Auditor of State
Betty Montgomery

Ohio Medicaid Program

Audit of Medicaid Reimbursements Made to Prasad C. Kakarala, M.D.

A Compliance Audit by the:

Fraud and Investigative Audit Group
Health Care and Contract Audit Section

Auditor of State
Betty Montgomery

August 4, 2005

Barbara Riley, Director
Ohio Department of Job and Family Services
Columbus, Ohio 43266-0423

Re: Audit of Prasad C. Kakarala, M.D.
Provider Number: 0391946

Dear Director Riley:

Attached is our report on Medicaid reimbursements made to Prasad C. Kakarala, M.D. for the period April 1, 2000 through March 31, 2003. We identified $80,479.20 in findings that are repayable to the state of Ohio.

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.

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 any final determinations regarding recovery of the potential findings identified herein.

Copies of this report are being sent to Prasad C. Kakarala, 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
HCCA	Health Care and Contract Audit Section
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 Prasad C. Kakarala, M.D. (hereafter called the Provider), Provider #0391946, doing business at 455 W. Market Street, Tiffin, OH 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 $80,479.20 in repayable findings, 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 pertinent 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, if warranted, calculate the amount of any findings due to non compliance. Within the Medicaid program, the Provider is listed as an individual physician in general practice.

Following a letter of notification, we held an entrance conference at the Provider's place of business on June 10, 2004 to discuss the purpose and scope of our audit. The scope of our audit was limited to claims, for which the Provider rendered services to Medicaid patients, not involving Medicare co-payments, and received payment during the period of April 1, 2000 through March 31, 2003. The Provider was reimbursed $744,465.94 for 42,146 services rendered during the audit period.

We used the Ohio Revised Code, the Ohio Administrative Code, and the OMPH as guidance in determining the extent of covered 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 Centers for Medicare and Medicaid Services (CMS).[2.]

Prior to beginning our field work, we performed computerized tests on the Provider's Medicaid payment data to determine if reimbursements were made for services to deceased patients or whether duplicate payments were made for the same recipient on the same date of service. Both of these tests were negative.

During our field work, we noted several apparent systematic errors in the billing practices of the Provider. Consequently, we performed a computerized extraction of all payments involving the following:

- Developmental testing services (CPT code 96110) billed in conjunction with HealthChek services, which also entail developmental assessment.
- Preventative Counseling visits (CPT code 99402) billed in conjunction with other office visit services.

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 (AMA). 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.*

To facilitate an accurate and timely test of the Provider's reimbursements, excluding the developmental and counseling services extracted for special review; we selected a stratified statistical sample of 154 recipient dates of service from the remaining population of 12,895 recipient dates of service. A recipient date of service is defined as all services received by a particular recipient on a specific date.

Our work was performed between April 2003 and May 2005.

RESULTS

We identified and projected findings of $23,911.00 for the services in the sampled population. Additionally, we identified findings of $56,568.20 for services in our exception testing. Together, our findings totaled $80,479.20. The bases for our results are discussed below.

Unsupported Services in Sample

During our review of medical records for statistically selected patient services we found exceptions with the levels at which evaluation and management (E&M) services were billed; and a lack of documentation to verify that certain billed services were performed.

Unsupported Level of Evaluation and Management Service Billings

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

> …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…
>
> 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.

E&M services for new patients are billed using CPT codes 99201 through 99205; while E&M 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 – defined by the American Medical Association (AMA) in its official CPT code book. For established patient E&M services, the provider has to perform at least two of the key components.

The Provider was paid $334,669.88 for E&M office visit services, which comprised 45 percent of the total reimbursement for the audit period.

We found the level of service billed for 14 of the E&M services in our sample was not supported by the documentation in the patients' medical records, or the documentation did not contain the required components established by the AMA.

We determined the difference between the reimbursement for the unsupported level of E&M service and the maximum allowed reimbursement for the level of service supported by the documentation in the patients' medical records. The difference of $230.28 was used in calculating the findings for the sampled population.

Undocumented Medical Services

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

Our review of the medical records for the statistically sampled patients found that 19 services in our sample lacked proper documentation. The medical records reviewed did not contain documentation to verify that the billed services were performed.

The payments ($387.10) for these services were disallowed and were used in calculating the findings for the sampled population.

Summary of Sample Findings

The overpayments identified for 38 of 154 recipient dates of service (51of 756 services) from our stratified statistical random sample were projected across the Provider's total population of paid recipient dates of service. This resulted in a projected overpayment amount of $37,311 with a 95 percent certainty that the true population overpayment fell within the range of $21,344 to $53,277, a precision of plus or minus $15,966. Since the range was greater than our procedures require for use of the point estimate ($37,311), the results were re-stated as a single tailed estimate (equivalent to method used in Medicare audits). This allows us to say that we are 95 percent certain that the population overpayment is at least $23,911.00.

Results of Exception Testing

Unsupported Developmental Testing Services

The Provider was paid $51,192.00 for 2,844 developmental testing services (involving 1,279 patients) billed as CPT code 96110. Medicaid paid the Provider an average of $18.00 each time CPT 96110 was billed. The American Medical Association (AMA) defines CPT 96110 as "Developmental testing; limited (e.g., Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report."

According to the AMA, CPT code 96110 requires interpretive testing and preparation of a written report. The AMA's CPT Assistant newsletter dated July 1996 states "...When reporting these codes, calculate to the nearest full hour the time spent in planning, administering, scoring,

interpreting, and reporting the assessments/tests ... these codes are used to report the services provided during the testing of cognitive function of the central nervous system." The same newsletter also states "This code, reported for limited testing, is generally used as a screening tool to identify children who should receive a more intense diagnostic evaluation or assessment."

The Provider justified billing CPT code 96110 on the basis that he performed a Denver Developmental Test. The Denver Development Test is a formalized developmental test, which meets the requirements of CPT code 96110. This test requires that a specific kit be used and an interpretation and report of the test finding be prepared. Additionally, this test is designed for children six (6) years old and under.

Based the doctor's description of services being provided and our review of patient records, we determined that the Provider did not perform the detailed developmental testing and evaluation required by CPT code 96110. This was confirmed by our sample review of 67 patient medical records, which lacked evidence that a Denver Developmental Test had been performed, or that the requirements for billing CPT code 96110 had otherwise been met.

In addition, although the Denver Developmental Test is designed for children six years old and under, the Provider's claims history showed that 580 of the 1,279 patients with 96110 billings were over age six, including one patient who was 28. While patient records for some of the remaining 699 patients age six and under included a Denver Developmental Pre-Screening (DDST) form, which had been completed by a parent or guardian while waiting for the child to see the Provider, the patient records lacked documentation to support that the doctor had performed subsequent developmental testing and reporting required by CPT code 96110.

We also took exception with the Provider's billings for developmental testing because out of a total of 2,844 CPT code 96110 services, 2,816 services (99 percent) were billed in conjunction with a HealthChek exam (CPT codes 99391-99395 for established patients and CPT codes 99381-99385 for new patients).[3] HealthChek reimbursements (ranging from $44.18 to $64.52 per service) include reimbursement for developmental assessments.

The HealthChek development assessment is defined in Ohio Adm.Code 5101:3-14-03(C):

> (1) A developmental assessment shall be performed or updated at each initial and periodic screening service. The developmental assessment shall include an age-appropriate developmental history and an assessment of the individual's motor, speech, mental, and social development.
> (2) Formal developmental tests that are performed during the screening service will be reimbursed in addition to the "HealthChek" (EPSDT) screening service as described in rule 5101:3-14-04 of the Administrative Code.
>
> ***

[3] An additional two CPT code developmental testing services (CPT code 96110) services were billed for patients aged 28. The remaining 26 services were billed in conjunction with a variety of services including: immunizations, blood tests, clear tone hearing tests and some other E&M codes.

Ohio Adm.Code 5101:3-14-04 (C)(1) states:

> In addition to the "HealthChek" (EPSDT) screening services, the department will reimburse providers for the following services provided during, or as part of, the "HealthChek" (EPDST) screening service.
>
> ***
>
> (c) Formal developmental tests;
>
> ***

Although Ohio Adm.Code 5101:3-14-04 (C)(1)(c) indicates the Provider could have been reimbursed for an additional "formal developmental test", we did not see evidence of formalized testing in patient records, and the Provider's description of the services performed did not include use of a formal developmental test. For example, patient records typically included notations of "G&D", which the doctor stated was used to denote that growth and development were within normal limits. The doctor stated that a growth chart was posted in each examining room to assist this assessment. The doctor also said he assesses a child's musculoskeletal, motor skills and neurological abilities by observing a child reach for a light or stethoscope; and by asking the child to hop on one foot or put a finger to the nose. These types of assessments are normally included in a HealthChek service but lack the formal testing and reporting required by CPT code 96110.

Therefore, because patient records lacked evidence to support that services beyond a general development assessment had been performed, we identified a finding for $51,192.00, which represents the total payment for all developmental testing services billed as CPT code 96110 during our audit period.

Unsupported Preventive Counseling Services

Ohio Adm.Code 5101:3-4-06(A)(1) and (B) state in part, respectively:

> …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…
>
> 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.

CPT code definitions are promulgated by the American Medical Association (AMA).

The Provider billed 156 preventative counseling services using CPT code 99402, which the AMA defines as "**Preventive medicine counseling** and/or risk factor reduction intervention(s)

provided to an individual (separate procedure); approximately 30 minutes." According to the AMA, CPT code 99402 is a type of evaluation and management service.

Code 99402 is further defined by the AMA's description of "Counseling and/or Risk Factor Reduction Intervention (99401-99429) New or Established Patient":

> These codes are used to report services provided to individuals at ***a separate encounter*** *[emphasis added]* for the purpose of promoting health and preventing illness or injury.
>
> Preventive medicine counseling and risk factor reduction interventions provided as a separate encounter will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health and diagnostic and laboratory test results available at the time of the encounter.
>
> These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital or consultation or other evaluation and management codes. . . .

Our analysis of the Provider's records determined the 156 preventive counseling services were not billed as a separate encounter, and were in fact billed in conjunction with services that included a counseling component. In 10 of the 156 billings for CPT 99402, the Provider billed for an evaluation and management office visit (code 99204 and codes 99213 – 99214), and in the remaining 146 instances, the Provider billed for "Periodic comprehensive preventive medicine" services (i.e. HealthChek) using codes 99392 – 99395.

According to the AMA, counseling is one of the seven recognized components included in an evaluation and management service.

Also according to the AMA, codes 99392 through 99395 (HealthChek) are defined as:

> **Periodic comprehensive preventive medicine** reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate immunization(s), laboratory/diagnostic procedures, established patient;

Because the evaluation and management services and the periodic comprehensive preventive medicine services rendered by the Provider already included a counseling component, and the patients' medical records did not document a separately identifiable counseling service, we identified a $5,376.20 finding for the 156 reimbursements for CPT code 99402.

Summary of Overall Findings

Our combined findings from our statistical sample ($23,911.00) and our exception testing ($56,568.20) totaled $80,479.20 for the audit period.

PROVIDER'S RESPONSE

A draft report was mailed to the Provider on May 31, 2005 to afford him an opportunity to provide additional documentation or otherwise respond in writing.

A post audit conference was held with the Provider on June 9, 2005 at which time additional documentation was presented for review. We received the Provider's written response on June 13, 2005, in which he discussed the inability to locate documentation for specific services. Based upon our review of the additional documentation received from the Provider, adjustments were made to the findings for our sample population.

The Provider also discussed developmental testing services in the response stating that for patients under age six (6), he "did not put a copy of the test in the chart" and that he was in error to bill for developmental testing for children over six (6) years of age.

In reference to the finding for preventative medicine counseling services, the Provider stated these services were primarily rendered to patients with Attention Deficit Hyperactivity Disorder (ADHD). However, the Provider admitted he did not document the time spent with the children, nor have a written report of the counseling.

Within the response, the Provider also discussed his planned corrective actions. He stated that developmental testing services for patients over age six will not be billed in the future . He also stated that he has started to document developmental testing by including a written interpretation in the medical chart of patients under age six. Also, he will no longer bill for preventative medicine counseling, although he plans to continue offering the service as a management tool of the ADHD patients. A copy of the Provider's correction action is being sent to ODJFS' Surveillance and Utilization Review Section under separate cover.

APPENDIX I

Summary of Sample Analysis for Prasad C. Kakarala, M.D.
Population: All Paid Services Excluding Exception Tests and Medicare Co-payments
For the period April 1, 2000 through March 31, 2003

Description	Audit Period January 1, 2001 – June 30, 2003
Type of Examination	Statistical Stratified Random Variable Sample
Description of Population	All paid services net of any adjustments and excluding Medicare cross-over payments and exception tests
Number of Population Recipient Date of Services	12,895
Number of Population Services Provided	39,146
Total Medicaid Amount Paid For Population	$699,858.30
Number of Recipient Date of Services Sampled	154
Number of Services Sampled	756
Amount Paid for Services Sampled	$11,404.08
Estimated Overpayment using Point Estimate	$37,311.00
Lower Limit Overpayment Estimate at 95% Confidence Level.	$21,344.00
Upper Limit Overpayment Estimate at 95% Confidence Level.	$53,277.00
Precision of Overpayment Estimate at 95% Confidence Level	$15,966
Single-tailed Lower Limit Overpayment Estimate at 95% Confidence Level (Equivalent to 90% two-tailed Lower Limit used for Medicare audits.)	$23,911.00

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PRASAD C. KAKARALA, 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
AUGUST 4, 2005