DEEPAK RAHEJA, M.D. dba D. RAHEJA, M.D., INC.
CUYAHOGA COUNTY

MEDICAID COMPLIANCE EXAMINATION REPORT

FOR THE PERIOD JANUARY 1, 2011 THROUGH DECEMBER 31, 2012

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DEEPAK RAHEJA, M.D. DBA D. RAHEJA, M.D., INC.
CUYAHOGA COUNTY

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INDEPENDENT AUDITOR'S REPORT ON COMPLIANCE WITH REQUIREMENTS OF THE MEDICAID PROGRAM APPLICABLE TO PHYSICIAN SERVICES

Deepak Raheja, M.D. dba D. Raheja, M.D., Inc.
2307 West 14th Street
Cleveland, Ohio 44113

RE: Medicaid Provider Numbers 2796283 and 0927395

Dear Dr. Raheja:

We examined your (the Provider) compliance with specified Medicaid requirements for provider qualifications and service documentation related to the provision of physician services during the period of January 1, 2011 through December 31, 2012. We tested service documentation to verify that there was support for the date of service and the procedure code paid by Ohio Medicaid. We also examined your provider qualifications. The accompanying Compliance Examination Report identifies the specific requirements examined.

Provider's Responsibility

The Provider entered into an agreement with the Ohio Department of Medicaid to provide services to Medicaid recipients (the Provider Agreement). The Provider Agreement outlines the responsibility to adhere to the terms of the agreement, state statutes and rules, federal statutes and rules, and the regulations and policies set forth in the Medicaid Handbook including the duty to maintain records supporting claims for reimbursement made by Ohio Medicaid. Therefore, the Provider is responsible for complying with the requirements and laws outlined by the Medicaid program.

Auditor's Responsibility

Our responsibility is to express an opinion and report on the Provider's compliance with the specified Medicaid requirements based on our examination. Our examination was performed under our authority in Section 117.10 of the Ohio Revised Code and conducted in accordance with the American Institute of Certified Public Accountants' attestation standards and, accordingly, included examining, on a test basis, evidence supporting the Provider's compliance with those Medicaid requirements and performing such other procedures as we considered necessary in the circumstances. We believe our examination provides a reasonable basis for our opinion. However, our examination does not provide a legal determination on the Provider's compliance with the specified Medicaid requirements.

Internal Control Over Compliance

The Provider is responsible for establishing and maintaining effective internal control over compliance with the Medicaid requirements. We did not perform any test of the internal controls and we did not rely on the internal controls in determining our examination procedures. Accordingly, we do not express an opinion on the effectiveness of the Provider's internal control over compliance.

Basis for Qualified Opinion

Our examination disclosed that all 186 developmental screens tested contained errors including eight with no supporting documentation and 178 services in which there was no interpretation and report as is required for this service.

Qualified Opinion on Compliance

In our opinion, except for the effects of the matters described in the Basis for Qualified Opinion paragraph, the Provider has complied, in all material respects, with the aforementioned requirements pertaining to provider qualifications, service documentation, and service authorization for the period of January 1, 2011 through December 31, 2012.

Our testing was limited to the specified Medicaid requirements detailed in the Compliance Examination Report. We did not test other requirements and, accordingly, we do not express an opinion on the Provider's compliance with other requirements.

We found the Provider was overpaid by Ohio Medicaid for services rendered between January 1, 2011 and December 31, 2012 in the amount of $3,636.81. This finding plus interest in the amount of $184.26 totaling $3,821.07 is due and payable to the Ohio Department of Medicaid (ODM) upon ODM's adoption and adjudication of this examination report. When the Auditor of State identifies fraud, waste or abuse by a provider in an examination,[1] any payment amount in excess of that legitimately due to the provider will be recouped by ODM through its Fiscal Operations, the state auditor, or the office of the attorney general. Ohio Admin. Code § 5160-1-29(B)

This report is intended solely for the information and use of the Ohio Department of Medicaid, the Medicaid Fraud Control Unit of the Ohio Attorney General's Office, the U.S. Department of Health and Human Services/Office of Inspector General, and other regulatory and oversight bodies, and is not intended to be, and should not be used by anyone other than these specified parties. In addition, copies are available to the public on the Auditor of State website at www.ohioauditor.gov.

Dave Yost
Auditor of State

November 14, 2014

[1] "Fraud" is an intentional deception, false statement, or misrepresentation made with the knowledge that the deception, false statement, or misrepresentation could result in some unauthorized benefit to oneself or another person. "Waste and abuse" are practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business, or medical practices; and that constitutes an overutilization of Medicaid covered services and result in an unnecessary cost to the Medicaid program. Ohio Admin. Code § 5160-1-29(A)

COMPLIANCE EXAMINATION REPORT FOR DEEPAK RAHEJA, M.D., INC.

Background

Title XIX of the Social Security Act, known as Medicaid, provides federal cost-sharing for each state's Medicaid program. The rules and regulations that providers must follow are specified in the Ohio Administrative Code and the Ohio Revised Code. The fundamental concept underlying 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. *See* Ohio Admin. Code § 5160-1-01(A) According to Ohio Admin. Code § 5160-1-17.2(D), Medicaid providers must "maintain all records necessary and in such form so as to fully disclose the extent of services provided and significant business transactions" for a period of six years or until any audit initiated within the six year period is completed. Providers must furnish such records for audit and review purposes. Ohio Admin. Code § 5160-1-17.2(E)

Dr. Raheja identified his specialty as neurology and described his practice as providing neurological services, pain management services, pediatric services, electroencephalogram (EEG) testing, electromyography (EMG) testing, and vagus nerve stimulation therapy. During the examination period, the Provider furnished physician services to 300 Medicaid recipients and received total reimbursement of $129,113.29 for 2,303 services rendered on 455 dates of service. From the total of paid services, there were 337 drug screens, totaling $28,117.66, rendered to 142 recipients; 342 developmental screens, totaling $3,027.63, rendered to 141 recipients; and 703 evaluation and management services (procedure codes 99204 and 99214 only), totaling $45,285.82, rendered to 271 recipients.

Ohio Medicaid recipients may be eligible to receive physician services provided by an individual currently licensed under the laws of Ohio or of another state to practice as a doctor of medicine and surgery or as a doctor of osteopathic medicine and surgery. A physician visit or an evaluation and management service is an encounter by a physician for the purpose of medically evaluating or managing the patient. See Ohio Admin. Code § 5160-4-01

Purpose, Scope, and Methodology

The purpose of this examination was to determine whether the Provider's Medicaid claims for reimbursement complied with Ohio Medicaid regulations. Please note that all rules and code sections relied upon in this report were those in effect during the examination period and may be different from those currently in effect.

The scope of the engagement was limited to Current Procedural Terminology (CPT) code 80101: drug screen, qualitative; multiple drug classes chromatographic method, each procedure; CPT code 96110: developmental screening, with interpretation and report, per standardized instrument form; CPT code 99204: office or other outpatient visit for the evaluation and management of a new patient which requires three key components; and, CPT code 99214 office or other outpatient visit for the evaluation and management of an established patient which requires at least two of three key components, that the Provider rendered to Medicaid recipients and received payment during the period of January 1, 2011 through December 31, 2012.

We received the Provider's claims history from the Medicaid Management Information System (MMIS) and the Medicaid Information Technology System (MITS) database of services billed to and paid by Ohio's Medicaid program. We removed any voids, services paid at zero, and services with third-party or Medicare co-payments. From the remaining sub-population we extracted all procedure code 80101 (drug screen) services and selected a simple random sample of these services, all

procedure code 96110 (developmental screen) services and selected a simple random sample of these services, and all procedure code 99204 and 99214 (evaluation and management) services and selected a simple random sample of these services to facilitate a timely and efficient examination of the Provider's services as permitted by Ohio Admin. Code § 5160-1-27(B)(1).

An engagement letter was sent to the Provider August 7, 2014 setting forth the purpose and scope of the examination. An entrance conference was held on August 26, 2014. During the entrance conference the Provider described its documentation practices and processes for submitting billing to the Ohio Medicaid program. Our fieldwork was performed following the entrance conference.

Results

We reviewed a statistical sample of 213 drug screens and identified eight errors resulting in an overpayment of $609.18. We also reviewed a statistical sample of 186 developmental screens and identified 186 errors. We identified an overpayment of $3,027.63, or 100 percent of all developmental screen reimbursements during our examination period. Finally, we reviewed a statistical sample of 67 evaluation and management services and identified no errors.

A. Provider Qualifications

Ohio Admin. Code § 5101:3-4-01(A)(1) states that a physician is an individual currently licensed under state of Ohio law or under another state's law to practice medicine and surgery or osteopathic medicine and surgery.

We verified through the Ohio e-License Center that the Provider was a doctor of medicine licensed by the State Medical Board of Ohio and that the license was in active status during our examination period.

B. Service Documentation

Medicaid providers are required to keep records that establish medical necessity and disclose the type, extent, and level of service rendered to Medicaid recipients according to Ohio Admin. Code § 5101:3-1-27(A). Ohio Admin. Code § 5101:3-4-06(B) states providers must select and bill the appropriate code. In addition, Ohio Admin. Code § 5101:3-4-25(A) states that the department will reimburse physicians for laboratory procedures that are necessary in the treatment of a patient's condition in accordance with Chapter 5101:3-11 of the Administrative Code.

Statistical Sample Drug Screens

The Provider described its process for drug screens which included a contract with Forensic Laboratories, now known as Rocky Mountain Tox, LLC, (the Lab). The Provider purchased specimen collection cups from the Lab. An employee of the Lab was present at the Provider's office during office hours and collected specimens from the Provider's patients. The Lab employee obtained a quick screen result from the specimen and submitted the results to the Provider. The Provider billed Medicaid for these screens. The Lab employee then sent the specimen to the Lab for a predefined profile of tests to be performed and the Lab reported the results to the Provider. It appears as though tests were ordered by the Provider based on a contractual predefined profile rather than the medical need of each patient. In addition, Dr. Raheja disclosed to us that prior to the entrance conference he went through his electronic records (the Provider transitioned from paper records to electronic records during our examination period) and deleted the quick screen results so that in the event the records were sent to another physician they would not be included. This resulted in no evidence that the screens were performed; however, this only impacted one service in our sample.

Our review of 213 drug screens in the statistical sample found seven services in which there was no documentation in the service record indicating a drug screen was performed and one service in which there were no results of the drug screen performed. These eight errors resulted in an overpayment of $609.18.

Statistical Sample Evaluation and Management Services

Covered services for evaluation and management encounters are billed based on the complexity of the medical decision making component of the service rendered within a range of four billing codes. We limited our examination to ensuring documentation was present for services rendered and that the documentation generally supported the service but we did not evaluate the accuracy of the billing code used.

The Provider stated he identifies the procedure code to be billed for each patient visit and he codes the service based on the number of diagnoses.

We reviewed documentation for 67 evaluation and management services to verify it supported the date of service billed to and paid by Ohio Medicaid. We found no exceptions with the components of the service documentation examined. The Provider stated that he started using electronic health records during 2012; however, he did not sign the electronic health record progress notes until a few days prior to our field review.

Statistical Sample Developmental Screens

CPT Code 96110 is defined as developmental screening, with interpretation and report, per standardized instrument form. Ohio Admin. Code § 5101:3-4-06(C) requires that for the reimbursement of physician services provided to a patient in a physician's office, a professional medical group office or a fee-for-service clinic, the provider must bill the appropriate code listed in the CPT.

The Provider used a self-administered instrument that was completed by each patient and the same assessment was performed on every appointment for many patients. The Provider sometimes noted the score from the assessment, but we saw no interpretation and report for the self-administered instrument.

Our review of 186 developmental screens found 8 services with no documentation and 178 services in which there was no interpretation and report of the screen. Based on the errors found in 100 percent of screens tested, we identified an overpayment of $3,027.63 for all developmental screens reimbursed by Ohio Medicaid during our examination period.

Recommendation

The Provider should ensure that an interpretation and report is present for every developmental screen billed to Ohio Medicaid as CPT code 96110. In addition, the Provider should review its practice for ordering drug screens and ensure only medically necessary services are ordered for each patient. Finally, the Provider should ensure electronic medical records are complete and accurately document all services performed. The Provider should address the identified issues to ensure compliance with Medicaid rules and avoid future findings.

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DEEPAK RAHEJA MD

CUYAHOGA 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
JANUARY 20, 2015

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.ohioauditor.gov