Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Provider Reimbursements Made to Ki Hwan Lee, M.D., Inc.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

January 20, 2004

Ki Hwan Lee, M.D., Inc.
421 South Burnett Road
Springfield, OH 45505

Re: Audit of Ki Hwan Lee, M.D., Inc.
Medicaid Provider Number: 0298066

Dear Dr. Lee:

We have completed our audit of selected medical services rendered to Medicaid recipients by Dr. Lee for the period October 1, 1999 through September 30, 20002. We identified $18,082.84 in findings, which must be repaid to the Ohio Department of Job and Family Services (ODJFS). A "Provider Remittance Form" is included at the back of this report for remitting payment. The attached report details the basis for findings.

Please be advised that in accordance with Ohio Rev.Code 117.28 and 131.02, if payment 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, Fraud and Investigative Group at (614) 466-4858.

Sincerely,

Betty Montgomery

Betty Montgomery
Auditor of State

88 E. Broad St. / P.O. Box 1140 / Columbus, OH 43216-1140
Telephone: (614) 466-4514 (800) 282-0370 Fax: (614) 466-4490
www.auditor.state.oh.us

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ACRONYMS USED IN THIS REPORT

CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCCA	Health Care and Contract Audit Section
M.D.	Medical Doctor
MMIS	Medicaid Management Information System
OAC	Ohio Adm.Code
ODJFS	Ohio Department of Job and Family Services
OMPH	Ohio Medicaid Provider Handbook
ORC	Ohio Rev.Code

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SUMMARY OF RESULTS

The Auditor of State audited Medicaid payments made to Ki Hwan Lee, M.D. Inc. (hereafter called the Provider), Provider # 0298066, doing business at 421 South Burnett Road; Springfield, OH 45505. 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 $18,082.84. The findings were based on reimbursements that did not meet the rules of the Ohio Medicaid Provider Handbook (OMPH) and the Ohio Adm.Code.

BACKGROUND

Title XIX of the Social Security Act, known as 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, which is jointly funded by federal and state government, 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 Adm.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 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) defines "waste and abuse" 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 calculate the amount of any finding resulting from non-compliance. The Ohio Medicaid program lists the Provider as an individual physician who specializes in providing obstetrical and gynecological services.

Following a letter of notification, we held an entrance conference with the Provider on May 1, 2003 to discuss the audit objectives. The scope of our audit was limited to claims for which the Provider rendered services to Medicaid patients and received payment during the period of October 1, 1999 through September 30, 2002. The Provider was reimbursed $940,645.92 for 12,895 services rendered on 9,208 recipient dates of services during the audit period. A recipient date of services is defined as all services received by a particular recipient on a specific date.

We used the Ohio Adm.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. The Provider bills services using the five (5) digit Current Procedural Terminology (CPT)[2] coding system or ODJFS local level codes[3].

Prior to beginning our field work, we performed computerized tests on the Provider's payment data to determine:

- If reimbursements were made for services to deceased recipients.
- Whether urinalysis services were billed in conjunction with antepartum visits.
- Whether any services had been potentially duplicate billed and paid.
- Whether evaluation and management (E&M) office visit codes had been billed in combination with surgical procedures on the same date of service.
- Whether any new patient E&M codes had been billed for patients who had received professional services from the Provider within the previous three years.

No exceptions were identified for services billed for deceased recipients or for urinalysis services billed in conjunction with antepartum visits. Potential invalid service codes or service code combinations were identified by the other three computer tests. The service codes identified by these tests were selected for 100 percent verification during our subsequent fieldwork.

To facilitate an accurate and timely audit, we divided the Provider's payments into six groups for examination during our fieldwork. The first three groups comprised the services with potential

[2] The CPT is published by the American Medical Association (AMA) for the purpose of providing a uniform language to describe medical services.

[3] Local level codes are published in the Ohio Medicaid Providers Handbook.

exceptions identified by our computer testing. We performed a 100 percent review of these billings:

- E&M office visit codes billed with surgical procedures on the same date of service.
- New patient E&M codes billed for patients who had received professional services from the Provider within the previous three years.
- Potentially duplicate billed and paid service identified by our preliminary computer analysis.

The remaining three payment groups contained all other services rendered by the Provider. We selected and reviewed statistically random samples from these groups as follows:

- A simple random sample of 60 delivery services taken from the 534 delivery services where postpartum care was included in the amount paid for delivery.
- A simple random sample of 37 recipient dates of service (71 services) selected from the 407 recipient dates of service (793 services) where an E&M office visit was billed in conjunction with a Depo-Provera injection.
- A stratified random sample of 63 remaining recipient dates of service (103 services) pulled from the 8,779 recipient dates of service (12,059 services) not already selected for review.

During our field work, we observed incorrect billings for postpartum services for recipients where a delivery service code inclusive of postpartum care had been billed. As a result of our observation, an additional computer analysis was performed of the Provider's billings for code X1453, a gynecological examination performed by a physician. We extracted all patient records when the Provider billed code X1453 with a primary or secondary diagnosis of routine postpartum care, and when the service was performed four to six weeks after a paid delivery service inclusive of postpartum. A separate finding was made for the X1453 services identified by this analysis and these services were backed out of the statistical samples and associated payment groups to avoid double counting of the findings.

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

FINDINGS

We identified and projected findings of $14,554.04 for the services examined in the three statistical samples. These findings were in three categories:

- E&M codes billed in conjunction with a Depo-Provera injection where the level of E&M code billed was not supported by documentation in the patient's medical record.

- E&M codes billed by the Provider that were not supported by the level of service documented in the patients' charts from the sample of all other remaining recipient dates of service.

- Recipients for which delivery codes inclusive of postpartum care were billed, but for which there was no documentation to show that postpartum care was provided.

Our extended analysis of inclusive delivery codes billed in conjunction with code X1453 (gynecological exam) identified findings of $3,484.80.

Our computerized analyses of the Provider's billing records identified findings of $44.00 for a duplicated service. No exceptions were identified in our other 100 percent reviews of (1) E&M codes billed with surgical procedures on the same date of service and (2) new patient E&M codes billed for patients who received professional services from the provider within the prior three years.

Together, our computer exception testing and statistical samples identified $18,082.84 in findings. The circumstances leading to these findings are discussed below.

Unsupported Billings for Level of E&M Services

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

> 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 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 descriptors for levels of E&M services recognize seven components, six of which are used in defining the levels of E&M services. These components are:

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

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

The key components[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 higher the level of service billed and the more a provider is reimbursed. E&M services for new

[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.*

patients are billed using CPT codes 99201 through 99205; while E&M services for established patients are billed using CPT 99211 through 99215.

We found, in our sample of E&M services billed on the same date of service as a Depo-Provera injection, that the level of service billed for 26 of 71 E&M services performed, involving 26 separate recipient dates of service, was not supported by the level of service documented in the patient's medical record or by the required components established for the CPT code. Specifically, the Provider was billing 99212 in conjunction with an injection for a Depo-Provera shot. In order for providers to be reimbursed for 99212, they must perform at least two of the three key components:

- a problem focused history;
- a problem focused examination; and
- straightforward medical decision making.

A review of the patient records did not indicate that any of these key components took place. In fact, the only notes made in the patient records were that a Depo-Provera injection was administered. Therefore, we reduced the payment amount for the evaluation and management services to that due the lower level CPT 99211 code. A finding was made for each of these services for the difference in amount paid for a CPT 99211 versus a CPT 99212.

The overpayments identified for 26 recipient dates of service in our sample were projected across the total payment group population of recipient dates of service where E&M codes were billed in conjunction with Depo-Provera injections. This resulted in a projected overpayment amount of $3,308.91 with a 95 percent certainty that the true population overpayment lies between an upper limit of $4,024.71 and a lower limit of $2,593.11 -- a precision of plus or minus $715.80 (21.6 percent.) Since the precision percentage achieved was greater than our procedures require for use of a point estimate, a finding was made for $2,593.11, the lower limit overpayment estimate amount. This allows us to say that we are 97.5 percent certain that the population overpayment amount is at least $2,593.11. See Appendix II.

Additionally, we identified one service out of 103 in our sample of all other recipient dates of service in which the Provider billed for a CPT 99213 E&M service that was not supported by the documentation in the patient's chart. The information in the medical chart supported that the patient had visited the doctor, but did not support that any of the three key components of medical history, medical examination or medical decision making had been performed. This service was reduced to a CPT 99211 service and a finding of $20.92 was identified for the difference in the amount payable for the two service codes.[5]

[5] *An error projection was not used for this sample because the single error found produced sample projection results that were outside the limits required by our procedures. Consequently, a finding was only made for $20.92, the actual error amount found in our sample.*

Unallowable Billings for Delivery Codes and Postpartum Care

Ohio Adm.Code 5101:3-4-08(E)(4) states[6]:

> For the reimbursement of CPT codes 59410, 59430, 59515, 59614, or 59622, the provider must render an evaluation and management service four to six weeks post-delivery.

From our sample of 60 delivery code services that were inclusive of postpartum services (CPT codes 59410, 59515, 59614 and 59622), we determined that the Provider did not perform the required postpartum service for 22 of the 60 delivery services (36.7 percent) examined. In these instances, we reduced the delivery code billed, which included postpartum care, to the corresponding non-inclusive delivery code (59409, 59514 and 59612) and made a finding for the difference.

Findings for Delivery Services and Postpartum Care

The payment amount for the 22 delivery services in our sample where the inclusive postpartum service was not performed were reduced to the amount corresponding to the same delivery service without postpartum care. The adjusted or audited payment for the services in our sample was then projected to the total population of delivery services with inclusive postpartum services. The resulting audited population payment amount was then subtracted from the actual population payment amount to arrive at the estimated amount that the provider had been overpaid for delivery services where the inclusive postpartum service had not been performed. The projected audited population reimbursement of $354,961 has a 95 percent certainty that the actual correct payment amount fell within the range of $350,069 to $359,854, a precision of $4,893.00 (1.38 percent.) The projected correct population amount of $354,961 when subtracted from the actual population payment amount of $366,901.01 resulted in a projected finding of $11,940.01. See Appendix III.

Additional Findings for Gynecological Exams Billed in Conjunction with Delivery Services

In reviewing the patient medical records to determine whether a postpartum service was rendered, we identified another 30 delivery services (50 percent of the 60 sampled) where the Provider was reimbursed for a delivery inclusive of postpartum care *and* a separate gynecological exam (code X1453) containing a diagnosis of routine postpartum care and performed four to six weeks after delivery. We determined that code X1453 service was not different than what would normally be provided in a postpartum service. This led us to perform an additional computerized exception analysis in which we identified 72 instances, including the 30 found in our sample, where the Provider had been reimbursed for both code X1453 with a diagnosis of routine postpartum care within four to six weeks after delivery, and a delivery service inclusive of postpartum care (CPT codes 59410, 59515, 59614 and 59622). Because the delivery code included the postpartum service, we allowed the inclusive delivery service codes but took exception with the reimbursement for the 72 code X1453 services, which resulted in an

[6] *Ohio Adm.Code 5101:3-4-08 (E)(4) is now OhioAdm.Code 5101:3-4-08 (E)(5), effective July 1, 2003.*

additional finding of $3,484.80[7].

Duplicate Payment

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

During our field audit, we audited instances where our computer analyses had identified that two or more claims were filed and paid for the same procedure code, the same recipient, the same payment amount and the same date of service. One duplicate claim was identified totaling $44.00.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on November 14, 2003 to afford an opportunity to provide additional documentation or otherwise respond in writing. A response from the Provider's Office Manager dated December 3, 2003 disagreed with our findings for delivery service billings inclusive of postpartum care when post partum care was not provided four to six weeks after delivery. She stated the rules do not state that the postpartum portion of the reimbursement should be repaid if the patient does not return for her four to six week post partum visit. Moreover, she said post partum services were provided three or four days after delivery. Based on our interpretation of the Ohio Adm.Code, we do not agree that services provided shortly (three to four days) after delivery qualify as post partum services. Therefore, we did not change our findings on this matter. With regard to other findings identified by our report, the Office Manager said they had corrected the way they were billing.

7 *These 72 services were backed out of our samples and their associated payment groups to prevent double counting of finding results.*

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APPENDIX I

Summary of Findings Results for: Ki Hwan Lee, M.D., Inc.
For the period October 1, 1999 to September 30, 2002

Description	Audit Period: October 1, 1999 to September 30, 2002
Unsupported Level for Evaluation and Management Services: ➢ Evaluation and Management Codes Billed In Conjunction With a Depo-Provera Injection – $2,593.11 (projected amount) ➢ All Other Non Sampled Services – $20.92 (actual amount)	$2,614.03
Delivery Codes and Postpartum Care (projected amount)	$11,940.01
Amount paid for X1453 Services Billed 22-56 Days After An Inclusive Delivery Code (Routine Postpartum Listed as Diagnosis)	$3,484.80
Duplicate Payment	$44.00
TOTAL FINDINGS	**$18,082.84**

APPENDIX II

E&M Codes Billed In Conjunction with a Depo-Provera Injection
Summary of Sample Record Analysis for: Ki Hwan Lee, M.D., Inc.
For the period October 1, 1999 to September 30, 2002

Description	Audit Period October 1, 1999 – September 30, 2002
Type of Examination	Statistical Simple Random Sample of 37 Recipient Dates of Service
Number of Population Recipient Date of Services	407
Number of Population Services Provided	793
Total Medicaid Amount Paid For Population of E&M Codes Billed in Conjunction with a Depo-Provera Injection	$32,315.16
Number of Recipient Date of Services Sampled	37
Number of Services Sampled	71
Amount Paid for Services Sampled	$2,921.88
Point Estimate of Amount Overpaid at 95% Confidence Level	$3,308.91
Upper Limit Overpayment Estimate at 95% Confidence Level	$4,024.71
Lower Limit Overpayment Estimate at 95% Confidence Level	$2,593.11
Precision	$715.80 (21.6%)

Source: AOS review of MMIS data and Provider Medical Records

APPENDIX III

Delivery Codes Including Postpartum Care
Summary of Sample Record Analysis for: Ki Hwan Lee, M.D., Inc.
For the period October 1, 1999 to September 30, 2002

Description	Audit Period October 1, 1999 – September 30, 2002
Type of Examination	Statistical Simple Random Sample of 60 Delivery Services
Number of Population Services Provided	534
Total Medicaid Amount Paid For Population of Delivery Codes Inclusive of Postpartum Services	$366,901.01
Number of Services Sampled	60
Amount Paid for Services Sampled	$41,218.42
Point Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level	$354,961.00
Upper Limit Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level	$359,854.00
Lower Limit Estimate of Audited (Correct) Population Payment Amount at the 95% Confidence Level	$350,069.00
Precision of Estimate at the 95% Confidence Level	$4,893.00 (1.38%)
Point Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($366,901.01) – Point Estimate of Correct Population Payment Amount of $354,961.00)	$11,940.01
Upper Limit Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($366,901.01) – Lower Limit Estimate of Correct Population Payment Amount of $350,069.00)	$16,832.01
Lower Limit Estimate of Population Amount Overpaid at the 95% Confidence Level (Total Actual Medicaid Amount Paid ($366,901.01) – Upper Limit Estimate of Correct Population Payment Amount of $359,854.00)	$7,047.01

Source: AOS review of MMIS data and Provider Medical Records

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AUDITEE 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
Post Office Box 182367
Columbus, Ohio 43218-2367

Auditee Name & Address: Ki Hwan Lee, M.D., Inc.
421 South Burnett Road
Springfield, OH 45505

Auditee Number: 0298066

Audit Period: 10/01/99 – 09/30/02

AOS Finding Amount: $18,082.84

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: Tom Tedeschi, at (614) 728-7398.

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Auditor of State
Betty Montgomery

88 East Broad Street
P.O. Box 1140
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Telephone 614-466-4514
800-282-0370

Facsimile 614-466-4490

KI HWAN LEE, M.D., INC.

CLARK 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, 2004