess Medicaid providers' compliance with reimbursement rules.

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

[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 February 27, 2004, the latest payment date in the random sample used for analysis.*

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

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 result in an unnecessary cost to the Medicaid program."

PURPOSE, SCOPE, AND METHODOLOGY

The purpose of this audit was to determine whether the Provider's Medicaid claims for reimbursement of medical services were in compliance with regulations and to identify, if appropriate, any findings resulting from non-compliance. The Provider is an oncologist, and within the Medicaid program is listed as an individual provider with a specialty in internal medicine.

Following a letter of notification, we held an entrance conference at the Provider's place of business on June 8, 2005 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 April 1, 2001 through March 31, 2004. The Provider was reimbursed $666,455.60 (excluding Medicare crossovers) for 6,364 services rendered on 1,057 recipient dates of service during the audit period. A recipient date of service is defined as all services received by a particular recipient on a specific date.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of services and applicable reimbursement rates. We obtained the Provider's paid claims history from ODJFS Medicaid Management Information System (MMIS), which lists services billed to and paid by the Medicaid program. This computerized claims data included but was not limited to: patient name, patient identification number, date of service, and service rendered. Services are billed using Healthcare Common Procedural Coding System (HCPCS) codes issued by the federal government through the Centers for Medicare & Medicaid Services (CMS).[4]

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:

[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.*

- Potentially duplicate payments to identify whether payments were made for the same recipient on the same date of service for the same procedure codes and procedure code modifiers, and for the same dollar amount.

- Payments made for services to deceased patients for dates of service after the date of death.

- Potentially inappropriate service code combinations on claims.

The test for deceased patients was negative, but the tests for duplicate payments and inappropriate service code combinations were positive. While performing our audit field work, we requested the Provider's supporting documentation for all potentially duplicate or inappropriate service code combination claims identified by our exception analyses.

To facilitate an accurate and timely audit of the Provider's remaining medical services, we also analyzed a stratified statistically random sample of 163 recipient dates of service, containing a total of 1,202 services.

Our work was performed between June 2004 and November 2005.

FINDINGS

We identified and projected findings of $20,293.45 for the services in the sampled population. Additionally, we identified findings of $18,023.72 for services in our exception testing. Together, our findings totaled $38,317.17. The bases for our results are discussed below.

Unsupported Services in Sample

During our review of randomly selected patients' medical records, we found exceptions with undocumented medical services, incorrectly billed units of service, unsupported levels of evaluation and management (E&M) services, and incorrectly coded chemotherapy medications. Findings from our sample were projected to the population of services remaining after removal of Medicare cross-over payments and services in our exception testing.

Undocumented Medical Services

Ohio Adm.Code 5101:3-1-17.2 (D) states in part:

> ***
>
> (D)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.

We determined that 26 services lacked documentation to support that the service billed had been rendered. Findings were identified for the amount reimbursed to the Provider for services which lacked proper documentation ($456.56) and were used in calculating the findings for the sampled population.

Incorrectly Billed Units of Service

Ohio Adm.Code 5101:3-1-17.2(D) states in pertinent part:

> ***
>
> (D)To Maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions.

We compared the units of service billed for saline, injectable medications, and intravenous administration of medication to the units documented in the patient medical records. In 84 instances, we found the units documented in the medical records were less than the number of units billed by the Provider.

Findings were calculated by taking the difference between the amount reimbursed to the Provider for the number of units billed and the Medicaid maximum allowed charge for the number of units documented in the patients' medical records. The total of this amount ($2,579.59) was used in calculating the findings for the sampled population.

Unsupported Level of Evaluation and Management Service Billings

Ohio Adm.Code 5101:3-4-06(A)(2) and (B) state in part respectively:

> (A)Definitions pertaining to physician visits.
>
> ***
>
> (2) A "physician visit" or an "evaluation and management (E&M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient…
>
> ***
>
> (B) Providers must select and bill the appropriate visit (E&M service level) code in accordance with the code definitions and the CPT instructions for selecting a level of E&M service.

The American Medical Association (AMA) defines CPT codes that are used to bill for medical services. E&M office visit services for new patients are billed using CPT codes 99201 through 99205; while E&M office visit services for established patients are billed using CPT 99211 through 99215. For new patient E&M services the provider must perform all three key

components – examination, medical decision making, and history. For established patient E&M services, the provider has to perform at least two of the key components.

The Provider was paid $23,861.67 for E&M office visits. We found the level of service billed for 12 of the E&M sampled services was not supported by the documentation in the patients' medical records. We recoded these services to the level supported by the medical documentation and took the difference between the amount paid for the service billed and the maximum Medicaid payment allowed for the recoded level of service. These differences ($172.27) were used in calculating findings for the sampled population.

Incorrectly Coded Chemotherapy Medication

Our review of medical records showed that in seven (7) instances the Provider administered chemotherapy medication to patients but, based on CMS' HCPCS guide, billed an incorrect code for the medication. For example, in one instance, the Provider administered Anzemet (HCPCS J1260) but billed for Kytrial (HCPCS J1626), which receives a higher reimbursement.

In two of the seven instances, the erroneous billings did not lead to an incorrect reimbursement; however, in the other five instances, the erroneous billings led to the Provider being reimbursed more than the Medicaid maximum allowed charge for the correct HCPCS codes. Therefore, we identified a finding for the difference ($2,235.04). This overpayment was used in calculating findings for the sampled population.

Summary of Sample Findings

Overall, we took exception with 127 of 1,202 statistically sampled recipient services (72 of 163 recipient dates of service) from a stratified random sample of the Provider's population of paid services (which excluded services associated with Medicare co-payments and services extracted for 100 percent review). Based on this error rate we calculated the Provider's correct payment amount for this population, which was $642,520, with a 95 percent certainty that the actual correct payment amount fell within the range of $611,202 to $657,282.34 (+/- 4.87 percent). We then calculated audit findings repayable to ODJFS by subtracting the projected correct population amount ($642,520) from the amount paid to the Provider for this population ($662,813.45), which resulted in a finding of $20,293.45. A detailed summary of our statistical sample and projection results is presented in Appendix I.

Results of Exception Testing

Our exception testing consisted of a 100 percent review of all services identified by our duplicate or exception tests as having potential overpayments. These services included duplicate payments; the refilling and maintenance of implantable pumps or reservoirs for drug delivery services (CPT code 96530); and therapeutic, prophylactic or diagnostic injections (CPT codes 90782 and 90784).

Incorrectly Billed Flushing of Implantable Pumps

AMA's Principles of CPT Coding Third Edition states in part:

> Code 96520 is used to report refilling and maintenance of a portable pump. Code 96530 describes refilling and maintenance of an implantable pump or reservoir for systemic drug delivery, to specifically identify drug delivery systems that include intravenous, intra-arterial drug delivery. Neither of these codes is to be used to report the accessing and flushing of a pump or catheter.

For 21 recipients (599 services), the Provider erroneously billed code 96530 (refilling and maintenance of implantable pump or reservoir for drug delivery) for heparin flushes of patient ports being used for chemotherapy administration and blood draws. In accordance with AMA coding guidance, code 96530 is not the correct code to bill under these circumstances.

Because CPT 96530 is not the correct code to bill for the accessing and flushing of patient ports, and because no other appropriate Medicaid billing code is available, we disallowed 100 percent of the reimbursement for the Provider's billings of CPT 96530 and identified a finding of $15,796.92.

Incorrectly Billed Administration of Injections

Ohio Adm.Code 5101:3-4-13 (A)(4) states, in pertinent part:

> Reimbursement for therapeutic, prophylactic or diagnostic injections ranging from code 90782 to 90788 will be made only when billed with an injection code (J code) and no other service is rendered by the same provider on that day. Reimbursement is considered bundled into the payment made for an evaluation and management service (visit) or other physician service billed on the same date by the same provider.

The Provider billed and was reimbursed for CPT 90782 (Therapeutic, prophylactic or diagnostic injection; subcutaneous or intramuscular) and 90784 (Therapeutic, prophylactic or diagnostic injection; intravenous) in conjunction with other physician services on the same date of service. The reimbursement for 147 injection administration codes was disallowed because the code was billed in conjunction with other physician services (136) on the same day; and/or the code was billed without an accompanying injection code. Total findings of $1,248.06 were identified.

Duplicate Payments

Ohio Adm.Code 5101:3-1-17.2 states in pertinent part that by signing an agreement to provide Medicaid services, a provider certifies and agrees to:

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

***

Our testing identified five patients where, on seven occasions, the Provider billed and was paid twice for identical services on the same date of service. Therefore, a finding of $978.74 was identified for the duplicated payments.

Exception Test Findings

Total combined findings of $18,023.72 resulted from our 100 percent exception testing, which included $15,796.92 in findings for reimbursements for services billed with CPT code 96530; $1,248.06 in findings for incorrectly billed injection administration codes; and $978.74 from duplicate payments.

Summary of Findings

A total of $38,317.17 in findings was identified. These findings result from the combination of our statistical sample results ($20,293.45) and our 100 percent exception testing results ($18,023.72).

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on November 17, 2005 to afford an opportunity to provide additional documentation or otherwise respond in writing.

A post audit conference was held with the Provider on January 12, 2006 to discuss the findings. At this time the Provider also submitted additional documentation which was used to adjust the audit findings.

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APPENDIX I

Summary of Statistical Sample Record Analysis for Renu Soni, M.D.
For All Paid Services Excluding Exception Tests and Medicare Co-payments
For the period April 1, 2001 through March 31, 2004

Description	Audit Period April 1, 2001 – March 31, 2004
Type of Examination	Stratified Statistical Random Sample of RDOS
Description of Population	All paid Medicaid services excluding Services involved with Medicare cross-over payments or the 100 percent exception tests
Number of Population Recipient Dates of Service (RDOS)	1,055
Number of Population RDOS Sampled	163
Number of Population Services Provided	6,182
Number of Population Services Sampled	1,202
Total Medicaid Amount Paid For Population	$662,813.45
Actual Amount Paid for Population Services Sampled	$183,893.70
Projected Correct Population Payment Amount	$642,520
Upper Limit Correct Population Payment Estimate at 95% Confidence Level	$657,282.34[5]
Lower Limit Correct Population Payment Estimate at 95% Confidence Level.	$611,202
Precision of Correct Population Payment Amount at 95% Confidence Level	$31,318 (4.87%)
Projected Overpayment Amount (Finding) = Total Medicaid Amount Paid for Population Services – Projected Correct Population Payment Amount	$20,293.45

[5] Upper Limit Correct Population Payment set to actual population payment amount less actual overpayments observed in sample services reviewed.

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RENU SONI, M.D.

SENECA 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